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

Counterpoint

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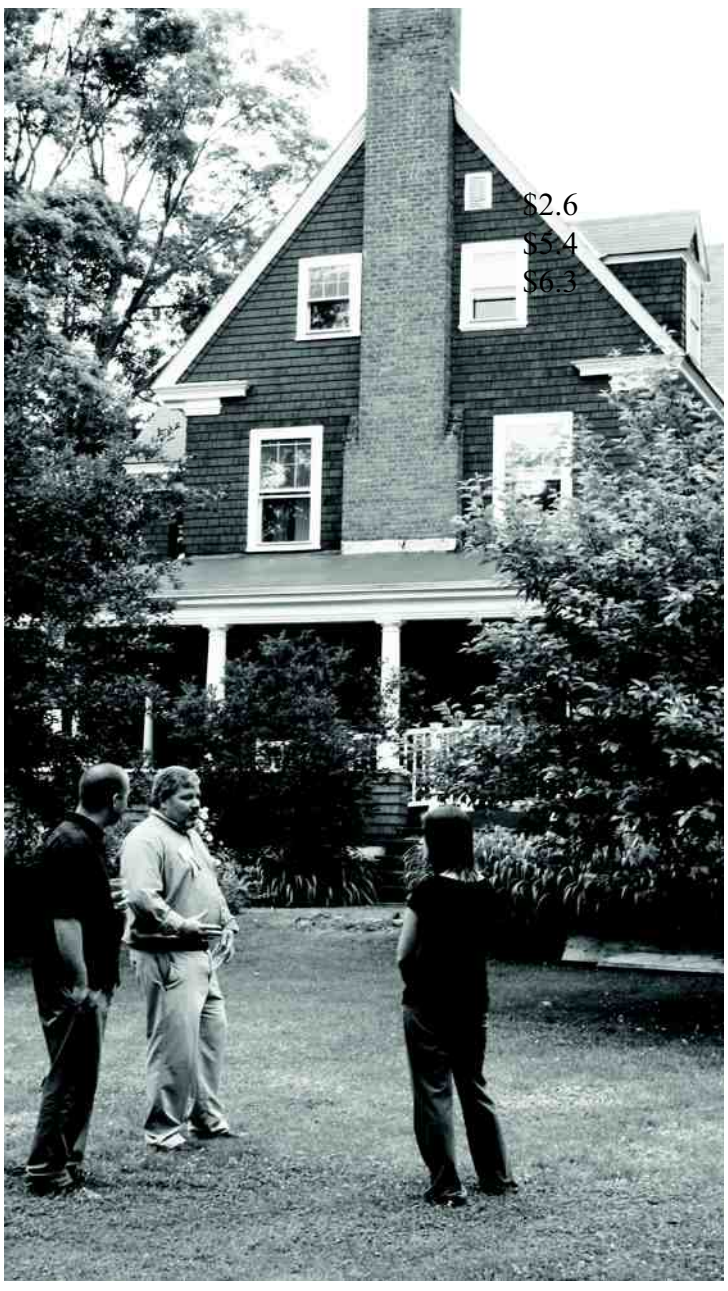

HILLTOP VIEW — Staff enjoy a chat in the spacious side yard of the new Hilltop House intensive recovery residence in Westminster during its open house this past summer. There were three admissions within the first several weeks. The residence will focus on young adults experiencing a first episode of mental illness. Dan Fisher, MD, a national leader in holistic alternatives to medication, will be doing training over the next six months with the staff and three physicians who will provide services there. More information about the development of intensive recovery residences in Vermont is on page 7. (Counterpoint Photo: Anne Donahue)

Mental Health And the Police:

Taser Death Puts Focus On an Even Faster Track

Commissioner says outcome 'probably would not have occurred' if current new policies were in place.

by ANNE DONAHUE
Special to Counterpoint

The death of a man in Thetford after being shot by a Taser made it "starkly clear" that police and mental health staff needed to move ahead rapidly with existing plans to work together more closely, according to Commissioner Patrick Flood of the Department of Mental Health.

"That incident probably would not have occurred" if the steps taken since then had been in place at the time, he said. He noted that in the hours of attempted response to Macadam Mason, there were four law enforcement officers but no mental health staff.

