Special This Issue

Exploring Recovery through Art

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

Counterpoint

Vol. XXIII No. 4 | From the Hills of Vermont | Free! | Since 1985 | Winter, 2009

Cuts May Be Drastic

EXPLORING RECOVERY THROUGH ART — The culminating project of a one-year grant to reach younger adults with recovery activities was an art show exhibited at the Rutland Farmers' Market. The public voted for winners, and awarded second place to this charcoal sketch, "Purple Haze and Pink Floyd Cemetaerian," by Ryan Goodwin. For more on the role of art in Recovery, see pages 18-21. (Counterpoint Photo: Anne Donahue)

Parents Work To Protect Children From School Restraint, Seclusion

by ANNE DONAHUE
Counterpoint

MONTPELIER — After years of stalemate, parents and child advocates have reached near consensus with the Department of Education on what policies should guide the use of restraint or seclusion for children in schools, several key players have reported.

Many of those involved remain stuck, however, over whether a bill should be pursued in the legislature or whether regulations are the best tool to reach the key goals.

A national report citing even deaths that have resulted from some types of restraints — particularly face down, " prone" restraint — helped create momentum for Vermont parents, according to Sherrie Brunelle of the Disability Law Project.

Although Vermont advocates say only a small number of schools fail to already use best practices, those are of great concern.

"Every time we've ever tried to get data in the state of Vermont, it has been a disaster," she said. Yet those opposed to taking any action argued that there was no data showing that there was a problem in Vermont.

After groundwork during the past two years, however, that barrier appears to have been overcome. Dialogue around the state and findings made under a grant to the Vermont Family Network created a reaction that "we need to do something," according to Claudia

(Continued on page 4)

Hospitals Back Up Into ERs; Police Predict More Crises

by ANNE DONAHUE
Counterpoint

MONTPELIER – *"We're marching towards the edge of a cliff" with the predictions of "drastic reduction in mental health services…We'll see more suicides," more hospital use, and more corrections use.*

"It's a ticking time bomb."

"I believe it's very unethical, [even] *what you had to start with" — let alone massive further cuts.*

"It is outrageous to me and it's very illogical."

Those were just a few of the reactions to news of a potential $12 million cut out of the $55 million budget for Department of Mental Health adult services, described at two meetings in late November.

At the same time, pressure on inpatient services has already resulted in the Vermont State Hospital closing to most referrals from local hospitals, and, as a result, some involuntary patients have been held for days – up to five days in one case – in an emergency room.

"There just isn't enough capacity," Bob Pierattini, MD, Chair of Psychiatry at Fletcher Allen Health Care, told the legislature's Mental Health Oversight Committee in October.

Burlington's Police Chief, Michael Schirling, testified at the committee's November meeting that the system is "more than bulging at the seams, [it has] overflowed onto the street" as a result of "erosion of services…over the last two decades. In order to get someone help, we are perverting the criminal justice system." He said he fears a tragedy will occur if services are not rebuilt.

It is massive new cuts that are more likely in next year's budget, according to Beth Tanzman, Deputy Commissioner, who addressed stakeholders at the Mental Health Transformation Council.

Reaching the $12 million target — a reduction of about 20 percent of the budget — would include cutting a third of the funding for CRT (Community Rehabilitation and Treatment) services for those with severe and persistent mental illnesses. All support to community mental health agencies for outpatient counseling services would be eliminated,

(Continued on page 3)

It's about

YOU

You are needed. These groups need consumer involvement!

Peer Support Leaders

The Depression and Bipolar Support Alliance made the following announcement looking for peer leaders to start new support groups in Vermont:

"Have you ever thought about the power of using your life experience to help others living with depression or bipolar disorder? The Depression and Bipolar Support Alliance makes peer-led support groups available through local chapters to provide people living with mood disorders, and their families, a place to find comfort and connections in a confidential, supportive, positive community. With almost 1,000 DBSA support groups across the country, there are still areas and people that are not being served.

"The first step in starting your support group is to request a free copy of the DBSA start-up materials at www.DBSAlliance.org/sugrequest. If you have questions about leading a peer support group in your community, contact Mary Mischka Dean, Chapter Recruitment Coordinator, at (800) 826-3632 x154 or startup@DBSAlliance.org.

"No special training is required to lead a DBSA group. All you need is a desire to give back, a commitment to helping your peers work toward wellness, and the knowledge that recovery is possible."

Boards and Committees

Statewide Program Standing Committee for Adult Mental Health: The advisory committee of consumers, family members, and providers for the adult mental health system. Second Monday of each month, 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. Contact the Department of Mental Health for more information.

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

Vermont State Hospital Advisory Council: 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. New members welcome. Fourth Monday of each month;.Stanley Hall, State Office Complex, Waterbury, unless otherwise posted

Consumer organization boards:

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

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

Hospital Advisory Groups

Rutland Regional Medical Center
Community Advisory Committee, Monthly meeting, fourth Mondays, noon; December 28; January 25; February 22; March 22; April 26; May 24.

Fletcher Allen Health Care
Program Quality Committee, Monthly meeting, McClain Rm 601A; third Tuesdays, 9-11 a.m., December 15; January 19; February 16; March 16; April 20.

Locations on the Web:

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

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

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New Publishing Schedule:

Counterpoint is returning to a schedule of three issues per year (with larger, 24-page issues) to help meet the state's budget crisis.
The new issues will be:
Spring/Summer (delivered in June; submisson deadline mid-April),
Fall (delivered in September; submission deadline mid-July) and
Winter (delivered in December; submission deadline mid-October.)

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GRAND OPENING — Lamoille County Mental Health Services held an open house and cookout this fall to celebrate a new home and its new name. Now Lamoille Community Connections, it is located at 72 Harrel Street, Morrisville. Another major change will be coming soon for the agency as Executive Director Alexander (Butch Ponzio) retires after 25 years. (Counterpoint Photos: Jean New)

Drastic Cuts

(Continued from page 1)

she said. Another $1.7 million would come from reductions in the $22 million Vermont State Hospital budget.

Tanzman estimated that 2,600 Vermonters would lose mental health services. "We are trying to keep intact the emergency services" and to shift some outpatient funds there to provide for an expected increase in the need for crisis help and to provide brief counseling support, she said.

Responses to the situation were immediate, and included the quotations at the opening of this article from, in order, Julie Tessler of the Council of Developmental and Mental Health Services, a hospital psychiatric unit director at a private meeting, Leslee Tocci of the CRT Council, and Joanna Cole of NAMI-VT.

"I hope it's not as bad as I'm saying," Tanzman said, but the deep loss of state revenues this year – likely also over the next several years – may mean that it will not be before 2014 that the state's income will be back to its 2008 levels.

Several Transformation Council members said that the cutbacks went contrary to the plan for replacing services and closing the state hospital.

"It's 100 percent counter to the Futures plan," which has been "all contingent on the community-based system," said David Fassler, MD.

Tocci added that, "It's very incongruous to me that we would be dumping money into the Futures project" under the circumstances.

Although Tanzman said final determining factors could be different choices by the legislature, including increased taxes, members of the Mental Health Oversight Committee did not express optimism at its meeting just a few days earlier.

"The administration will propose things and we will have to vote on things that will be devastating," Rep. Mike Fisher (D-Lincoln) said.

Sen. Doug Racine (D-Burlington), a candidate for governor, pointed out that "as we cut the budget, we are not saving money…we are shifting it" to other more expensive services.

Police Fear Tragic Outcome

Racine's comments came after lengthy testimony by Schirling, who said he spoke for other police chiefs around the state as well.

He described a situation that is worsening "at an alarming rate" in both frequency and severity, when police have to intervene because people lack the mental health supports to keep them stable.

Schirling said that he sees a need for more inpatient capacity, but, more importantly, that "there is no middle ground." There are not enough of the kinds of supported living programs that make it possible for some people "to manage their lives and live successfully in the community" so that they "don't deteriorate into crisis." The impact of inadequate funding includes the increased risk of those persons being victimized on the street and, in a few instances, escalating to the point of harming others.

"We're fearful that we're on the brink" of a major incident or crime, Schirling said — the type that could cause a public reaction that would bring negative public policy changes.

"We're using the wrong tools" by responding with police, fire, ambulance, and emergency departments at substantially greater costs, which Schirling calculated to be as high as $17,000 per person for high system users over a period of just a few weeks. It stretches police thin and diverts them from their primary work, he said. Mental health intervention "is not what law enforcement is designed to do."

Ed Paquin, Executive Director of Disability Rights Vermont, said that the "erosion of political support for outpatient mental health services...fits well with what you are saying. I hear over and over again...yes, we tried to get mental health services...and we couldn't get them."

Schirling gave both the legislators and the council several recent, dramatic examples of the type of situations his department has been addressing:

- A woman chasing an airplane on the Burlington airport runway; police "had to fight to get her into VSH;" the only alternative to releasing her would have been to charge her with a federal crime;
- A man with a machete, requiring a building evacuation and a police tactical response; he "can't handle the stimulus" of large apartment buildings, "yet he keeps being dropped back into the same situation" after doing well for a few weeks in a more structured setting;
- A man with a history of serious violence and mental illness recently released after 18 years in prison, where he had learned to identify his own urges and told officials he was out looking for a victim to rape and kill, and wanted help. Police were told he had "no acute mental illness that [was] treatable in our hospital."

Patients Left in Emergency Rooms

Commissioner Michael Hartman told the Adult State Standing Committee in October that increased pressure on inpatient care seemed to be occurring because "people are wearing down all their coping mechanisms" during the stressful economic times.

He said that despite requirements that hospitals stabilize and find treatment resources for every patient, "that is certainly not the way that psychiatric care is working." It isn't clear "what we can do to enforce this" since a hospital can't be mandated to admit someone, even if it has empty beds, Hartman said.

Emergency rooms are "becoming accepted" as an alternative to admission when hospitals become "self-protective of their resources…in case [they] get in over [their] head," he said later at a meeting of the VSH Steering Committee. Hartman said that the hospitals "need to be more collaborative with each other."

The legislature's oversight committee heard from hospital representatives on the issue at its October meeting. Admitting patients who are not appropriate for a community hospital's staff and facility capacity is not the answer, even if beds are available, said Jeff McKee, the unit director at Rutland Regional Medical Center.

"At best it degrades the quality of care" for everyone and "at worst [it's] a safety risk."

Adequate safety is "virtually impossible" on a unit with only one common area if there are too many patients with high needs at a time, he said. "There is also a lack of adequate step-down" that creates a backup in discharges, he said.

The perception that there is "capacity that we're not using and wasting" isn't accurate, agreed Pierattini, from Fletcher Allen. Hospitals have no desire to "hold people in the most expensive beds," in emergency rooms.

There are some individuals who are "so discontrolled" that they cannot be admitted to a general hospital psychiatric unit that has no separate staffing or space, without "disrupting the care of everyone else," he said.

He reminded legislators that persons in a psychiatric inpatient setting are "at a low point in their ability to cope" with other stress, and staff have "very limited tools" to control the environment.

In conversations off the record, several hospitals have said that they are, in fact, going to extreme lengths to provide care when needed. Even when the census has gone down at times, "they're not taking new patients" at VSH.

There is pressure to "fill every bed" even when the staff's ability is "at absolute max." Some patients have been placed on regular hospital units or held at hospitals without a psychiatric unit, hospital leadership has said. Despite precautions such as ongoing patient monitoring, this places the hospital itself at significant risk, as well as patients, they have noted.

That includes the risk of being cited by regulators for not providing a sufficiently safe environment of care – an issue that has been raised repeatedly by licensing agencies in the past several years, creating more restrictive patient environments across the state.

CONFLICT OF INTEREST NOTICE: The writer of the articles that report on Mental Health Oversight Committee meetings, Anne Donahue, is a state representative who is also a member of that committee.

Progress on Child Drugs In Dispute

by ANNE DONAHUE
Counterpoint

BURLINGTON – Any appearance of inaction by the state in addressing the prescription of psychotropic medication for children is misleading, according to Department of Mental Health officials. They say there is active work on implementing the recommendations of a work group that met several times last spring.

Those assurances received a strong reaction from Ken Libertoff, Executive Director of the Vermont Association for Mental Health, who has led efforts to demand a state response to the "perceived over-reliance and possible misuse of psychotropic medications for children and adolescents."

"It is hard to believe that in a state like Vermont, 18 months would pass without specific state action on a health care issue as important as this," said Libertoff.

Bill McMains, MD, the department's medical director, said in an interview that the efforts "can't happen fast enough" given even newer research on the risks that anti-psychotic medication present for children.

"This is new knowledge," he said, pointing to a study published in October in the *Journal of the American Medical Association*. "We need to move quickly."

According to an article in *The New York Times*, the study showed that children and adolescents who take the newest generation of antipsychotic medications risk rapid weight gain and metabolic changes that could lead to diabetes, hypertension, and other illnesses.

"The magnitude is stunning," according to one expert interviewed by *The Times*.

An earlier national study showed that overall, almost three-quarters of Medicaid youth receiving antipsychotics were being treated only for conditions for which no FDA (Federal Drug Administration) clinical indication existed.

Vermont rates of psychotropic medications prescribed to children on Medicaid were produced in 2008 after advocacy groups led by the Vermont Association for Mental Health lobbied for access to the data. It showed that 16 percent of all the children were on some type of psychotropic medication. That information led to the formation of Vermont's stakeholder work group last winter.

Given the high percentage of Vermont children on Medicaid, that data "are a good indicator of what the practice is out there" among Vermont providers, McMains said.

In May, Libertoff, along with Lt. Governor Brian Dubie and Senate leader Peter Shumlin (D-Windham) held a press conference to demand state action.

"Since that time, there appears to be little or no progress in dealing with this critical health-care issue," according to Libertoff, who discounted the steps described in an interview by *Counterpoint* with McMains and Charlie Biss, who heads the children's division at DMH.

The work group made five recommendations, and each is being pursued, Biss said.

The recommendation moving forward most quickly is development of "academic detailing" for the drugs, which means providing information to doctors that is based upon best practices rather than by the pharmaceutical companies that market them.

DMH is working with the University of Vermont, which has had "a very active academic detailing program," McMains said.

The child psychiatry department is "very excited" about developing a component on children, and the new fellowship program in child psychiatry will be able to provide direction. Its focus is on minimizing medication in favor of psycho-social interventions.

Hand-in-hand is the followup on monitoring trends in the data. The issue is "what do you do with it" when statistics show a trend.

John Pandiani, head of statistics at DMH, is narrowing data to show which physician groups do more of such prescribing, and that information "can direct the academic detailing" to "get it focused on the people who need it," McMains said.

A third work group recommendation was to have a pediatrician and a psychiatrist on the state's Drug Utilization Board (DUR), which makes recommendations on approval and limitations on drugs prescribed to Medicaid patients.

That was delayed because of a vacancy in the DUR medical director position that has now been filled, Biss said. The plan is to use an existing model from Washington state for using data.

DMH is also being scheduled to meet with the Act 129 committee at BISHCA, the department of state government that has oversight of insurance companies. The Act 129 committee monitors parity enforcement. Under a statute passed last year, managed care companies must do an annual quality improvement initiative on integration of mental health and other medical care.

The work group recommended that DMH approach the private insurers about doing a joint quality project with the state's Medicaid branch on the use of psychiatric medication with children.

The fifth recommendation was to create a link on the DMH web site for family education. Biss said a link has been created to the one source located thus far, a "Facts for Families" web site created by the American Academy for Child and Adolescent Psychiatry.

It is not exactly the kind of information and detail that was the focus of the work group, and Biss said he is continuing to seek out other resources.

Libertoff indicated that he was unimpressed. "The Department of Mental Health and other state agencies seem to think that internal review is sufficient and that public engagement and transparency is unneccesary.

"After months of closed door internal meetings on the subject, several public meetings were held with stakeholders including advocates, parent groups and treatment providers.

"For the last five months, there has been no further communication by the state with the group," he said.

McMains said the department was waiting to have more specific information on the points of progress before meeting with the work group again.

Families Work To Address Retraint, Seclusion in Schools

(Continued from page one)

Pringle, who headed the project.

"We got them on board," Pringle said of the Department of Education. She also believes schools will be pleased with the affirmation that there is "a lot of really good stuff going on in Vermont." It is a small minority of schools where serious problems remain and need to be addressed, she said. Those are schools where restraint is still being used as the first response to a problem, instead of following best practices to use positive intervention first, she said.

However Brunelle said that although there is "on some issues, some degree of consensus" with educators and administrators, the law project still wants to move ahead to develop new law. It would address, in particular, a ban on prone restraint and on seclusion of children.

She said that a bill introduced last year was a placeholder while attempting to work collaboratively with the Department of Education after the Commissioner "indicated willingness" to do so.

That bill is now being revised, and the fact that federal officials are developing requirements for data collection is "not a reason to wait," she said.

"They [the federal officials] are not asking for the detail we are." She acknowledged that the state's current budget crisis could well block any initiative that would cost schools money, but said that other issues were well-defined and should move ahead.

Pringle, on the other hand, said she remained optimistic that consensus on the most critical issues to protect families could be reached, and that she was far less concerned with how change was achieved than whether a statute would be passed.

"What I want to agree on is the ingredients and the cake," not the process of where it goes afterwards, she said. At a meeting in November that brought all the interested parties together, everyone "was stuck on the process" of legislation versus department regulation. That diverted the dialogue away from agreement on the basic principles.

Pringle said that after her research and presentations around the state in 2008, she believed that absolute bans should not necessarily be the goal. She found that rather than a "sharp line" with strongly opposing sides, there was much general agreement on the need for some changes.

Last June, small focus groups began meeting on three key topics: the use of positive behavioral interventions, data collection, and restraint and seclusion.

The groups include department representatives and special education and behavior specialists, she said, noting that "you can't build the bridge without the engineers."

Only the restraint and seclusion group has remained stuck on some "very challenging" issues, she said.

She said she is in agreement that there are specific "extreme situations...where a safer restraint wouldn't work" and a child was in serious jeopardy, where prone restraint should not be banned.

In addition, very limited use of an emergency time-out room might sometimes be justified — although "you never want to use" seclusion in its traditional meaning.

Pringle said she recognized the concern that those uses are a "loaded gun" if allowing such exceptions means some schools continue to use them as "the first thing to pull out." Most schools already use best practice with positive intervention and "use it well," she said.

When consensus is so close, five months of collaborative work, "if thrown out the window, would be a shame," Pringle said.

PROTEST — "What do we want?" "The canteen." "When do we want it?" "Now." Those chants echoed across the statehouse lawn in November as former patients, Vermont State Hospital staff, and advocates protested the decision by the Department of Mental Health to close the canteen. The mock figure of Governor Jim Douglas with budget-cutting scissors, above, joined other picketers. Inside, a press conference was held. **(Counterpoint Photo: Anne Donahue)**

Canteen Cut; Protests Come from All Sides

WATERBURY — Patients, staff, advocates and others have raised voices in objection to a budget decision to close a small canteen adjacent to the Vermont State Hospital by December 5.

The hospital's medical director, Jay Batra, MD, decried the decision, saying that it was "the most normalizing experience" patients had, and it would have a "huge clinical impact." He was speaking at a NAMI-VT conference.

The Commissioner of the Department of Mental Health has stood firm, saying it was "the only place I could see" that would do the least damage under the position cuts that he was required to make. Michael Hartman said that closing the canteen would save $150,000 per year, and protected VSH from direct care staff reductions.

Terry Rowe, VSH Executive Director, said that an internal committee was being formed to review alternative uses for the space that would also allow for informal socializing.

The projected budget savings was contested by the canteen's director, who said the canteen broke even through sales until two years ago, when an "activities coordinator" was shifted to its budget and when the administration refused to allow price increases as food costs rose.

That contention appeared to be supported by an email from Rowe to Hartman in October that was accessed as a public document by advocate Laura Zeigler. Zeigler presented it to the legislature's Mental Health Oversight Committee.

"I think we are on dangerous grounds arguing this cost issue. The fact is we could raise prices, cut back on staff and not eliminate the service," Rowe said in the email.

Further questions were raised in an investigative news article on the internet, which noted the overhead costs listed in the canteen budget that would be unchanged if it closed .

In an earlier private email, Rowe said that "most patients at the VSH have a gradual increase in privileges which allows them to leave the Brooks building and go to the canteen as part of their preparation for community placement... (and) to develop new skills to manage their psychotic symptoms or difficult behaviors."

Hartman said that to reduce the number of staff positions that were required this fall, he needed to consider "state only" funded positions as a priority. This is because cutting positions that receive federal matching funds only results in one third of the amount saved to the state budget.

VSH – the only department previously "held harmless" in budget cuts – was difficult to target for staff reductions because it was already under stress from the higher-than-budgeted census.

In addition, he said that VSH was "on the edge of DOJ and CMS," with the Department of Justice settlement coming to a close next July, and a potential of recertification by the Centers for Medicare and Medicaid Services. That progress could be damaged if clinical staff was reduced just at this point in time, he said.

The department cut the three staff positions for running the canteen, and two quality review positions in the DMH central office.

Among those objecting to the decision was a community mental health agency psychiatrist. Sandra Steingard, MD, of HowardCenter, wrote:

"I also know that quietly and without fanfare, the VSH canteen has embraced the principles of recovery that everyone – on all sides of the discussion – embraces and values.

"Patients, who have had no hope in their lives, found solace and comfort at the canteen. It has served a critical rehabilitative function for clients and former clients and it is a place of camaraderie and support for patients who are currently hospitalized."

Steingard also noted that "it is striking that many parties – who are often on opposite sides of the discussion – have come together in uniform agreement over the value of the canteen."

Advocacy groups and individuals joined in a letter as well, pointing out that, "In the past seven years, the hospital has become an increasingly restrictive setting as patients have lost access to the gym, the library, the Hideaway (an off-ward social space) and Father Logue's camp in Duxbury. Now the State is taking away the only place patients have left outside the confines of the secure area.

"It is also vital in reducing the pressures on the hospital wards by providing a positive incentive and a humanizing and integrated setting where patients can get away from the crowded, volatile ward environment." AD

Funding and Access to Placements Can Delay Youth Hospital Discharges

BRATTLEBORO — A striking increase in hospital use by children in Vermont, reported this past summer by the Department of Mental Health, has more to do with difficult discharge placements than added use, according to both DMH and the Brattleboro Retreat.

The increase was in the total days of hospital use, not in the number of children sent to the Retreat. The Retreat is the sole provider in Vermont for inpatient care for children and teens.

"Since 2005, the number of youth admissions has been going down (314 in 2005 and projected 222 in 2009)," said Pewter Albert, a Retreat spokesman. He noted all admissions are prescreened by community mental health centers.

However, the length of stay has been increasing as a result of greater difficulty in finding appropriate aftercare and an increase in severity of illness, he said. A report compiled by the Performance Indicator Project of the Department of Mental Health shows that the number of hospital days for patients under age 18 increased from 3,225 in 2003 to 5,605 in 2007.

DMH officials were in agreement with Albert's assessment, and also said that the length of stay has begun to show a decline in the past several months, since the state restarted oversight by the state's Medicaid office, OVHA.

In addition, "when we look at the data, there are a few clients who get stuck there who skew that," Charlie Biss, Director of Children's Services, said of the length of stay figures.

OVHA's role has been to assist in making the many connections among different state agencies in the effort to get a placement, and to identify the funding available for it, according to Biss.

Albert agreed that this was helping, in addition to improvements in the way community mental health agencies and the Retreat are working to meet and coordinate care.

The OVHA reviewer, Cindy Thomas, agreed that having a person in state government who "can pull in all the players" is an asset.

Different sources for funding, which may include Medicaid, the foster care system, or schools, among others, have sometimes debated over which system has responsibility, in order to protect its limited funds.

However, "sometimes we just don't have the place" and children's issues are "much more complex" now, she said.

There are also "not enough diversion beds" that can be accessed, leaving children to reach a higher level of crisis: "that definitely would affect" the length of inpatient care required later.

She said that sometimes a longer stay was a better assurance for effective treatment and "not seeing the children coming back" for rehospitalization, as they might otherwise.

Albert said the Retreat was facing a new financial challenge as OVHA — apparently in cost-saving efforts — has created a new billing code for youth "awaiting placement" who no longer need hospital care but are unsafe to discharge to resources that are available. Albert said this meant the Retreat's actual costs are not covered, "as all the kids on our units receive the same level of care" regardless of status. AD

"We are Vermonters who have lost loved ones to suicide. Our goal is to provide comfort to each other through monthly support group meetings. It can be powerful to connect with our survivors, and a huge relief to be able to talk openly about suicide with people who really understand." The Vermont AFSP web site.

OUT OF THE DARKNESS — Vermont's chapter of the American Foundation for Suicide Prevention held its sixth annual walk for awareness and fundraising in Burlington this past fall. The organization also offers support groups for those who have lost loved ones to suicide. More information is available at www.afspvermont.org. (Counterpoint Photos: Anne Donahue)

TRANSPARENCY IN COERCED TREATMENT

What Do Screeners Have To Do for an 'EE'?

The *Guide for Qualified Mental Health Professionals* (also known as QMHP, or "screeners") *for Involuntary Psychiatric Evaluations and Hospitalization* provides the details on what must happen for a person to be taken to or held involuntarily at a hospital for the purpose of an emergency examination (an "EE").

If the person is admitted for an EE, the hospital then has three days to complete the exam and to decide whether to continue to hold a patient while an application is filed for a commitment hearing.

The screener guide begins with a statement of purpose, which says: "The protection of the civil rights of all persons is a priority in this process. The Vermont legislature has authorized a system... to ensure that every effort is made toward the preservation of personal freedoms and rights under the law."

The guide states the three criteria that, by law, must be established to require an emergency exam: Presence of mental illness as defined by Vermont statute (a developmental disability may not be the primary diagnosis); danger to self or others; absence of less restrictive alternatives.

The guide includes these key steps:

1. A screener and a psychiatrist must determine through a face-to-face evaluation that the individual meets all of the criteria. (Although the law permits an application to be made by an "interested individual," not necessarily a screener, for an emergency exam an agreement between the Department of Mental Health and the hospitals requires all involuntary psychiatric admissions to be initiated by a screener.)

2. The screener and psychiatrist complete the Application for Emergency Examination. A designated hospital is identified by the screener and an admission referral is completed.

3. Transportation is arranged by the screener.

The guide says that the documentation for an EE serves several functions: the law requires it, it provides the foundation for the legal case, and it identifies potential witnesses.

The application must give the history that led to the individual's current status, and provide current clinical justification that the individual meets the legal definition, either through direct observation or reliably reported from an identified source. *The other people who can apply for an emergency exam for a person who agrees to go to a hospital are: a guardian, spouse, parent, adult child, close adult relative, a responsible adult friend or person who has the individual in his or her charge or care (e.g., a superintendent of a correctional facility), a law enforcement officer, a licensed physician, a head of a hospital or his or her written designee, a selectman, a town health officer or a town service officer, or a mental health professional. However, if the person is to be involuntarily hospitalized as a result, a screener must make the required legal determinations.*

The psychiatrist's application must swear that: "In my opinion this patient is (A) not only mentally ill, but (B) poses a danger of harm to him/herself or others, and (C) should immediately be admitted to a designated hospital for an emergency examination."

The Department of Mental Health's new web site — www.mentalhealth.vermont.gov — has significantly expanded the number of documents that the public can review. When it comes to issues regarding involuntary treatment, this is particularly important for following the recommendations of the national Institute of Medicine. The IOM states that, until the issue of coercion can be addressed through better data and standards, the most important thing that can be done is to to help empower consumers through its principle of transparency: "Policies and practices not only for initiating coercive treatment, but also for terminating it, should be transparent, providing information on what one has to do to be discharged from involuntary inpatient or outpatient treatment or to have one's status changed to voluntary."

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

The physician must list all steps taken in exploring alternative forms for care and treatment.

If an individual is not already at the hospital, and is refusing to go voluntarily to be evaluated, an application can be made for a "warrant for an immediate examination."

A law enforcement officer or mental health professional who makes the application may take the proposed patient into temporary custody while the application for a warrant is being sought from a judge — either by phone or in person — "without delay." Only the following persons may make application for this emergency examination: a law enforcement officer (i.e., a sheriff, deputy sheriff, constable, municipal police officer, or state police), or a mental health professional (i.e., a physician, psychologist, social worker, nurse, or other qualified person designated by the Commissioner of the Department of Health).

A screener must find through a face-to-face evaluation that the individual meets the same criteria for an emergency exam, but also that "a psychiatrist is not available [at the location] without serious or unreasonable delay."

A judge's authorization for a warrant provides the authority for involuntary transportation by a law enforcement agent or the screener for the purpose of an emergency examination by a psychiatrist, which must occur without delay.

The judge's order must list findings that:

Probable cause exists to believe that the proposed patient is a person in need of immediate examination based upon the required information in the application and affidavit; that there are reasonable grounds to believe that the proposed patient is a "person in need of treatment" as defined by law and further, that he or she presents an immediate risk of injury to him or herself or others if not restrained; and that, because of the emergency circumstances, it satisfactorily appears that a certification by a physician is not available without serious and unreasonable delay.