Public Safety Commissioner Keith Flynn said that the state "is learning from Thetford and other [situations]... the value of training is always understated."

Flood said it was Flynn who reached out to him after the death, but "we were thinking the same thing at the same time." They issued a joint media statement on July 2, 11 days after the death, to announce the intent to "step up the pace" in the efforts to "work together to improve responses" to persons in crisis.

"Situations like the recent death in Thetford illustrate the need for improved coordination and mobile outreach," it said. The statement committed to establishing contact persons in every area within 48 hours, and to create a joint protocol to guide response within three weeks. Both departments are now fully involved in working together to establish joint training.

Neither commissioner, however, was willing to give support for a suspension of Taser use until a statewide policy was in place and all police have updated training for addressing a mental health crisis. The call for a suspension came from a group of advocates shortly after the death, and signatures on a petition are still being collected.

"We need to assess how we're using the Taser; what value it has to the people of Vermont," Flynn said, but not to remove the weapon without evaluation.

Taser is the trade name for a specific electronic control device. A Taser is a "safer

(Continued on page 5)

Hospitals To Proceed if Funding Is Cut

MONTPELIER — Hospital renovations and the new facility to replace the Vermont State Hospital need to go forward, even if the amount of federal emergency money that was expected falls through, legislative and administrative leaders have told *Counterpoint.*

The money was expected because Tropical Storm Irene forced the closure of the Vermont State Hospital. The legislature agreed to a total of about $40 million last spring to be spent in Brattleboro, Rutland, Morrisville and Berlin. At that time it appeared that federal funds would contribute as much as 90 percent of the cost.

"We don't see a lot of wiggle room" in what has been committed to new inpatient beds, Jeb Spaulding, the Secretary of the Administration said. "We haven't slowed down." That includes the new construction planning that is underway in Berlin, with its groundbreaking set for late this fall.

"I think that we are committed to replacing the state hospital," said Rep. Alice Emmons, chair of the House Institutions Committee. "I would anticipate that we will continue on that [original] course."

An interpretation of rules by the Federal Emergency Management Agency [FEMA] has raised questions about whether the projects will be found eligible for the amount of flood replacement money state officials had been counting on. That could leave the state with a much higher cost. AD

For more on progress of the reforms to the mental health system, see pages 5 through 9.

Your Advice Is Wanted!

Consumer Organizations:

Vermont Psychiatric Survivors
Contact Linda Corey (1-800-564-2106)

*Counterpoint Editorial Boar*d
The advisory board for the VPS newspaper, assists with editing. Contact counterp@tds.net

Alyssum Peer crisis respite.
Contact Alyssum.ed@gmail.com

Disability Rights PAIMI Council
[Protection and Advocacy for Indivisuals with Mental Illness] call 1-800-834-7890 x 101

State Program Standing Committee for Adult Mental Health: The advisory committee of consumers, family members, and providers for the adult mental health system. Second Mon. of each month, 12:30-4 p.m.; Redstone Bldg, 26 Terrace St., Montpelier. Stipend and mileage available. Contact the Department of Mental Health for more information.

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

Transformation Council: Advisory committee to the Mental Health Commissioner on transforming the mental health system. New members welcome. Check with Department of Mental Health for times and locations.

NAMI-VT Board of Directors: Providing "support, education and advocacy for Vermonters affected by mental illness. Contact Marie Luhr, mariel@ gmavt.net, (802) 425-2614 or Connie Stabler, stbler@myfairpoint .net, (802) 852-9283.

Hospital Advisory Groups

Vermont State Hospital: Advisory Steering Committee; SUSPENDED.

Rutland Regional Medical Center: Community Advisory Committee; fourth Monday of each month, noon, on unit .

Fletcher Allen Health Care: Program Quality Committee; third Tuesdays, 9 -11 a.m., McClain bldg, Rm 601A

Brattleboro Retreat: Consumer Advisory Council; third Tuesdays, contact Retreat at 800-738-7328.

NAMI Vermont Family Education Classes

Do you care about someone living with a mental illness? Illness is a family matter, support your loved one!

Berlin, Rutland and Bellows Falls

Classes starting mid September 2012

Join our FREE Education Program:
An evidence-based educational program consisting of 12-weekly classes structured to help families and friends of individuals with mental illness understand and support their loved ones while maintaining their own well-being. To register call 802 951-9154 or email juniperdr@comcast.net. Space is limited, advanced registration is required.

2012 NAMIWalk-VERMONT
September 22
at the Burlington Waterfront.
Registration starts at 10 a.m.
Walk starts at 10:30 a.m.

The Department of Mental Health

Redstone Building, 26 Terrace Street
Montpelier, VT 05609-1101
802-828-3824

E-mail for DMH personnel can be sent in the following format:
FirstName.LastName@ahs.state.vt.us

http://mentalhealth.vermont.gov/

For Department of Mental Health public meetings, go to web site (above) and choose "calendars, meetings and agenda summaries."

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
- **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 Institute of Mental Health:** www.nimh.nih.gov
- **National Mental Health Association:** www.nmha.org
- **National Empowerment Center:** www.power2u.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/
www.nolongerlonely.com (meeting MH peers)
www.brain-sense.org (brain injury recovery)
http://www.crazymeds.us/CrazyTalk/index.php

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

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Check Deadlines Before Sending Information!

Writers Needed

Counterpoint **offers stipends for writers accepting assigned articles to research and write. There are always new and interesting topics!** **Contact the editor: Anne Donahue Counterpoint, VPS, 1 Scale Ave, Suite 52 Rutland, VT 05701, or counterp@tds.net**

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Help Offered for Medicare Open Enrollment

Medicare's annual open enrollment period for choosing a new plan is October 15 to December 7. This is an opportunity for all Medicare beneficiaries to review their Medicare Drug Coverage and Medicare Part C plan.

Experts advise those who receive Medicare to mark their calendar with those key dates. In preparation, everyone enrolled in Medicare should check how their plan coverage works. This is the responsibility of the individual.

"If you need help, don't wait. You can contact one of the organizations featured in this article right away," advisors said. Help is available to Vermonters enrolled in Medicare, those approaching Medicare eligibility, and qualifying younger persons with disabilities.

If a person's current plan is discontinued, open enrollment is the only time to choose a different plan. A person may also decide to switch plans because he or she finds a choice that better meets his or her needs. Sharon O'Neill, of the non-profit Senior Solutions, advises all Medicare beneficiaries to ask these questions to prepare for open enrollment:

Is the cost (premium) of my plan changing?

Will my plan still cover the drugs I need?

Are there any drug restrictions?

How does my plan coordinate with any state or federal benefits, if I receive these?

Is there a plan that fits my needs better than my current one?

"Watch your mail," said O'Neill. "Your current drug plan will send you information in the fall about any changes they are making. For example, they may change the cost of the premium, deductible and co-pays, or the list of drugs included in the formulary. You can compare your current plan to other plans and choose the one that's best for you."

Doing the homework for open enrollment can be confusing, but free personalized advice is available for Medicare beneficiaries in Vermont, through the Vermont Area Agencies on Aging.

Vermont's State Health Insurance assistance Program (SHIP) helps Vermonters learn everything they need to know about Medicare. SHIP provides free, unbiased information. They are Vermont's experts on Medicare. The federal government's "Medicare & You" handbook lists the SHIP number on the back cover. SHIP offers free classes, information by internet and telephone, and in some cases one-on-one meetings. Medicare classes are happening now. To find out about class dates all over Vermont, call the Senior Helpline/SHIP at 1-800-642-5119. If there's no class near a person, SHIP will provide personalized answers and information over the phone. SHIP's staff and trained volunteers provide confidential counseling and answer questions about confusing medical bills and statements, Medicare, Medigap, Medicaid, the Drug Cards, and more.

Open enrollment does not apply to those new to Medicare who have not yet enrolled. Such individuals can contact the Social Security Administration and ask if they are eligible for Medicare Part A and Part B. Then, SHIP can tell them if they are eligible for assistance in paying premium. It is also recommended that they take a Medicare class.