Science Sees Brain as Able To Adapt

by ANNE DONAHUE
Counterpoint

MONTPELIER – Beginning to understand the interaction between life experiences, genes, and mental illness has led science to recognize we can create long-lasting changes to adjust our brain, based upon influences in our environment.

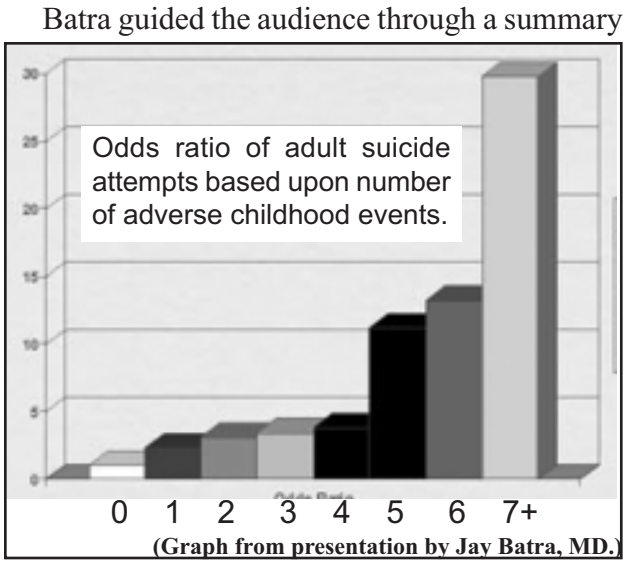
The ability of the brain to regenerate was not considered possible just a few decades ago, Jay Batra, MD, told the audience at the NAMI-VT annual meeting this fall. Batra is the Medical Director of the Vermont State Hospital.

For many years, science followed a determination made in 1928 that, "Once development has ended, the fonts of growth and regeneration of the axons and dendrites dried up irrevocably."

Genetics was the important area of research in the 1980's and 1990's, but neuroplasticity – the changes that can occur in the brain – now demonstrates that it is the interplay between genes and the environment that is more important, he said.

Neuroplasticity is the ability of neural circuits — pathways in the brain — to be altered based upon a variety of factors in the outside environment as well as internal actions of hormones and neurotransmittors.

Batra guided the audience through a summary



(Graph from presentation by Jay Batra, MD.)

of some examples of research and findings.

"Adverse childhood events," most commonly physical or sexual abuse, are related to later mental illness. It is the number of events, however, that is tied by a "steep curve" to an increased risk of depression and, even more, to later suicide attempts or suicide.

He said that this demonstrated that society has a significant tool for actual prevention efforts for mental illnesses, through prevention of child abuse. "Many other life stressors we can't avoid. This, we can avoid."

Chronic stress, such as ongoing abuse, causes much more damage than "acute" stress because of the brain's way of releasing hormones to react to a crisis. Batra explained that the brain creates responses to defend against danger, but then also "turns off" the extra stimulation when no longer needed.

That brain response cannot remain on a high charge for too long without damage, and if its ability to suppress the extra activity is lost, cell damage can result.

Where do a person's genes fit into the picture?

Batra began by referring to studies of twins, in which the likelihood of developing the same illness is compared between fraternal twins (genetic difference the same as any other two siblings) and identical twins (same genetic codes.)

The "most remarkable genetic link" is for substance abuse, where the likelihood of its development is seven to eight times greater in identical twins. However, most still do not develop the illness, so the genes are not what predict or cause it.

Instead, there are far more complicated interactions between built-in brain protectors and stressors in the environment.

Batra demonstrated such an interaction with one specific brain function that is impaired by mental illnesses: "working memory," or the ability to sort and hold onto information that is needed for reuse. The brain itself can be on any one of three levels of efficiency in doing that kind of sorting, depending upon a brain chemical that is related to a specific gene that changed in some persons several generations ago.

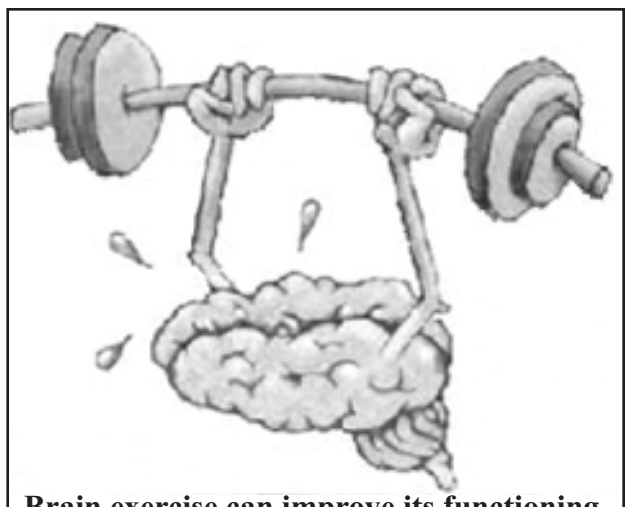
A person with schizophrenia has an impaired working memory as a result of the illness, but the degree of the impairment increases by the same degree as the difference caused by which changed gene (with its greater or lesser efficiency) the person has.

This does not mean that a brain with a less efficient gene can be predicted to have a greater risk of schizophrenia. Instead, it is at a disadvantage when other, additional risks confront it; it is less able to protect against the illness. He said an example of a risk to the brain from the physical environment is heavy marijuana use.

Batra then discussed the interrelationship with the brain chemical, dopamine. An excess can cause the hallucination symptoms of schizophrenia. The purpose of antipsychotic medication is to try to block dopamine.

This "actually makes this worse... in terms of working memory" because it reduces brain efficiency, he explained. This comes on top of the fact that, already, the "brain is not working its best" when affected by schizophrenia.

"We're far, far behind in where we need to be" for treatment, he said. "Hallucination is not the only symptom" of schizophrenia, yet it is the only symptom that current medications address.


Brain exercise can improve its functioning.
(Cartoon illustration from presentation by Jay Batra, MD.)

Batra then spoke about depression and its very high link to stress. Again, there is one genotype that is more efficient than another in protecting against depression. Having the less efficient genotype does not equate to identifying depression. If there are no external stressors, the rate of depression is not very different among people based on the genotype.

However, the greater the amount of stress, then the greater degree to which the rate of depression is linked to the genotype. What differs is the ability of the brain to protect against depression as stressors increase, Batra said.

Childhood abuse carries the same relationship. There is no difference in rates of adult depression based on the gene type unless there is a history of maltreatment. In that case, the greater the abuse, the more having the protective type of gene becomes important.

Knowing that the brain can learn from and be affected by the environment is important not only in understanding how the risk of illness can increase, but also in how to respond to it, Batra said.

Turning a brain chemical on or off isn't the answer, he said. What matters is addressing the question of how to protect the brain, particularly if it has greater vulnerabilities. Protecting the environment around a person – things such as getting enough sleep and reducing stress – gives the brain a best ability to protect itself. The brain can also learn to "recalibrate" and return to equilibrium.

Batra closed by reminding the audience that touching upon a few genes and traits was only a sample of how complex the relationship was. He said that no one gene has a single tie to a particular trait; there are many other traits involved than the example of "working memory;" and interactions beyond those with the environment add even more complexity to the research.

Name and Address Changes

Department of Mental Health Offices Return To Waterbury

WATERBURY — The Department of Mental Health returned from Burlington to offices at the state hospital grounds and office complex on December 5.

DMH's new main number is 802-241-2601. The new mailing address is: DMH, Wasson Hall, 103 South Main Street, Waterbury, VT 05671-2510.

Structural and environmental improvements and technological upgrades to the building were started last summer, and cost $2.5 million to complete. The department had moved to Burlington in 2005, when it temporarily had become a division of the Department of Health.

VT Protection and Advocacy Is Now Disability Rights Vermont

MONTPELIER — Vermont Protection and Advocacy has changed its name to "Disability Rights Vermont."

Executive Director Ed Paquin said the purpose of the name change was to make the organization's purpose more visible.

Staff email addresses have changed to end in disabilityrightsvt.org, and the new web site under construction is www.DisabilityRightsVt.org.

Under federal law, every state must have a designated organization to protect the rights of persons who are institutionalized or in the community receiving services for mental health or developmental disabilities.

Combined Speaker's Bureau Is Named 'Faces and Voices'

MONTPELIER — A newly combined speakers bureau called "Vermont Faces & Voices (VFAV) — *Public Education from Personal Experience*" has been formed through the merger of the Mental Health Education Initiative with Friends of Recovery-VT (FOR-VT).

The Vermont Association of Mental Health is the host agency for FOR-VT. Ken Libertoff, Executive Director of VAMH, said he is delighted about the merger, noting it creates "a unified approach to recovery from addiction and mental health conditions." Many speakers can now talk about recovery from both. The web site is www.friendsofrecoveryvt.org.

A Former Patient Reflects:

MAKE A WISH — Blowing out the candles for the Retreat's 175th birthday include, from left, Board Chair Pete Sherlock, Board member Julie Peterson, Jim Maxwell (playing early Trustee Dr. William Rockwell), keynote speaker Ken Howard, and Gay Maxwell (playing Anna Marsh, whose gift began the Retreat's mission). Rob Simpson, Executive Director, can be seen at right rear.

(Photo courtesy of the Brattleboro Retreat)

Birthday Bash Marks 175th

BRATTLEBORO – More than 400 friends, employees and supporters gathered together under a grand tent at the Brattleboro Retreat this fall for a birthday bash in honor of the institution's 175th consecutive year of service to people with mental illness and addiction challenges.

"Not many American institutions can trace their beginnings all the way back to 1834 — at least not institutions that remain as essential and vibrant in 2009 as the Brattleboro Retreat," a press release from the Retreat said. The Brattleboro Retreat was originally chartered by the state of Vermont in 1834. Its mission began with $10,000 Anna Hunt Marsh left in her will for the establishment of a hospital dedicated to the care and treatment of the mentally ill.

"We are celebrating the gift that Anna Marsh gave us 175 years ago — the gift of her vision that no person suffering from mental illness should be treated with less than the dignity that we reserve for every family member and friend," said Dr. Rob Simpson, president and chief executive officer, in his remarks to guests. "We are a community. We have taken care of each other for 175 years…because we must, because we want to, and because we can."

Nationally-known actor Ken Howard, a college friend of Simpson's with a career on TV, Broadway and in film, gave the evening's keynote address. Howard's remarks included a description of his own brother's struggle and eventual death from complications related to alcoholism.

"I am happy to lend my voice to the Retreat's efforts," said Howard. "In this day and age, all of us have been touched in some way by issues of mental illness and drug addiction. The key to dealing with these issues is to shed light on them."

The evening was also a launch of the new 1834 Fund, which has been established to support the renovation and preservation of the Retreat's historic buildings and grounds. Through a combination of ticket sales, corporate sponsorships, outright donations, and a dollar-for-dollar match by the Thomas Thompson Trust, the evening generated more than $130,000.

'I celebrate and remember how much good the Brattleboro Retreat has done in my particular life.'

by Vida Wilson

I'd been eagerly awaiting the 175th birthday celebration of the Brattleboro Retreat last month, and even on that very morning had fully intended on going and even enjoying myself, as I would also be writing an article for *Counterpoint* about it. My illness had other plans. That is the mystery of PTSD (post traumatic stress disorder) — it is full of twists and turns, highs and lows. On the very night of the grand celebration, I would be sitting silently, frozen, numb...unable to use the tickets that were generously provided to me.

Since I was not able to attend the event, I cannot write a first-person account. What I *can* do is write my recollections of my many stays at the Retreat, and the dignity, validation, and respect that I felt there. It was because of the staff at the Retreat and their belief and faith in me that I began to try to get better — to even want to get better.

What I *can* tell you is that when I arrived there, broken-down, suicidal, and devoid of any hope, I felt safer there in that "mental hospital" than I ever did in the real world, let alone my biological family.

I have been an orphan all my life, in the truest, most raw and gnawingly painful sense of the word. At the Retreat I felt cared for and listened to; staff members took an interest in me, as a person. They saw a future for me, and began to help me believe in it. They saw something in me that I still do not see in myself, a person *worth* saving.

I was there in the '90s, and it was a very special place. I felt even privileged to be there, a private hospital renounced for its work, especially with trauma survivors, and I knew if anyone could understand me and help me, they would.

We had a "trauma track" in which patients with trauma disorders could work out their issues in many varied ways in the safest of surroundings. We had sessions of closed and intensive trauma-based group therapy and individual sessions that focused truly on the heart of the matter. The head clinician of the group would then gather us together in the community room on the floor for hot tea and pastries sent up from the kitchen, and he, himself, poured each one of us the tea and served us.

It bonded us and made us feel valuable and important, especially after all the demeaning and horrible things we had just shared in the group session. It was akin to a "decompression" stage, such as an astronaut would have after landing back on earth from outer space. It grounded us again, and showed us that despite all the horror and pain, we had each other, we each were important, and that yes, we could even smile again.

Another aspect was the strong emphasis on telling our traumatic stories, in any way we were able, so as to get it outside of ourselves where it could be validated, confronted, and healed. Otherwise, in isolating ourselves in shame, those stories would only continue to fester inside of us.

One of the best ways was through art expression. One time I was particularly struggling with trying to explain in words how deeply empty I was feeling and how that emptiness was torturing and disabling me.

The staff brought me to the art room, and gave me the time and privacy I needed to say in art what I was completely unable to express in words. The emptiness took a literal form in the medium of art. I was able to see that my emptiness was actually filled with layers of embedded and even hidden emotions stacked one on top of another and only disguised as blackness; disguised as emptiness.

I now saw red, for rage; blue for grief and sadness; purple, for unfulfilled passion; and grey — lots of grey — for the pain-numbing drug of dissociation.

It wasn't all serious at the Retreat. We bonded in ways we never could have guessed. The activities staff at the Retreat were wonderful. We went on van rides through the beautiful Vermont countryside, past lakes, waterfalls, and mountain streams; we went to movies together, and shopping. I remember swimming in that beautiful and very large swimming pool in the summer. I cannot discount the healing value of good meals, and of friends to talk to.

As the Retreat celebrates its birthday, I reminisce about all it's done for me. My file must be as thick as a Bible! (I was there a *lot*.) But I had therapy of the highest quality, and nurses, doctors and mental health workers who really and truly cared about me and all the patients.

I was lucky to be there when I was. I remember, still, the day I threw my wedding ring from my second marriage into the water behind the Retreat. I left it, and the memories of him, at the bottom of that lake, as I made a decision to let go of his hold on me and move on with my future.

The Retreat helped me feel safe enough, surrounded by enough support, to make that decision.

Although I was not at the celebration that night, I do celebrate and remember how much good the Brattleboro Retreat has done in my life, and in the lives of others I've known.

Some of us made it, some of us didn't, and some of us are alive, yet still fighting our battles in the long, hard war of mental and emotional illness.

As we continue to fight each battle, we try to remember our names – and they are, "Survivors."

Vida Wilson describes herself as "a writer who now lives once more in the Green Mountains of Vermont, but who chooses to make her "home" in the movement of her pen across a blank page, the sunset over the ocean, the brilliance of the stars, and in the heart of a red, red, rose."

Vermont State Hospital Futures Plan Update

DRAFT OF SECURE RESIDENCE — Plans are beginning to take shape for a proposed 15-bed secure recovery residence in Waterbury. This draft architectural sketch of the building exterior shows approximately what the building may look like from the front, with the view of the mountains from windows and a yard in the back. The locked residence is intended to meet the needs of involuntary patients currently served at the Vermont State Hospital who do not need inpatient care but who are not eligible for the unlocked Second Spring (14 beds currently in operation in Williamstown) or Meadowview (six beds soon to open in Brattleboro) residences. The residence will be reviewed in 2010 by the legislature for possible construction funding, estimated at about $15 million. (Sketch courtesy of Black River Design)

Law Change Proposals Include Drug Orders

WATERBURY – A change to allow for faster use of involuntary drugs is on the Department of Mental Health's agenda for the legislative session beginning this January. So are four other bills:

- An end to the right of children under age 14 to an attorney and court process if they object to hospitalization;
- The creation of new hospital designation requirements for involuntary care;
- Elimination of the authority of courts to order hospital placements for forensic evaluations, unless a physician admits the patient; and
- The authority to create a governing body for the Vermont State Hospital.

The bills are a response to a requirement from the Legislature that the department report on all changes in law it believes are necessary to proceed with the Futures project to replace the services at VSH.

The proposals on admission of children and on the VSH governing body are not related to the Futures project, but are additional changes in law being included in the response to the legislature, the department said.

The involuntary medication proposal drew strong objections at both the Joint Legislative Mental Health Oversight Committee and the Transformation Council meeting in November.

"This is a frontal assault on due process," Laura Zeigler told legislators in reaction to allowing some drug orders to occur more quickly.

The proposal would allow one round of short-acting forced medication within days of admission if a person was judged to lack capacity and need medication. An independent panel, including a consumer, would also have to review the case before the involuntary treatment could occur.

Every patient being admitted involuntarily would receive a preliminary court hearing and would be assessed for capacity to make treatment decisions. Neither of those protections exists now, said Wendy Beinner, Assistant Attorney General and legal counsel for DMH.

"Having your rights gutted does not feel better" by getting that brief chance to be heard, Zeigler said.

The proposal, which Beinner said was still just in an early conceptual stage, would require the full current Act 114 court process if a person who objected to medication did not regain capacity after the first round of involuntary medication.

Ed Paquin of Disability Rights Vermont said that it violated the state's values to put efforts into making it "fast and easy" to drug someone "at a time when we're seriously eroding the system" for providing voluntary services. *(See budget article, page one.)* Vermont law establishes the intent to build a system that does not use coercion.

But Joanna Case from NAMI-VT asserted that "the brain is getting damaged" while a person who is psychotic is not receiving medication.

Strong concerns also were voiced regarding proposed changes in the law for children who object to hospitalization. Nick Emlen of the Council of Developmental and Mental Health Services said the Council would "furiously oppose this legislation" if it did not include an "impartial third party," such as a mental health screener.

There is a potential conflict of interest if only a parent and the hospital are involved, he said, but in addition, there is a need to include "somebody who knows about the options" available to avoid inpatient care.

Consumer Kitty Gallagher agreed. "For a child to be involuntarily thrown into a hospital would be devastating," she said. "Every [other] resource should be tried or attempted to be used."

Bill McMains, MD, from the Department of Mental Health argued that "the majority of parents look after their child's best interests."

Child psychiatrist David Fassler said that situations still exist in which inappropriate admissions can occur. He cited a recent situation in New York where the most significant issue was the parents' concern over their 13-year-old daughter's relationship with a 20-year-old boyfriend. The hospital was willing to admit the child, but with intervention, a better alternative was identified.

The hospital designation bill would propose a formal process to approve any hospital that admits involuntary patients. It would allow for a special status and higher payment rates for a hospital designated for providing "intensive services" for "all comers," Beinner explained.

Hospitals support a law for special intensive service designation as part of the Futures project, she said, but designation for hospitals serving other involuntary patients has not yet been discussed. Emlen questioned whether hospitals would have any incentive to serve involuntary patients if formal structures were imposed.

Fassler added that hospitals not designated at the intensive level might reject higher-needs patients if they were not getting additional reimbursement; they might argue that a hospital with the higher designation should be expected to meet that need.

The other two proposals generated less discussion. DMH agreed that it was a change in the traditional view of the role of a state hospital if courts could not make forensic referrals unless a doctor agreed there was a clinical need for an inpatient admission. The proposed change has not yet been discussed with the courts. AD

Meadowview Now Near Opening Day

BRATTLEBORO — The second residential recovery program under the Futures project is planning to open "on or before the first of the year," according to George Karakabakis, Chief Operating Officer at Health Care and Rehabilitation Services (HCRS). It was originally scheduled to open this past fall.

The program — named Meadowview — will provide six bedrooms in a "staff secure" setting. Staff secure means unlocked, but with staff supervision to prevent unauthorized departures.

HCRS and the Brattleboro Retreat are collaborating in the program. Karakabakis said technical issues about contracts, construction and permits delayed the opening.

Staff training is already under way, he said, including sessions planned with Disability Rights Vermont (formerly P&A), Jane Winterling of Vermont Psychiatric Survivors, peers from the Springfield Peer Recovery Center, Steven Morgan of Another Way, family members and an assortment of providers. Karakabakis said the intent was "to make sure we provide them with the knowledge, skills and understanding that will lead to a successful program." AD

Legislature Releases Money for Planning New Rutland Wing

MONTPELIER — Planning money for the possible 28-bed new psychiatric wing at Rutland Regional Medical Center was released by the vote of two legislative committees this fall.

Sixteen of the 28 beds would replace the exiting Rutland psychiatric unit, and the 12 additional beds would begin the replacement of Vermont State Hospital inpatient beds.

The $250,000 in state planning money will be combined with a $250,000 contribution by the Rutland hospital to allow architectural and other planning to move forward.

Last spring, the money was designated by the Legislature, but was not allowed to be released until a study to see whether the plan to pay for the construction was "reasonably feasible."

The plan would create a new company that would borrow the money and build the addition. It would pay back the loan by renting the building to the hospital. The hospital would pay for the rent through an extra charge to the state for all Medicaid patients.

Other hospital replacement bed proposals from Springfield Hospital, the Brattleboro Retreat, and Dartmouth Hitchcock Psychiatric Associates are currently under review. AD

Importance of Peers Highlights the Day At VISI Conference

Moe Armstrong at his workshop presentation. (Counterpoint Photo: Anne Donahue)

KILLINGTON – Powerful messages about recovery and empowerment were a theme at the annual "Walk a Mile in My Shoes" VISI conference, which gave a series of optimistic messages about progress in the state.

"We can't do it by ourselves" as individuals, Moe Armstrong told a packed meeting room of participants. "The psych condition is bigger than we are."

Armstrong, from Massachusetts, creator of the Peer Education Project and the Vet-to-Vet program, was a keynote speaker, along with Philip Valentine, head of an initiative in Connecticut to build a statewide network of community recovery centers.

VISI – the Vermont Integrated Service System – focuses on co-occurring disorders, and the title of the conference, "Moving Toward a Peer-Driven Recovery-Oriented System of Care," brought national and local voices together to discuss how to continue positive momentum.

Among panel presentations was a discussion of the role of medications led by William Grass, MD *(see page 13)*. The wrap-up panel, "Reflections and Predictions" for Vermont, included representatives from the Department of Mental Health.

The Adult Division Director, Trish Singer, MD, said that since coming to the state, "I've been really impressed by the dialogue in Vermont" between the substance abuse and mental health community.

"I don't think you can have a quality system of care without peers."

Commissioner Michael Hartman said that a good health care system, more than anything, depended upon people.

Peers have a role to play not only in their own recovery, but in the recovery of others, and should be involved in "the everyday parts of services and policy making."

He encouraged the audience to "keep hold of the focus that we can make this happen."

The workshop on peer support by Moe Armstrong was a dynamic presentation on the philosophy of "Mental Illness Anonymous," a parallel to AA that integrates recovery from mental illness and substance abuse.

"Sanity, stability, sobriety" was the key theme, he said — beyond individual recovery to where "everybody can have peace of mind."

"This stuff is big and it's biological," he said, and "it's easier to heal a broken arm than a broken mind."

But Armstrong said "the therapeutic construct of the future is going to be educational" and based upon "people working side by side" as peers.

"Mental health is going to have this new discipline, and the new discipline is going to be peer support." Peers will be "the next generation of psychiatric workers."

"You are at ground zero… [but] you're on the threshold…as major parts of your mental health system across the state," Armstrong told the group.

In the Alcoholics Anonymous model applied to co-occurring illness, admitting powerlessness takes the form of "learning how not to be irritable and angry," he said. "We have a lot of residual depression… we feel better being angry." Peers "have got to get free of that stuff."

Drugs and alcohol bring 15 minutes of relief and six hours of mood swings, he observed. The only way out of that is to "understand the immense magnification that mental illness puts on substance abuse."

"The psych stuff goes way over the top."

Second is recognition that a power greater than the self can help in restoring health.

"The greatest form of empowerment is asking for help," he said.

Next is turning the issues over to the power of God, as understood personally.

A key is "setting aside the time for quiet," Armstrong explained. "Nothing beats a little meditative prayer."

Then a "moral inventory" should be taken to be "thankful for what we have;" otherwise the brain goes into "overdrive," remembering the 15 minutes of negative in a day.

The other side is to "admit to other people the extent of our wrongs" that occurred during an illness. "Unless we really talk openly and honestly" we won't get past those wrongs, he said.

Armstrong said that "the hardest part of your job as a peer [facilitator] is staying as an equal" and to "practice mutuality," a role that is "easily forgotten and sometimes never learned." AD

FOR PUBLIC COMMENT

FDA Seeks Input on ECT

ROCKVILLE, Md — The Food and Drug Administration (FDA) is seeking comments that relate to the safety and effectiveness of electroconvulsive therapy (ECT) and ECT equipment, "including adverse safety or effectiveness information," according to the Federal Register. The FDA has never removed ECT devices from Class III, the most risky category, because ECT existed before the federal agency was established, and has therefore never been evaluated by the FDA. It is now being considered for reclassification. The deadline for comments is January 8, 2010.

Written comments may be submitted to the Division of Dockets Management (HFA-305), Food and Drug Administration, 5630 Fishers Lane, Room 1061, Rockville, MD 20852. Include the Docket Number: FDA 2009-N-0392. Submit electronic comments and information by going on the internet to http://bit.ly/fda-ect>http://bit.ly/fda-ect and then on "Submit Comment." For further information, contact: Victor Krauthamer, Center for Devices and Radiological Health, Food and Drug Administration, 10903 New Hampshire Ave., W066-1106, Silver Spring, MD 20993, 301-796-2474.

DOT Reviews Service Dogs

The federal Department of Transportation is accepting public comment about a law that requires people with psychiatric service dogs who use air travel to bring documentation not required for people with other kinds of disabilities. The deadline to make a comment is December 17.

The Psychiatric Service Dog Society's response to the DOT's request for comments on these recent changes to the Air Carriers Access Act regarding people with disabilities using psychiatric service animals can be found on the internet at www.psychdog.org/attach/ PSDSACAA comments.pdf. The DOT request for comments, and the site to submit comments, is at www.regulations.gov/search/Regs/home.html#documentDetail?R=0900006480a2662c

New Publications Offered

Women's Mental Health and Prejudice. Two free publications focusing on women's mental health are being offered by The Office on Women's Health of the U.S. Department of Health and Human Services. *"Women's Mental Health: What It Means to You"* addresses the prejudice associated with mental health, while offering women advice. *"Action Steps for Improving Women's Mental Health"* explores the role gender plays in the diagnosis, course, and treatment of mental illness and outlines action steps that policy makers, healthcare providers, researchers, and others can take. Both publications can be ordered or downloaded through the Substance Abuse and Mental Health Services Administration's Health Information Network (SHIN) at http://mentalhealth.samhsa.gov/publications/allpubs/OWH09/default.aspx or by calling 1-877-SAMHSA-7 (1-877-726-4727).

Health Care for Those with Disabilities. The National Council on Disability has issued a report entitled "The Current State of Health Care for People with Disabilities." Among the NCD's findings: "The Americans with Disabilities Act (ADA) has had limited impact on how health care is delivered for people with disabilities." The report may be downloaded free at the following link: http://www.ncd.gov/newsroom/publications/2009/pdf/HealthCare.pdf

NAMI-VT Says Drug Ties Here Are Limited

WATERBURY — Vermont's branch of the National Alliance on Mental Health (NAMI-VT) has pointed to its own financial documents to distinguish itself from the issue of ties to pharmaceutical companies that brought criticism nationally this fall.

The New York Times reported in October that the national organization received about three quarters of its donations from drug makers in the years 2006-2008.

In Vermont, where state funding also helps with its budget, the NAMI chapter received three percent of its fiscal year 2009 budget directly from drug companies, and one percent from the national parent organization, according to Connie Stabler, NAMI-VT Board President.

The nation-wide information was gathered by Senator Charles E. Grassley, R-Iowa, as part of his investigation into the drug industry's influence on the practice of medicine, according to *The Times* article.

NAMI "has long been criticized for coordinating some of its lobbying efforts with drug makers and for pushing legislation that also benefits industry," the article said.

It said NAMI was considered as "one of the nation's most influential disease advocacy groups," and "has refused for years to disclose specifics of its fund-raising, saying the details were private."

Stabler said that NAMI-VT's audited financial statement is available on request, and its Form 990 IRS tax return and annual report are available on the Web.

"The money from pharmaceutical companies is used to help pay for our annual conference and for our NAMI Walk, with some having been used for our anti-stigma efforts.

"In addition, in FY 2009 less than one percent of our income came from NAMI National and this was used for scholarships for an annual Leadership Conference," she said.

Additional money appears on the books from NAMI National, but those are a pass-through of membership funds from Vermonters that are returned to Vermont, Stabler explained.

She said the information and NAMI-VT's corporate funding policy were sent to Grassley when his request — sent to all similar organizations — was received.

The corporate policy states that, "Like most nonprofits, we would certainly reject any proposed funding with conditions attached which would violate our mission, or compromise our integrity and independence."