Vermonters and their caregivers can access all of these services by calling: The Senior Helpline (serves all of Vermont): 1-800-642-5119. Individuals may also want to call their current drug plan provider, or 1-800-MEDICARE (1-800-633-4227). Helpful web sites include:

www.VermontSeniors.org has contacts for all of Vermont's Area Agencies on Aging;

www.SeniorSolutionsVT.org/medicare has comparison charts and more;

www.Medicare.gov has a comparison tool for drug plans, medigap policies, and more.

Act 114 Evaluation of Involuntary Medication Administration

Did you receive court-ordered involuntary medication at the Vermont State Hospital any time between 2003 and August 2011 - or at the Brattleboro Retreat, Rutland Regional Hospital or Fletcher Allen Health Care between September 2011 and June 2012 ?
If so, you should be receiving a letter in September from Legal Aid/Mental Health Law Project inviting you to earn $50 by discussing your experience with independent researchers.

What is Act 114 and what is the purpose of the evaluation? Act 114 is the Vermont law that deals with non-emergency, involuntary psychiatric medication.

Every year, the Vermont State Legislature requires that an independent research firm conduct an evaluation of how this law is being followed. Before Tropical Storm Irene, the evaluation looked at how the Vermont State Hospital and Department of Mental Health were following this law. With the closing of the state hospital, the evaluation will expand its research in order to examine how the law is being followed now at the Brattleboro Retreat, Rutland Regional Hospital or Flectcher Allen Health Care.

A major part of the evaluation is based on information and suggestions gained from individuals who have been medicated involuntarily, any time between 2003 and June 2012, under an Act 114 court order at any of these four hospitals.

Why might you consider being interviewed for this evaluation?
If you receive a letter in September from Legal Aid inviting you to participate in an interview with the independent researcher, you will have a chance to:

Point out any major problems that you think the Department of Mental Health and/or the State Legislature should address around implementing this law.
Talk about anything either positive or negative that resulted from your receiving involuntary medication
Give your recommendations about how the law should be changed
Make a difference in how involuntary medication is used in the future with other individuals

How will you be compensated for your interview? Each person who agrees to be interviewed will receive $50 for their time and feedback.

Who conducts this evaluation? Joy Livingston and Donna Reback, from Flint Springs Associates, are independent evaluators who have received the contract to conduct the evaluation and write a report to the Legislature.

How can you find out more about this project before making a decision?
If you receive a letter from Legal Aid about this evaluation you will be given a toll-free phone number where you can speak with Marty Roberts, an advocate and Vermont Psychiatric Survivor representative. Marty will give you a complete description of this evaluation and answer your questions.

How can you sign up to be interviewed? If you decide to be interviewed, Marty will put you in touch with Donna Reback to set up an interview time and place. Donna can interview you in person or on the phone, depending on what is best for you. Interviews are completely confidential - your identity will not be revealed. Donna will be conducting interviews between mid-September and early November 2012.

Peer Group Raises $1,000 Plus

BENNINGTON — The CRT peer support group raised more than $1,000 through a 5k fund raiser run in June. The race was called "Go the Distance" and was in support of group activities. The group is peer-run and is for individuals to help in recovery and to provide support that they may not be receiving in the community, according to the United Counseling Service newsletter, which announced the fundraiser outcome.

Warm-Line Employment Opportunity

Rutland County Peer Run Warm-Line

Part time position with a peer operated telephone service which provides support to individuals within Rutland County, state, and nationwide. Looking for an individual willing to be a leader, and team-oriented. The position requires respectful communication skills and abilities to provide attentive listening to other individuals. To inquire contact team leader Trina Tatro at 802-770-4248.

CORRECTION

The article "Vets Work Together To Build Self-Respect" in the Summer, 2012 issue of *Counterpoint* inaccurately stated that Donald Stone was one of the original five facilitators of the Vet-to-Vet program. *Ed.*

In the Kingdom, Funding Brings Hard Work To Fruition in Police-Mental Health Planning

by ANNE DONAHUE
Counterpoint

St. JOHNSBURY – The groundwork laid by a team of dedicated advocates, law enforcement representatives, and health care leadership may be what makes the difference in helping others in the state jump quickly into improved emergency responses.