"Accepting funding from any source does *not* constitute endorsement by NAMI-Vermont of that individual or entity's public policy views. In fact, we recognize and will act upon our responsibility to offer criticism (and credit) to any of our funders, when due.

"Their support does *not* buy our silence.

"Only unrestricted grants and contributions to further NAMI's established mission and program priorities will be solicited and accepted. No funds will be accepted for direct legislative advocacy on any issue," the NAMI-VT policy says.

NAMI-VT has been criticized by local advocates for accepting drug manufacturing money in any amount on principle. Other mental health nonprofits in Vermont have pledged to accept no such funding. Some consumers have also made a direct link to NAMI-VT's advocacy agenda, which includes supporting an expedited court process for involuntary drugging orders.

The national NAMI executive director, Michael Fitzpatrick, said in an interview with *The New York Times* that the drug companies' donations were excessive in recent years.

"For at least the years of '07, '08 and '09, the percentage of money from pharma has been higher than we have wanted it to be," Fitzpatrick said in the interview. He promised that the industry's share of the organization's fund-raising would drop "significantly" next year.

"I understand that NAMI gets painted as being in the pockets of pharmaceutical companies, and somehow that all we care about is pharmaceuticals," Fitzpatrick said in *The Times* article. "It's simply not true."

Grassley's scrutiny has been unnerving for patient and disease advocacy groups, which are often filled with sincere people who are either afflicted with serious illnesses themselves or have family members who have been affected, *The Times* said.

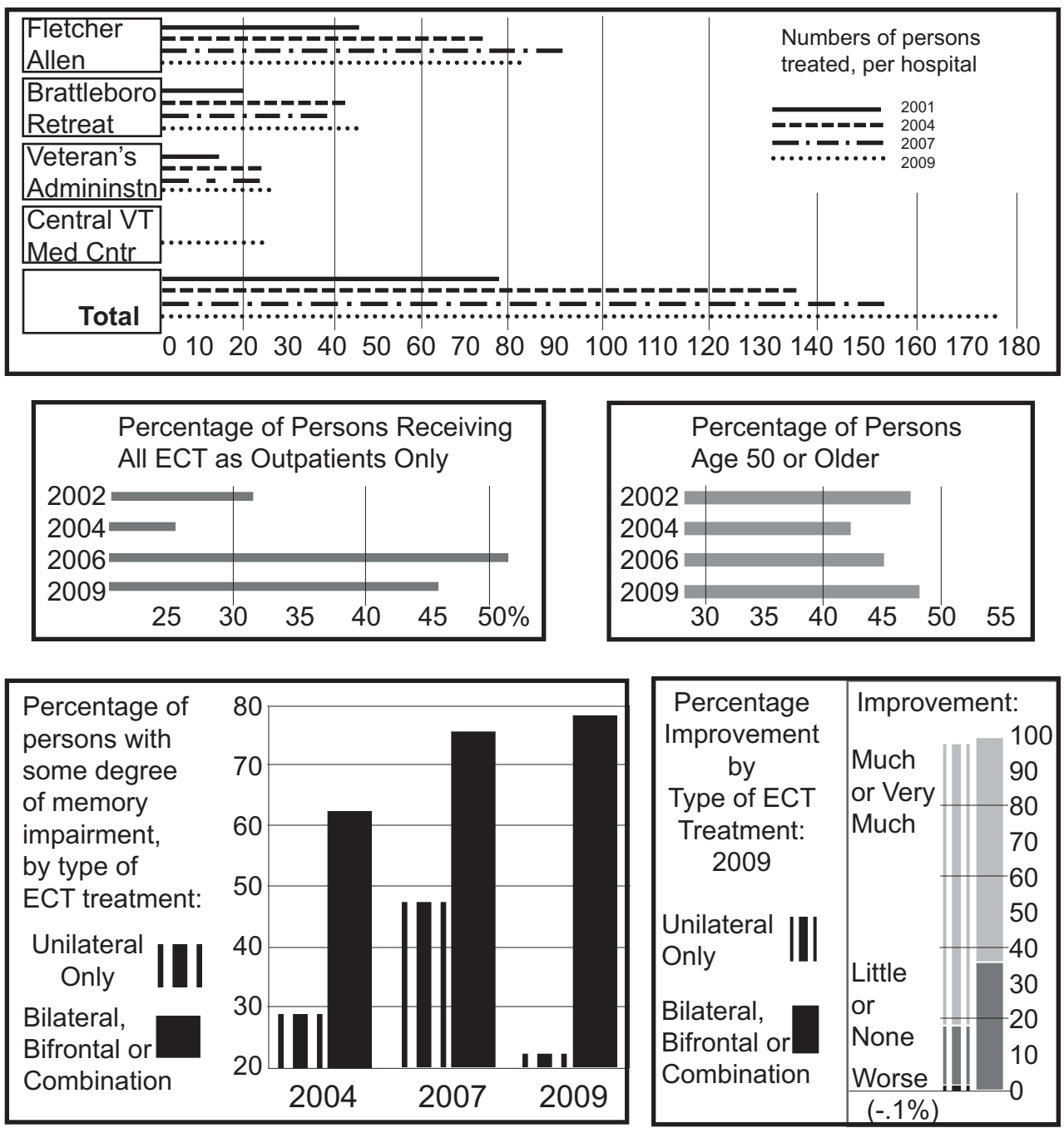
"Many join the groups in the hope of making sense of their misfortune by helping to find a cure or raising awareness of a disease's risks and frequency. Drug makers are natural allies in these pursuits since cures may come out of corporate laboratories and the industry's money can help finance public service campaigns and fund-raising dinners."

"But industry critics have long derided some patient organizations as little more than front groups devoted to lobbying on issues that affect industry profits, and few have come under more scrutiny for industry ties than the mental health alliance," *The Times* article stated.

For years, it said, the alliance has fought states' legislative efforts to limit doctors' freedom to prescribe drugs, no matter how expensive, to treat mental illness in patients who rely on government health care programs like Medicaid.

Some of these medicines routinely top the list of the most expensive drugs that states buy for their poorest patients.

Documents obtained by *The New York Times* show that drug makers have over the years given the mental health alliance — along with millions of dollars in donations — direct advice about how to advocate forcefully for issues that affect industry profits, its article said. AD



The Department of Mental Health has moved back to Waterbury:

New phone number: 802-241-2601

New mailing address: Wasson Hall, 103 South Main Street, Waterbury, VT 05671-2510.

web site: **www.mentalhealth.vermont.gov**

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

New direct phone lines:
Commissioner Michael Hartman – 802-241-4008
Deputy Commissioner Beth Tanzman – 802-241-4008
Operations Director Frank Reed – 802-241-4003
Adult Services Director Dr. Trish Singer – 802 -241-4010
Children and Family Services Director Charlie Biss – 802-241-4029 ; Finance Director Heidi Hall – 802-241-4030; Research and Statistics Chief John Pandiani – 802-241-4049 ;
Legal Services – 802-657-4310

Debating Treatment

Point

'Minds on Edge' - Does It Challenge The Assumptions?

by ANNE DONAHUE
Counterpoint

SOUTH ROYALTON – How should decisions be made about people who appear to be in a mental health crisis? How can society best meet the needs of those with serious mental illnesses?

Those questions and others were at the core of a lively debate this fall, when a panel of Vermonters responded to issues raised in a PBS film in a forum presented for state legislators and hosted by Vermont Law School and the University of Vermont School of Medicine.

The video, "Minds on the Edge," presented the stories of two fictional characters, Olivia and James. A panel of experts on the video reacted to descriptions of what was happening to the two, and the live moderator in Vermont cut in at times to ask questions of the local panel.

The forum was preceded by a lecture by attorney Mark Heyrman of Illinois, who has defended patients against involuntary commitment and has advocated against more coercive laws, but who also stresses adequate access for people to get treatment.

"There are legitimate disagreements," he told the group of some 30 legislators and almost as many panelists and other members of the public. But, he said, public discussion should "focus on the goal first," and avoid the "unproductive disagreements" that divert from the values held in common.

Olivia's story began at her college. After she started to show signs of possible manic behavior but refused her professor's offer for a referral to counseling, the professor debated whether to call her parents.

Some panelists objected to the invasion of privacy:

"It alienates them [individuals] within the system," said Linda Corey, Executive Director of Vermont Psychiatric Survivors.

Both Michael Hartman, Commissioner of the Department of Mental Health, and Delores Burroughs-Biron, MD, Medical Director of the Department of Corrections, suggested that it was too early to identify what was happening. Olivia needed a "non-threatening circle of support" at this point, Burroughs-Biron said.

Others warned about the consequences of being rapidly drawn into the mental health system.

"This will become part of her identity," said Steven Morgan, Executive Director of Green Mountain Support Group, which runs Another Way in Montpelier.

Ken Libertoff said that the lack of parity was an issue for Olivia as well — that if she had to leave school, a tuition insurance policy would probably not protect her unless she ended up being hospitalized. Such policies cover other illnesses based upon a doctor's note, he said. Libertoff is Executive Director of the Vermont Association for Mental Health.

Olivia could also be thrown out of school for being diagnosed with a mental illness, Heyrman told the audience.

When the professor did tell her parents, they rushed to the school and then tricked Olivia into accepting a ride with them from a local park to the emergency room. Heyrman asked the group whether that was the best way to get help for her.

A.J. Ruben, an attorney with Vermont Protection and Advocacy, said theparents would have to turn to the emergency room because there was no place in Vermont to get immediate help.

Julie Tessler, Executive Director of the Council for Mental Health and Developmental Disabilities, disagreed. She said they could have used a phone book to call a local agency to have someone to go to the park and meet with them and Olivia.

"That's what I would want to see," she said.

Corey noted how betrayed Olivia would feel when all she probably needed was "someone who's willing to just listen."

When individuals are left feeling they have no one they can trust, the system "teaches them it's going to do something to them, not for them," said Jack McCullough. McCullough is the Director of the Mental Health Law Project.

Robert Appel, the state's Commissioner for Human Rights, predicted, "her state will become increasingly agitated" and she will end up being "put into a much more chaotic, dysfunctional system [of care]."

In fact, as the narrative continued, the emergency room doctor discharged her. Olivia headed for the door, according to the imaginary story. What will happen to her?

"That is the appropriate standard," Appel said, but it happened because the entire interaction took place in the wrong setting.

"The world the way it is, is not the world as we would want it to be," said Jonathan Weker, MD, a Montpelier psychiatrist. In such a situation, "one then tries to find as soft a landing as one can" for a person — perhaps by finding a support person that "she does trust and relate to."

Libertoff commented that in terms of the "probability for long-term success" with Olivia, "we've gone downhill already."

The video presentation then shifted to a discussion of another imaginary case history. James was described as a person diagnosed with schizophrenia who had recent emotional losses and went to the emergency room to ask for help with his increased symptoms.

James was given an appointment card to see someone in three weeks.

Libertoff said that it would not be long before "Corrections may end up being the major intervention."

The capacities of the treatment system in Vermont for early intervention "have been eroded and will erode (further)." He also predicted that the only help that James would be offered would be drug therapy.

Hartman defended the system's ability to "see someone right away" and use options such as diversion beds or a followup call the next morning.

James' story continued with his arrest for public urination. A panelist on the video itself commented that "the mental health system is the definition of insanity," with "no money at the front end to keep people out," but then imprisoning them "to restore competency in order to imprison them."

Vermont's Judge George Crawford commented that "it's a wrong thing to lock people up" when they haven't committed a crime, and asked, "how much wrong are we willing to do to someone" for them to receive help?

The video returned to Olivia's story; she was being involuntarily committed for treatment.

Morgan said the system shouldn't be "just assuming she's diseased and doesn't have insight." There are better alternatives where she could be in a safe place with people who understand and can be "in her mind and listen," and guide her gently, he said.

Xenia Williams commented from the audience that the involuntary treatment system "tells us we're worthless."

Ruben said that "we need to be cautious" and remember that Vermont has had "well-minded people" in the past who supported the eugenics movement, having undesirable persons sterilized so that they could not reproduce.

Vermonters need to "nurture the great programs that we do have," he said, rather than changing laws as a "quick legislative fix."

Hartman said that coercion represented a failure of the system, but "we don't have the capability of having the right choice for everyone who walks in the door."

Heyrman, in his opening talk, urged the legislators in the audience to "think carefully

(Continued on page 13)

***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**

Drugs? Other Options? And Who Decides?

Patient Choice: Is It Essential To Recovery?

KILLINGTON — "We both have a vote; we both have a veto."

Bill Grass, MD, sees himself as the employee of patients, who should inform them about best options but understand their right to make the decisions. He said he finds it "very rare" to encounter someone who is unable to make a decision for themselves.

Grass is currently the inpatient psychiatrist at the Windham Center in Bellows Falls. He, Mark Ames and Linda Corey were panelists on the role of medications, hope, and choice at the annual conference of the Vermont Integrated Service Network (VISI).

Dr. Grass introduced himself as a "recovering psychiatrist," who was trained in applied medical science, but who sees his work differently based upon learning a recovery philosophy that puts the focus on the solution instead of the problem.

He experienced depression that led to leaving medical school for five years before returning to finish his degree, and then the disease of addiction, which led him to rehab and AA, and then into psychiatry.

Grass said his concept of recovery was "success despite adversity," and that "it's not a thing, it's not a place, it's a process."

Grass said he sees medications as a tool, but that "medications don't provide recovery" and there is "more than one way to change body chemistry."

The problems some doctors need to address is that when they see only one tool, it becomes the only way to address the problem. He used the expression, "When you have a hammer, everything looks like a nail."

There are both risks and benefits of medications in trying to find "adequate, safe treatment," he said. There is often not a lot of attention paid to the addictive potential of some psychiatric medications, and people have the right to choose among alternatives for treatment.

"I start out with the assumption, whether I agree with [a person] or not, you have a right to do that. Some things I don't agree with, I have to accept."

Audience member Steven Morgan raised the question of whether seeing mental issues as a disease was helpful, noting the differences in how people respond to different situations.

Grass said he didn't find the argument over whether it was an illness or not was useful, in contrast to focusing on the solution for the individual.

"The more I shift in the way I think about it, the more I am able to help people," he said. "Where you really get your traction" is on the focus on recovery.

As a doctor, seeing it as a medical issue "works for me because it de-stigmatizes the immoral implications" that social judgment may cause, and because "it makes it a treatable entity."

The second panelist, Mark Ames, started by commenting on the "hammer" expression that Grass used.

"There are a lot of hammers out there in the community, and you all look like nails to them."

Ames is coordinator of the Vermont Recovery Center Network and is an addictions professional who considers himself in long-term recovery.

He said that a key for people in recovery is that they "establish some hope in their lives."

"Hope and spirituality are really the same thing," Ames said. People need to recognize that "there's work I have to do" that goes beyond the use of medications.

Linda Corey focused her presentation on the need to have choices as "a big key to recovery." Corey is the Executive Director of Vermont Psychiatric Survivors.

She says she sees people becoming ill from the medications that are supposed to help them, but that they often feel they have to follow what the doctor says instead of having "the opportunity to choose what medication they take."

If they "are not in the driver's seat," people fear "being lost in a medication world" and losing self-expression. People need to be a full partner, and need to be given choices, Corey said. AD

Counterpoint

NEW PERSPECTIVES FRESH FROM RESEARCH

Digestive Disease and Psych Symptoms Linked

BUDAPEST, Hungary — A new report from Hungary has focused on the connection between the brain's neurotransmitters and the digestive system.

The gastrointestinal tract is closely connected to the central nervous system, and communication between them involves neural pathways as well as immune and endocrine mechanisms.

The brain-gut axis plays a prominent role in the modulation of gut functions, the report explained. Signals from different sources (e.g., sound, sight, smell, somatic and visceral sensations, pain) reach the brain.

These inputs are modified by memory, cognition and affective mechanisms and integrated within the neural circuits of the central nervous system, spinal cord,and autonomic and enteral nervous systems, it said.

One of the most important neurotransmitters is serotonin, which is also believed to be a key factor in symptoms of mental illnesses. It plays a key role in the most common chronic functional gastrointestinal disorder: the irritable bowel syndrome. It is a biopsychosocial disease, resulting from the dysregulation of the brain-gut axis, according to the report. Reflux disease and obstructive sleep apnea also mutually generate each other and their severities significantly correlate. *Abstract reported on Medline.*

'Minds on Edge' Brings Challenge to Assumptions?

(Continued from page 12)

about the goal" and "what it is we want to happen" when making public policy.

"Try to think about the causes" of problems that laws are trying to address, he said, instead of arguing over areas of disagreement that make "enemies of people who should be friends and allies."

He gave several examples of "time and energy" that were wasted. In Illinois, he said, there was a public fight that occurred twice over reducing the standard for civil commitment . Both times, there were fewer commitments after the standards were lowered.

"You can't commit people to non-existent beds," he said, so "nothing changed."

Debating outpatient commitment is also "not a useful conversation" because "there is no such thing" — everyone means something different by it and there is no uniform definition.

Mental health courts, and whether they are useful tools or not, is the same kind of debate.

"Let's look at the fact that there are too many people in the criminal justice system" and start from there, he said.

Small Israeli Study Finds Shiatsu Massage Can Help

JERUSALEM, Israel — A small study of 12 individuals diagnosed with schizophrenia in an inpatient ward at Herzog Memorial Hospital who received four weeks of shiatsu massage found that all were doing better by the end of the treatment. A follow-up three months later found that the improvement was maintained, according to an abstract published on the National Center for Biotechnology Information's PubMed Web site. The study was published in the October issue of Alternative Therapies in Health and Medicine. *From the National Clearinghouse.*

Editorial Page Opinion and Letters

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

EDITORIAL

Never Again

Oh how easy, how wishful, those words are.

Never again.

After a tragedy, we pledge, "Never Again."

Something terrible happened this past summer in one of Vermont's prisons. A young woman, only 23 years old, died because she didn't receive vital and life-sustaining medication.

She was there to serve a 30-day sentence for careless and negligent driving. Her moment of inattention while driving had resulted in a serious accident that permanently disabled a man. But her actions did not meet the legal criteria for "gross negligence." It was a terrible accident, but it was an accident.

What was her illness? It was an illness of self-punishment in anguish and guilt over the harm she had caused. She was in and out of hospitals for severe depression and an eating disorder. Her heart was weakened by anorexia — starving herself — and she needed potassium to help keep it stable. She had dropped to 87 pounds.

Knowing all this, the judge still felt a need to make an example of her, and of the consequences of inattention at the wheel, through the 30-day sentence that ended up becoming a death penalty.

Ashley's family had made sure that corrections officials knew in advance what her medical condition was, and the medications she needed. Prisoners are not allowed to bring in their own prescribed medications.

Someone — more than a single someone — among the staff of the medical company that serves Corrections, messed up. A message didn't get through; a medication wasn't among the prison supplies and was supposed to be picked up at a local drug store, but wasn't. It was negligence, and it caused a death, but according to the Franklin County prosecutor, no single person was negligent enough to be charged.

Ashley Ellis went to jail for a moment's inattention at the wheel. Licensed medical professionals who were inattentive to crucial messages and a doctor's directives will not even be charged for their negligence.

The more significant negligence may be at a higher level, above even the profit-making medical company that the state pays to provide medical care in our prisons. It is state Corrections' policy, after all, that makes all new prisoners go "cold turkey" off medications, until the health service doctor evaluates them. Then, despite what prescription they might have been on, or for how long, the new doctor substitutes his or her own judgment for medication.

How coldly ironic that when someone has side effects from "going off their psych meds," we penalize them, and if sent to prison, we take them off their psych meds.

We know we have the policy and that our state officials justify it. It isn't a momentary lapse in judgment. How long will it be before that gross negligence causes a death? Will criminal negligence be identified then?

"Never again" may be too high a standard when human beings — all of us flawed — are involved. But accountability for gross negligence needs to be in place. And when we know we have established policies that make another tragedy likely, there is no excuse for allowing them to remain in place. Otherwise, we are left standing, watching, just waiting for it to happen...again.

PERSONAL REFLECTION

Learning About OCD

Severe obsessive-compulsive disorder interfering with daily activities – that is how my disability is described. I suffer from a variety of OCD symptoms, such as contamination fears (causing obsessive handwashing and avoidance of touching things or people), superstition rituals, counting rituals and touching rituals.

Contamination fears are so strong that I have a great deal of difficulty performing any kind of personal hygiene (such as bathing, brushing my teeth, washing and combing my hair, changing clothes). Anxiety in doing these tasks is the worst feeling, or symptom.

I don't know anyone else with OCD as their main diagnosis. I think everyone has a touch of OCD. I mean, people have their own routine of accomplishing daily tasks of life. But their routines are not so overwhelming as to take over their entire life.

I have wanted to write a letter to *Counterpoint* as a way to educate and to reach out to others with OCD. I want you to know that you are not alone.

I first received treatment in 1993. I didn't know that I had depression, also. All I knew was that I washed my hands all the time – with burning hot water until my hands would bleed. I could not function, I was crying all the time and I wanted to die and kill myself all the time.

Medication, therapy, time and hard work have now made my life more livable. But it is still a tremendous struggle, living.

Did you know that there is an OCD foundation with a newsletter and several sites on the internet about OCD? Now there are literally hundreds of books about OCD. There is a lot more knowledge about OCD — but no cure.

Usually, the OCD patient is looking for perfection in everything he or she does in life. We don't want bad things to happen to people we love or bad things to happen in life, in general.

We think if we just do things right or touch things just right, then we can control things in life, and nobody will get hurt and nothing will go wrong, but this is magical thinking.

Do you have OCD? If so, I hope you can receive treatment such as medication and therapy. I just wanted to get this article in *Counterpoint* to educate and help people. I hope I did; thank you, *Counterpoint*.

NAME WITHHELD

LETTERS

Reverse VSH Canteen Closure

To the Editor:

While the Vermont State Hospital (VSH) remains open, I have come down on the side of opposing the closure of the hospital canteen, out of respect for those currently as well as formerly incarcerated at VSH who have indicated the canteen is needed for the time being as their one small bright light at the end of the tunnel, even if only a glimmer of hope is provided by such.

That said, I am also among those who have long been working to have VSH closed down as well as at the same time working to have put into place a very different system of providing for the actual needs of those either currently or previously incarcerated there as well as those who could be in the future, and will not shy away from continuing to do so at all.

These needs include real, safe, decent and affordable housing, income, training, employment, transportation and other such supports and services that allow one to live independently where and how they may choose to reside.

This, of course, runs contrary to what has basically been the sole focus of the Commissioner of Mental Health: to chiefly replace the role or functions of VSH and merely move what is done there in the form of institutionalization in one fashion or another to other places, while mostly giving poor lip service to providing truly community-based opportunities and real inclusion for people whom too many within our society would rather keep out of sight, out of mind.

The fact is that dumping people without their being offered basic housing as well as independent living opportunities and supports or services they can freely choose from when they are without such is no solution either. The commissioner along with his supporters have mixed up priorities and, as such, have been headed in the wrong direction for quite some time.

Even though closing VSH is highly desirable and sorely needed in order to move ahead with what will be required, the closure of the canteen while the current facility remains open is not desired, certainly not among those incarcerated or employed there, nor by those of us who stand in solidarity with them, either.

MORGAN W. BROWN
Montpelier

Thanks for the Great Time

To the Editor:

I would like to take this time to thank all those who attended camp at Lake Elfin in Wallingford this year! I had a great time, as I expected and planned. I look forward and hope to see all of you and more next year.

SCOTT J. THOMPSON
Morrisville

Your Opinions Matter Here.

Share What *You* Think

with Your Peers, in *Counterpoint*

We welcome your letters! Your name and phone number must be enclosed to verify authorship, but may be withheld from publication if requested. Write to ***Counterpoint***, 1 Scale Ave, Suite 52, Rutland, VT 05701 or email to counterp@tds.net.

The editor reserves the right to edit overly long, profane, or libelous submissions. Letters should not identify private third parties. **Opinions expressed by contributors reflect the opinions of the authors, and should not be taken as a position of *Counterpoint*.**

Op-Ed Opinions and Letters

Revisiting Mental Health Treatment within Vermont

Self-determination and independence versus force and dependency

by MORGAN W. BROWN

The very nature of self-determination, as well as independence, would seem to dictate not merely having freedom of choice, but rather also include both the freedom as well as the right to ensure one's self-defined and self-expressed wishes, choices and decisions not defined, limited, narrowed or controlled by outside influences, no matter how well-intended or well-meaning.

Each person needs to decide, as well as do, what is best for themselves and, as such, they are the only one who actually knows what that is during any given moment or circumstance.

When it comes to health care and, most particularly concerning mental health *treatment* and related matters, save (i.e., except for retaining one's own) true and actual freedom of choice regarding such decisions, this means that like most anything else in this life there truly are no absolutes, nor should there be any imposed on any person(s) by anyone else.

Hence, in order to ensure true parity between health care and mental health care treatment systems (versus merely addressing how these separate and unequal systems and services are paid for under the pretense of parity), the use of force and coercion within the mental health system needs to be completely done away with before these systems can truly become ones of *empowerment* for everyone involved.

In addition, the criminal justice system should never be misused simply to compel forced or coerced mental health treatment when no actual or real crime has been proven to have been committed by an accused person. There needs to be serious protections against such being allowed to happen, as well as stiff penalties imposed and enforced upon those who falsely report someone else of a crime the person in fact did not commit in order, to attempt to compel treatment for that individual.

Whether on an inpatient, outpatient, or *community* basis, the use of force or coercion in mental health treatment is clearly wrong. Force and treatment do not go or work together. In fact, each works in opposition to the other.

Treatment that is free from the use of force or coercion in all forms embodies what is essential to what often becomes termed as *recovery:* i.e., person-hood, self-determination, hope, faith, responsibility, and independence, as well as interdependence.

Force and coercion only work to foster and enforce dependency, victimization, anger, violence, helplessness, and irresponsibility.

Force and the fear, as well as the intense anger and even rage that it creates do **not** ensure safety or security; rather, it is the use of force that destroys them.

Using force is easy. Choosing alternatives to force may at times appear to be difficult, yet it need not be impossible. Many options are available when force and coercion is not the governing paradigm.

Resources currently being employed to bolster the force/coercion paradigm could be better and more readily used instead to meet the basic human needs of individuals; needs that are either not met in a way of a person's choosing or not met at all.

To accomplish such, however, would take a major shift in resources to fund these and other much-needed programs and services.

We must do several things, including but not limited to these:

- End civil commitment and abolish the insanity defense;

- Hold people fully accountable for their actions if a crime is committed and then proven within the criminal justice and correctional systems, regardless of whether or not an individual is labeled with a psychiatric disability;

- Shift resources to fund a system that helps to meet the needs of individuals in a way of their choosing and make mental health systems completely voluntary;

- Use a voucher system to allow people real choices both in selecting care and/or service providers and the actual care and/or service that they may choose to receive.

Often there are concerns raised about what should be done if someone is *out of control*, *troubled* or *in need of treatment* when their state of mind and/or behavior is being questioned.

While the issue appears to be complicated by several factors, including current constitutional law regarding an individual's rights in criminal proceedings, it is my belief that people can be held more accountable by changing how they are treated as well as by abolishing the insanity defense and ending civil commitment.

Being *out of control* or labeled with a psychiatric or emotional disability should not be an excuse, and violent or other criminal acts should **not** be tolerated if a person is proven to have committed a crime.

If no crime is proven to have been committed however, yet the person appears to be *out of control* or *troubled*, they should be offered voluntary assistance only or otherwise be left alone. In addition, more tolerance and understanding of others and their differences is actually needed, not less of it.

If an individual is **not** committing a crime, but her or his actions are annoying others, then they should **not** be detained or interfered with — just like anyone else. Being annoying, *out of control*, or being labeled with a psychiatric or emotional disability in itself should not be grounds for imposing society's will.

We should **not** be able to hold people accountable for actions that we think that they might do at some future point in time. People should, however, be held fully accountable for proven criminal violations of the law.

In closing, it is my strong belief that it is possible for us as a state and society to finally rid ourselves of the terrible burden of force and coercion within the mental health system.

Doing so would be very liberating to mind, body and spirit on both an individual and collective basis, especially when sharing with and supporting each other as we journey into the unknown together.

Morgan W. Brown is an advocate, writer and blogger living in Montpelier, Vermont.

DISABILITY RIGHTS VERMONT ANNOUNCES FY 2010 PRIORITIES

Disability Rights Vermont (DRVT) [formerly Vermont Protection & Advocacy, Inc. (VP&A)] is a private non-profit agency dedicated to defending and advancing the rights of people with mental health and disability issues. We are empowered (and funded!) by the federal government to investigate abuse, neglect and serious rights violations. Our fifteen member staff teams with the ten member staff of the Disability Law Project of Vermont Legal Aid (DLP) to create the cross-disability legal protection and advocacy system for Vermont.

This past year DRVT was busy defending the rights of people with disabilities both in individual case work and in systemic change. Of course we can't list everything here that we have done this year but following are a few of our important activities.