"We helped create this" in the Northeast Kingdom, said A.J. Ruben of Disability Rights Vermont. Now other areas "are getting the benefit" of that work as the money becomes available to expand crisis staff to work with police, he said.

A collaboration agreement was signed last December by an impressive group of local agencies and a communication protocol was already nearly complete in June, and adopted in July.

It became the model for what was rapidly put in place across the state after an emotionally distraught man died after being hit with a Taser barb fired by a state police officer on June 20.

Tina Wood credited the success in implementing the project on the commitment of those involved.

"The players were always at the table," she said: Northeast Kingdom Human Services, the district's state police commander, the Caledonia sheriff's office, Northeastern Regional Medical Center, and local ambulance services. "They always treated it as a high priority."

It took more than two years of regular meetings and discussions to identify the problems and solutions, she said. "They all agreed upon what was needed" and "now it is up and running."

Wood believes that the ability of other areas to now move rapidly will depend in part on "the relationships that already exist" among the key players.

Law Enforcement: 'Open Arms'

For Police Chief Clem Houde, the evidence of success is already there, and he believes any law enforcement agency "would accept with open arms" the help being provided to police.

Mental health intervention is something "that we're not qualified to work at," he said. Police are put in situations that are "above our head," but "we are the last option." The police can't just say we'll leave it to someone else to deal with, when no one else is there, he said.

The only apparent option is sometimes for police to take a person unwillingly to the hospital. It takes police away from responding to other needs, and isn't helpful to individuals in crisis when they face long waits without trained support.

"I have sat at that hospital many a time with someone who is very volatile," Houde said, and they get increasingly volatile as they wait.

In fact, it was a situation where a person was refusing hospital intervention which brought the need for improvement to the attention of Disability Rights Vermont. They received a complaint about an individual who had made a call threatening suicide during the Christmas holiday in 2010.

An ambulance responded, but its staff couldn't talk the woman into going to the hospital, so the Vermont state police were called. After they, too, spent time unsuccessfully, she was ordered for an involuntary emergency exam.

She was taken from her home in her panties, a T-shirt, and shackles in front of her neighbors, Reuben said. She then ended up being discharged the next day as not being in need of hospitalization. All of that might have been avoided if a trained mental health clinician was on the scene.

Now, Houde said, NEKHS has the trained staff who can go to a home directly. The police role is focused on ensuring the situation is safe.

Luck of Timing Brought Funding

The progress on developing a best response hit a stroke of luck in its timing.

"We all agreed to get together and stuck to that commitment," said Bernard Norman at NEKHS. The aim as identified early in the process was to create "more timely and relevant mental health crisis response."

But the agency only had a "skeleton crew" for emergency work, with no ability to go on the road and no money for expansion.

NEKHS recognized the need both for emergency coverage as well as funding for the "ability to do case management out in the field" with individuals who were not agency clients, something termed "non-categorical case management."

Just as the group was at the stage of drafting its memorandum outlining what was needed, Tropical Storm Irene struck, and with it came the state's decision to add major resources to community intervention.

"It all came about at the same time. All of a sudden the resources were there" to put the plan into place, Norman said. Two of the four positions created have now been filled, he said.

"It wouldn't have happened without Irene," Reuben said in agreement.

All those interviewed said that one of the most exciting parts of the new initiative is the preventive work that has emerged.

A so-called "hot referral" from the police means "we need some assistance right now," Norman said. A "cold referral" is a non-urgent need, but a situation where there is "someone they have seen that seems to be struggling."

Police share the information with the clinical team, and the team then offers services. It becomes "a bridge between law enforcement" and the services needed, Houde said.

The actions workers may take remain confidential, so the police don't get a report back, but Houde said he doesn't need that kind of information to measure what is happening. The police can see the change in the pattern of behavior that led to the referral.

Houde gave an example from the past that involved a woman calling police because she was convinced her home was being burglarized. The evidence she offered was that her bed was not made up. "There wasn't much you can do" from a police perspective, but without help, she could end up in crisis and losing her ability to live independently.

He had new examples, in contrast, of "the social work that's going on with the non-emergency" that is now available to prevent such potential declines.

In one case, a woman lost her driver's license after being recommended for a re-exam by the police. The police were just "doing what we have to do," but it was "devastating to her," and her anger was focused on the police, he said.