- DRVT continues to believe that there is more progress to be made in reducing or eliminating seclusion, restraint and emergency involuntary medication at the Vermont State Hospital. We have analyzed the use of these interventions over some time and have been pleased to see periods when their staff was able to make significant reductions and we are happy to see them being trained in new de-escalation protocols to handle emergencies. It is unfortunate that the high census, the physical environment and old attitudes seem to have conspired to keep progress from being steady in the right direction. This issue will keep our attention, particularly as we disagree with what we see as the unneeded use of emergency interventions in combination. DRVT continues to participate in an advisory capacity with the federally sponsored effort to reduce the use of seclusion and restraint at both the VSH and Brattleboro Retreat. We are completing, with DLP, an evaluation of special education at the Woodside Juvenile Detention Facility and look forward to working with the State to insure that children there receive the free and appropriate education to which the law entitles them.

- We continue to monitor our settlement agreement with the Department of Corrections that requires an outside expert to evaluate the Department's compliance with policies to protect prisoners who self-harm. DRVT is pleased to have had a hand in educating the legislature about the protections needed by individuals with a range of significant functional impairments and are engaged with state officials in a cross-department effort to problem-solve particular cases in order to either prevent inappropriate incarceration or to facilitate workable community placements for folks finishing their sentences. We also work with the Vermont Legal Aid and the Human Rights Commission to assure the implementation of the DOC's ADA policy to help assure that people with disabilities in correctional facilities will be supervised and cared for by individuals who are aware of their duty to provided needed accommodations. We continue to monitor all the designated psychiatric hospitals in Vermont, as well as perform outreach to residential and community care homes.

- DRVT reaches out at events and recovery groups around the state. This was an active year for our efforts at registering voters with disabilities and in doing accessibility surveys of polling places across the state. We are working with the Center on Disability and Community Inclusion at UVM to identify barriers to registration and voting and to assess how effective we have been in our voting outreach efforts. In October of '08, partnering with AARP and Vermont Public Television, we sponsored a gubernatorial debate at the Austine School for the Deaf. The major candidates met in Brattleboro to exchange their views for a packed house of people from all walks of life with and without disabilities!

- We also:
  - continue to work with beneficiaries of Social Security who face barriers to employment
  - have presented to both state and national audiences on our work helping veterans with TBI.
  - republished an updated edition of *Overcoming Barriers to Employment* resource manual and will soon be updating our publication *Your Rights as a Vermonter Diagnosed as Having a Mental Illness*.

This is not the whole story, however. In addition to working with people with mental health issues, our system has projects that help individuals with developmental disabilities, physical and sensory disabilities and individuals with Traumatic Brain Injury. Each of our staff has made real and positive differences in the lives of the many individuals who have contacted DRVT and for whom we have provided information, referrals, short term assistance, investigations, and litigation.

DRVT is once again publishing the priorities adopted by our Board for the current fiscal year (October 1, 2009 – September 30, 2010.) We would welcome your thoughts about how our unique system can best serve people with disabilities and mental health issues. DRVT is publishing our formal priorities for the Protection & Advocacy for Individuals with Mental Illness (PAIMI) program on the adjoining page.

These priorities serve to focus the work of the agency and are developed for our Board by our PAIMI Advisory Council, who get input from the community and staff.

Your input is appreciated! We strive to do as much as we can with the resources we have and we can do that best when folks in the community let us know their greatest advocacy needs!

DISABILITY RIGHTS VERMONT FY'10 PAIMI PRIORITIES

(PAIMI is Protection & Advocacy for Individuals with Mental Illness)

Priority 1: Investigate individual cases of abuse, neglect, and serious rights violations in inpatient facilities (VSH, designated hospitals, designated agencies, emergency rooms, facilities for minors), prisons/jails, and community settings.

Measure of Success:

- Work on a minimum of 100 cases of abuse, neglect, or serious rights violations of people with mental health issues. Among closed cases, a strong majority of those not withdrawn by client or found to be without merit by VP&A staff should be resolved favorably.
- In at least 2 opened cases at VSH, DRVT will advocate for adequate discharge in the spirit of the community integration mandate of the Olmstead decision.
- Note whether the individual describes the issue as having occurred during a first contact with the mental health system because of the potential for trauma involved.

Priority 2: Reduce the use of seclusion, restraint, coercion and involuntary procedures through systemic efforts. Continue systemic work to create culturally competent, trauma-informed, violence free and coercion free mental health treatment environments.

Measures of Success:

- Work with at least two institutions to create respectful, trauma-informed, violence free and coercion free mental health treatment environments, particularly during an individual's first contact with the psychiatric system.
- Monitor the legislature and administration to insure that the rights of individuals with mental health issues are enhanced or at least not abridged, particularly their due process rights vis-à-vis involuntary medication, providing education as appropriate.
- DRVT will participate in systemic efforts to improve state services for individuals in or at risk of incarceration to speed successful reintegration.
- Provide one intensive training for VP&A staff on violence free and coercion free mental health environments.

Priority 3: Reach out to community settings, designated facilities, emergency rooms, prisons/jails, residential and therapeutic care homes. Monitor conditions and educate residents about rights and self-advocacy. Engage in systems work to improve conditions.

Measure of Success:

- Outreach is conducted at a minimum of 20 residential care homes, therapeutic community residences or licensed residential childcare facilities. This will include giving information to staff and residents as well as monitoring of conditions.
- Outreach is conducted at all eight state prisons.
- Outreach is conducted at all five designated facilities and the state hospital.
- DRVT literature is distributed to all of the community mental health agencies, group homes, prisons, and designated hospitals, including their emergency departments.
- Outreach to individuals labeled with a disability who are victims of crime or domestic abuse.
- Monitor all treatment environments (e.g. designated hospitals & their emergency departments, residential care homes, correctional facilities) to assure that unnecessary or inappropriate use of seclusion, restraint, coercion or involuntary procedures are not used and that treatment is only administered with proper informed consent.
- Expand outreach to diverse communities and non dominant cultures, monitoring that they receive services in a culturally competent way.

Priority 4: Advocate for self-determination and access to alternative treatment options and community integration. Use legal advocacy to enforce and expand rights across the State of Vermont.

Measure of Success:

- Four self-advocacy and/or advance directive trainings for 40 individuals.
- Continue to work with other advocacy groups and individuals on the replacement of the VSH with a wide array of treatment options in the least restrictive and most community based settings possible.
- Assist at least 5 individuals across the State of Vermont with their preparation of Advanced Directives.
- Participate in coalition efforts to address transportation infrastructure needs of low-income people with mental health issues.

Arts **Sketches and Painting**

Art Blooms On Scene

by ANNE DONAHUE
Counterpoint

MONTPELIER – Art is a critical part of recovery.

That was the message at this fall's Vermont Psychiatric Survivor annual meeting, where Gayle Bluebird presented the keynote address, and consumers responded with pleas to the Mental Health Commissioner to allow greater access to art supplies at the Vermont State Hospital.

The Capital Plaza forum was filled with art work, including the winners of the VPS Young Adult contest, and the products of the Addison County storyboard project. (*Some of the art is pictured on this page; see page 21 for the storyboard project.)* Several advocates were also honored at the meeting.

Bluebird is the Director of the newly formed Office of Technical Assistance (OTA) Center for Peer Networking for the National Association of State Mental Health Program Directors (NASMHPD).

She told the group the art work of psychiatric patients hold a "rich history" of "stories of institutionalization." Bluebird's message is that writing, music, painting, dance, and other arts are pleasurable activities but also can be a conduit for expression of those parts of the self which may not have been expressed in any other way.

"Art can be used as a powerful healing tool to explore deep emotions — the sorrows, the struggles, and joys. It has the ability to transform us by awakening parts of ourselves to recover and heal from earlier traumatic memories. Through artwork, people can develop their own personal vocabularies for a fuller identity," Bluebird has written previously.

"Art and creativity can be used by anyone — that is what is so exciting. It does not require being taught or require a therapist to help one be creative," Bluebird writes.

"Art for some may be writing a journal, creating a garden, or making a recipe. Others may take photographs of something that is particularly inspiring to them, or draw cartoons. There is a place for everyone."

Art captures "life and perspectives on psychiatric experiences," she said, and she shared sources such as "Still Sane," "The Altered State," "The Awakening Review," the cemetery project, and "Pillows of Unrest," which captures the theme, "if these pillows could talk…"

A sample "pillow project" came at the end of the session, allowing participants the chance to write their own messages on symbolic pillow cover material.

Bluebird also recommended a self-help manual for arts programs, available at www.altered-statesofthearts.com.

When Commissioner Michael Hartman spoke at the meeting, his introductory comments were

(Continued on page 19)

Artist from Springfield

Getting Started: Advice from Gayle Bluebird

*Here are some of the ways to get started: * Have a private place and time to work. * Write or draw in a journal. * Set up a time to write each day. * Go to cafes and write and draw. * Get tickets to performances. * Set up a talent show or "open mike." * Use the library as a resource. * Read favorite authors. * Go to art exhibits. * Go to a disco to dance. Go early. Sharing of your art, whether poem, painting or song, can be used to create a new understanding of a culture. Art shows can be developed around a theme such as recovery, with each person's art being valued as an expression of their path. What you have is a "tossed salad" or a "stew". The result is not a standard prescription but a sharing: interpretations of personal beliefs and experiences creating a message of recovery.*

Artist from Springfield

Artist from Bennington

As a Recovery Tool

(Continued from page 18)
shifted to a focus on art by the meeting participants.

Laura Zeigler said that the state hospital needed to create an "affirmative list" to identify art supplies that were not considered contraband and could be used safely in a secure setting.

Without such a list, vagueness in the policy blocked almost anything patients might use for self-expression.

PRIZE WINNER — David Hebert holds his first prize award and winning wood carving from the art show and contest sponsored by Vermont Psychiatric Survivors. See othercontest photo, page one. (Photo courtesy of the Evergreen Center)

Artist from Springfield

Artist from Bennington

"I firmly believe in the power of the arts to help heal," said Marla Simpson, a peer and staff member at Second Spring, a residential recovery program in Williamstown.

It allows for "tapping into the core of the soul," with a focus on mental health instead of illness.

Simpson said residents at Second Spring have completed three movie projects – something that others said couldn't be done by persons with such disabilities.

"You never know what's possible until you try it," she said. Art enables "relaying something of yourself."

VPS peer support staff person Karen Lorenzton pointed out that the storyboard project of photography and written expression created "a message to the world" through the stories of individuals.

"We've been on the path of storytelling (as consumers) for a long time…we've created a history of people who have been oppressed," she said.

At the state hospital, however, individual access to any kind of art supplies — even as safe as washable markers that are made to be safe for kindergarten use — is not permitted, participants told Hartman.

If one person uses an item for harm, "collective punishment" occurs for all patients, Xenia Williams said.

Every time an issue comes up, "the patients always get it in the neck."

"So many things are arbitrary and constantly changing," she added. "People might think of working on their recovery if they don't think they're under siege all the time."

Lisa Carrera told Hartman, "I'm not a criminal…I got made to feel like a criminal."

Hartman's presentation brought the message that inpatient hospitals and crisis beds in the state are "about as full up as that system has been," and that the time is coming "where decisions are going to be made" about what to do.

Peers need to speak up — and the system needs to look at how to include peers in decisions, he said.

"If you want us there, help us get there," Morgan Brown responded. Consumers need transportation costs and per diems "up front," he said.

Four persons were honored with certificates of appreciation for their work as advocates: Morgan Brown, Marty Roberts, Marla Simpson, and Gayle Bluebird. Art contest winners commended were David Hebert, first, for his carved wood piece; Ryan Goodwin, second, for his charcoal sketch; and Jennifer Kidd, third.

2010 Louise Wahl Memorial Creative Writing Contest

Encouraging creative writing in honor of former Vermont activist Louise Wahl.

Entries now welcome for the 2010 Louise Wahl Memorial Creative Writing Contest.

A total of $200 in prizes are awarded in two categories: prose (short stories, maximum 3,000 words) and poetry. Maximum of one entry per category per person. Works must be original, and not previously published.

Entry deadline: March 15, 2010

$200 in Prizes

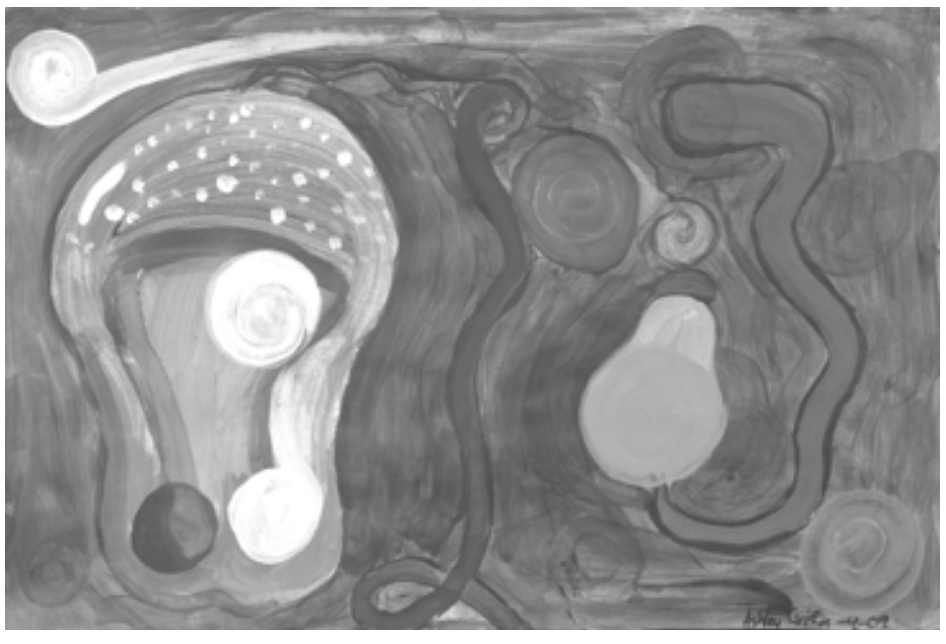
Send entries by email to counterp@tds.net or mail to Counterpoint, 1 Scale Ave, Suite 52, Rutland VT, 05701

Arts

Drawing and Books

Retreat Patient Annual Show Premieres At Brattleboro's 'Gallery Walk' Evening

Art from patients at the Brattleboro Retreat was on display at the Hooker-Dunham Gallery in Brattleboro during October as part of Mental Health Awareness Month activities around the state. The Brattleboro Retreat Patient Art Show — an ongoing tradition at the Retreat — was kicked off during the town's annual Gallery Walk. Some 40 works of art were on display. Administrative and clinical staff from the Retreat were on hand during the opening night to greet guests.



BOOK REVIEW

Animals Make Us Human, and Other Good Reasons To Read

by ELEANOR NEWTON
Counterpoint

Animals Make Us Human, by Temple Grandin and Catherine Johnson, could change your perceptions on the morality of eating meat. No kidding. You could gain a whole new perspective on animal emotions and behavior and of the relationship of humans to the rest of the animal kingdom.

You could also learn a lot about mental health and mental illness in both humans and animals. This could make you a better pet owner, animal trainer and even parent — because this book could help train *you*.

Dr. Grandin deals in animal psychology, especially that of large meat animals. She obviously loves animals and understands how they feel. She's also expert at figuring out why they act and feel as they do. What she brings to her field is empathy. She thinks in non-language mental images, as the animals do.

Dr. Grandin is a college professor, but she is also autistic, with Asperger's syndrome. She can tell you a lot about that, too.

If you are starved for food for thought, maybe you could find it here. Her thoroughness and her strong focus are probably due to her Asperger's. It's impossible not to love someone who loves animals so much.

I've been discovering (rediscovering?) the world of books these past few years. I found reading as therapy during my first hospitalization. Other patients were often unable to concentrate on reading as long as I could, however, when I read anything that caught my interest, Ifound that I could increase my concentration and reading time. Books transported me to a better place, a mini-vacation from the depressing ward. Reading also provided the structure of a daily activity. One chosen, not imposed.

Another benefit of reading is that you can carry a book anywhere and read to fill the time when waiting for an appointment or transportation. Plus, if you're largely sedentary, like myself, you can still read — or if you can't, you can enjoy books on tape.

A neighbor recently said, "All of life is therapy." It can be. It's what you make of it. There's a whole world out there, and you can access it by a good choice of books.

Eleanor Newton is a frequent contributor to Counterpoint. She lives in Williston.

Arts Photography and Stories

Storyboard Fights Some Public Myths

MIDDLEBURY — The storyboard project began with a grant, and ended with an eye-opening insight into the thoughts and feelings of persons with mental health disabilities.

Funded as an anti-stigma activity, at its start, "We really didn't know what it was going to entail," said Lea Richards, Director of the Evergreen Center at Counseling Services of Addison County.

"When the stories were finished...it was totally amazing," she said.

Karen Lorenzton, who does outreach for Vermont Psychiatric Survivors, said that once the idea of using photography to help people tell their stories came up, consumers at Evergreen became actively involved in group decision-making on how it would take shape.

Lorenzton said the overall intention was to share the message that it was myth to think individuals with a mental illness lacked insight.

Most of the stories that were shared started out much longer, and Lorenzton helped participants identify the main message they wanted to convey, and "went through the stories and pulled that out" with them.

The group members — about 16 in all — "helped each other with decisions," and with how to work together if a person's disability meant they were unable to do their own photography. The final work highlighted was also the result of a group consensus, Lorenzton said.

The storyboard, in its function to address stigma, is now a travelling display that has appeared in area libraries and at several conferences.

"We didn't know the impact" it was going to have among the participants and their families, Richards said. When the stories were finished, family members began requesting copies.

Lorenzton said that with a small amount of unused funding, she was also able to start a similar project in Springfield, at HCRS (Health Care and Rehabilitation Services of Southeastern Vermont.) Because of limited funding, it was a smaller project with fewer participants, she said.AD

I love to fish. I like everything about it but I do not eat fish. If they are the right size I might give them away or I just put them back in the water. I get night crawlers for bait. They are the best for what I do, lake or pond fishing. I like the warm spring sun, the breeze from the lake and no one likes bugs but that is part of fishing. It is hard to find someone to fish with and my balance is not what it used to be so I have to be careful to not fall in!

Mostly what you need for fishing is patience, more important then worms or bait, patience and quietness. Patience with myself is what has kept me sober and it took patience to get here after more than 25 years of drinking. Remember there are good fishing days and bad fishing days, good fishing years and bad fishing years but patience will always win. I know this because I am over 50 years old born and raised in Vermont.

Maybe I will go fishing this weekend.

L.W. (2009)

Arts

Poetry and Prose

My Humble Home

Two-storied cube of wood and glass,
Survivor of the March lion's lusty roar,
The machine gun fire of woodpeckers crass
The gnawing mice at the ancient door,
You are my humble home
Which I adore.
Needing paint which I can't afford,
You are my nest of dreams,
The womb of my creative word,
The source of all that seems.
Imprisoned in winter's ice,
Crowned white with Arctic snow,
Your ancient woodstove's paid the price
Of many a wood stick's warming glow.
But you are my love
Despite my marital woe,
My Grace from Above
That only God can sow;
You are my warmth in cold,
My coolness in summer's heat,
My light that dreams unfold,
My living works replete.
I do not know if I shall die
Within your wooden womb,
But I think you'll capture my final sigh
And be my spiritual tomb.
My soul will walk within your walls
If you still stand a century hence;
For between the stately halls
Of time and eternity there's no fence
To restrain roaming souls and dreams
From venting from hell or paradise
Their deepest, immortal screams
That from the spirit rise.
At night I hear within your rooms
Spirit-whispers, nostalgic creaks;
The sense of a ghostly prayer forever looms
In those sounds your ancient wood thus speaks.
I am your soul and you are mine,
Ancient architecture so well related;
You are in every artful line
My pen and mind in you created.
And you have borne my angry pain
Of a marriage so badly turned;
Of my wife's most cruel disdain
For my love so poisonously spurned.
A heathen life I live alone
In a house so often filled
By those who wouldn't care a bone
About a life whose heart is stilled.
The world's as cruel as the rain and wind
That batter your paint-shredded face;
Perhaps we have both mortally sinned
To merit Nature's cold disgrace.
I do not know; I cannot comprehend;
No more how you put up with flogging winds
That shudder your walls as if to rend
Your heart with atmospheric sins.
Oh, time will move and time will pass
Until the day you stand forgotten;
Your lights forever out,
your lawn's unmowed grass,
Your doors and windows rotten.
No more the squeals of infants,
The many voices singing;
No more the heart's fleeting instants
Of joy and pain so stinging
To the soul and mortal mind;
No more, no more, for fading thought
Will have left them all behind
And the Grim Reaper your deed bought.
And now demolished in your ruins,
My spirit will ask why
In these devastated dunes
Did life have to live and die?
What means this pilgrimage
Of birth and death in an old house,
What purpose the mortal image
Of a man no more than a tiny mouse?
We are born, we build, we breed, we die,
And are so soon forgotten.
From fresh embryo it seems we fly
To the grave so rotten.
Old house, you are such as I,
A mystery trapped in time;
We both were born and thus must die
As must my word and rhyme.

by PATRICK WILLIAM BRADLEY, Jr.

"My Humble Home" was a runner-up in the 2009 Louise Wahl writing contest.

Life

On and on life will go
Forever do we move so slow
And now we concentrate on this:
For life can be so full of bliss
Moving forward and backwards
I do not understand all of this
For there are times when it is nonsense
Be thoughtful and also considerate
Also don't be judgmental and sit
Thinking about times of astonishment
Enjoy life for it is a short time!

by WILLIAM F.

I Met a Man

I met a man who had no feet. He had a countenance so sweet, like that of an angel.

I met a man who had no feet. His wife was at his side to help him at this trying time.

I met a man who had no feet. He did not moan or cry, shake his fist at the sky, or ask "why me"?

I met a man who had no feet. He had his faith and with that he walked with God.

by Cathy A. MacKinnon

Brooks Time

The journey of mental illness: barred windows; frightened in a corner alone; violence and persecution; blame and shame.
Trust no one as one walks the halls. Sadness and anger because of misunderstandings. Belts and chains in one's heart and all that remains.
Tired but moving along. Each step a new story. Each door, there is no way out. Never feelings of acceptance; tragic moments in one's morning.
Inhumane treatment is no gain or new news. Moods uncontrolled searching endlessly for a way to change.
Relationships hard to understand. Pain so apparent but unable to cure. Confusion adds to helplessness.
How could this happen to me? How is it this must be? What did I do to deserve this dump? Why is there so much hate for fallen friends?

by LISA CARRARA
Springfield

Art... Makes a body feel good!

Share your art in Counterpoint
Your drawings, photography, cartoons, poetry, stories, reflections...

It's as simple as mailing it to *Counterpoint,* 1 Scale Ave., Suite 52, Rutland, VT, 05701 or emailing to counterp@tds.net. Please include name and town.

Arts

Poetry and Prose

by Lisa Carrara

An Old Time Christmas

Families gathered round the tree
Carols sung neighbor to neighbor.
Christmas as it used to be
With helping hands, and little favors.

Trees decorated, presents on the floor,
Turkeys cooking, the smells of pies.
Visitors welcomed at every door,
A friendly handshake, a warm "hi."

Church bells calling, sleigh bells ringing,
Snowflakes softly floating down.
Little children gathered singing
Of Frosty the Snowman, coming to town.

Festive halls are dressed in holly,
Wreaths on a door, sparkle with snow.
All are reason to be jolly,
Like Christmas of long ago.

by REBECCA FARLEY
Woodsville, N.H.

Thinking Back

Sipping my tea, listing to music
On this cold November night
I think back
To sitting in this exact spot
Smoking pot, guzzling beer
And tipping shots, listing to music
I remember how unhappy I felt
And I remember feeling cloudy in my head
I remember how easy the fake smile was
After tipping a couple shots
I remember how easy the fake laugh was
After guzzling a couple beers
I remember the lies and deceit and denial
To myself and others
Now some days are tough
But overall they are real days and nights
With real smiles laughs and tears

by MANDY FOSTER

Mantras

One man's trash can be another man's treasure,
if it doesn't take too much to give that man pleasure.
So, enjoy the little things in life
A glass that is half empty is also one that is half full.
It just depends upon the views and values of the individual.
So, try to think positively
Sometimes, the road not taken is exactly where we should go,
but if we don't follow through, how will we know?
So, think outside the box and don't just give in
Look on the bright side and the world will seem less grim.
Things don't always have to come down to sink or swim.
The world is about more than black and white,
So, enjoy its many shades
The road to Hell is full of good intentions.
The way to heaven is to mind our own business.
It's not always about you, so leave it be
The keys to happiness lie somewhere within these mantras
but, it's up to you to open the door!

by DAVID P. HESSE II

Wait Watching

A true testimonial
of a Vermont State Hospital patient

We wake up every morning
and wait for breakfast
After the meal
we wait for goals group to begin
Next we are asked whether or not
we wish to attend
the new Treatment Mall
Then we have to wait
to have to be escorted over
We wait for staff
to coordinate their paperwork and
for patients who are behind schedule
Then we are escorted
by staff to the Mall
Upon arriving, we wait
for the Mall coordinator to tell us
what groups are happening and
in which rooms –
even though this information
is posted on the bulletin board
We walk to our appropriate room
and wait for the instructor
and all attendees to appear
When the group is over we wait
our turn for coffee or juice
Then we wait again
for the coordinator to explain
the next groups available,
even though they're posted
on the bulletin board
We hurry to our rooms
and wait once again
After groups, we wait
to be "wanded" for contraband
and for staff to escort us
back to our wards
Next, we wait for lunch
but not in a hurried manner
This was written while I was waiting
for something in a hurry.

Anonymous

Resource Directory

Community Mental Health

Counseling Services of Addison County
89 Main St. Middlebury, 95753; 388-6751
United Counseling Service of Bennington County; P0 Box 588, Ledge Hill Dr. Bennington, 05201; 442-5491
Chittenden County HowardCenter
300 Flynn Ave. Burlington, 05401
Franklin & Grand Isle: Northwestern Counseling and Support Services
107 Fisher Pond Road
St. Albans, 05478; 524-6554
Lamoille Community Connections
(formerly Lamoille County Mental Health)
72 Harrel Street, Morrisville, 05661
888-4914 or 888-4635 [20/20: 888-5026]
Northeast Kingdom Human Services
154 Duchess St., Newport, 05855; 334-6744
2225 Portland St., St. Johnsbury; 748-3181
Orange County: Clara Martin Center
11 Main St.,Randolph, 05060-0167; 728-4466
Rutland Mental Health Services,
78 So. Main St., Rutland, 05702; 775-8224
Washington Cnty Mental Health Services
P.O. Box 647 Montpelier, 05601; 229-0591
Windham and Windsor Counties: Health Care and Rehabilitation Services of Southeastern Vermont, 390 River Street, Springfield, 05156; 802- 886-4567

24 HOUR EMERGENCY SERVICES

(Orange County)Clara Martin (800) 639-6360
*(**Addison** County)* Counseling Services of Addison County (802) 388-7641
(Windham,Windsor Counties) Health Care and Rehabilitation Services (800) 622-4235
(Chittenden County) HowardCenter for Human Services (adults) (802) 863-2400
First Call – Baird Center (children and adolescents) (802) 864-7777
(Lamoille County) Lamoille Community Connections (802) 888-4914
(Essex, Caledonia and Orleans Counties) Northeast Kingdom Human Servicse (802) 748-3181
(Franklin and Grand Isle Counties) Northwestern Counseling and Support Services (802) 524-6554
(Rutland County) Rutland Mental Health Services (802) 775-1000
(Bennington County) (802) 442-5491 United Counseling Services (802) 362-3950
(Washington County) Washington County Mental Health Services (802) 229-0591

Drop-In Centers

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

Vermont Psychiatric Survivors

Support Groups

Northwestern
Call Jim at 524-1189 or Ronnie at 782-3037
St. Paul's United Methodist Church, 11 Church Street, St. Albans, 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.

Depression Bipolar Support Alliance

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

Bipolar Support

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

Turning Point Clubs

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

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

Vermont Veterans and Family Outreach Program:

Bennington/ Rutland Outreach: 802-773-0392; cell: 802-310-5334
Berlin Area Outreach: 802-224-7108; cell: 802-399-6135
Colchester Area Outreach: 802-338-3077/3078; cell: 802-399-6432
Enosburg Area Outreach: 802-933-2166
Lyndonville Area Outreach: 802-626-4085; cell: 802-399-6250
Vergennes Area Outreach: 802-877-2356; cell: 802-881-6680
Williston Area Outreach: 802-879-1385; cell: 802-310-0631
Windsor Area Outreach: 802-674-2914
Outreach Team Leader: 802-338-3022/ 802-399-6401
Toll-free Hotline(24/7) 1-888-607-8773

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.

www.vermontrecovery.com
Links to just about everything...including back issues of ***Counterpoint.***

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
Rutland: Transitional Residence: Dodge House 802-775-6772
Burlington: Waystation / The Wilson 802-864-7402
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.

Disability Rights Vermont

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 on Mental Illness - VT (NAMI-VT)

Support, education and advocacy for families dealing with mental illness. 1-800-639-6480, 162 S. Main St., Waterbury, VT 0567; www.namivt.org; namivt@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)