The clinician's intervention has helped her with getting rides and with building supportive relationships.

Another individual has frequent "bouts" with being suicidal, and the referral means the police know the person is being offered help.

The team is using the term "embedded case workers" for the outreach staff, because of the way they link up in direct contact with the police. They have been "circulating through the police department" and doing police ride-along. Workers are checking in weekly at meetings both here and in Newport.

Cross-training is also a commitment made in the December agreement, and Reuben said it was essential to the process to include police, ambulance personnel, case workers and peers.

DRVT has been assisting with expansion in other areas, such as Rutland.

Thus far, he said that a significant system concern was that "peers are getting left out," when they could be the most ideal persons to help intervene. DRVT and Vermont Psychiatric Survivors met with police and others in Rutland recently, only to find out that a meeting had just been held that included only the Department of Mental Health, the police and the local mental health agency.

Ruben said they found Rutland police to be facing the same concern as elsewhere. "The police are saying we don't feel safe leaving them [persons in crisis] there," sometimes leaving no option but arrest or hospitalization.

Could Taser Have Been Avoided?

Behind the Northeast Kingdom project lurks a question. If it had existed in Orange County on June 20, could the use of a Taser and the subsequent death have been avoided?

"I think it's unlikely that it [the use of the Taser] would have happened," Ruben said, if a qualified mental health provider had been there to provide information to the officers on what the actual level of danger was.

Chief Houde was more cautious in his assessment, and did not address the specific incident, saying he didn't have access to the full facts.

"If circumstances arise where you have [enough] time," he said, mental health support is likely to be of value.

"But law enforcement must make sure it's safe" first, he said. "The officers do the best that they can to ensure safety."

The newly adopted emergency services protocol also makes that clear:

"The enhanced mental health worker should never arrive on any [crisis] scene without confirmation that the scene has been cleared and it is safe for them to do so," it emphasizes. That includes safety clearance by police, and safety clearance from ambulance personnel who may be treating a critical medical situation.

Although the Northeast Kingdom project was in development before the new Act 79 requirements, it was not the first initiative to create improved collaboration between police and mental health staff. A Bellows Falls model has existed for years, and the Burlington police created a social work position last year to help with similar situations. More recently, Barre police and Washington County Mental Health received a grant for the same purpose.

Taser Death Speeds Change

(Continued from page 1)

alternative to other uses of force," its manufacturer satates. Its web site says that a Taser carries "fine wires that connect to the target and deliver the [Taser] into his neural network. These pulses delivered by the [Taser] overwhelm the normal nerve traffic, causing involuntary muscle contractions and impairment of motor skills." The Taser web site includes a section on "Taser in the news" which makes no reference to the Vermont death.

In the meantime, state police officers "have all been mandated to go" to the training currently offered by the police academy, according to Cindy Taylor-Patch, who directs that training. Seats at two regional trainings are "filling up."

Flood said he did agree that there should be state standards for requiring such training for all law enforcement, but with the understanding that the type of training, including number of hours and other details would need to be assessed.

Mason had called for a hospital for help, and the state police were contacted and told that he was threatening to harm and kill himself and others, according to media accounts at the time. Mason ran into the woods behind his home shortly after troopers arrived.

He returned several hours later. Accounts about what happened next differ, and no formal reviews have been completed yet. Some witnesses said he was not threatening anyone. A trooper saw that he was unarmed and reholstered his drawn gun, but police said he moved towards the trooper with a closed first, yelling aggressively. It was then that the trooper fired theTaser, hitting Mason in the chest. He collapsed and was not able to be revived.

At a meeting to discuss development of joint training, Taylor-Patch said that attitudes on the part of police are changing. While some older officers still may say with regret, "What happened to the good old days when we just picked them up and brought them to Waterbury?" newer recruits join law enforcement because "they want to help people," she said.

"There's so much cynicism" because officers are "burned out on feeling they're not getting anywhere," Taylor-Patch said. There is a need to build "trust that the screener's not going to cause safety problems" at a crisis scene.

'What happened to the good old days when we just picked them up and brought them to Waterbury?'

As a result of the start of lines of communications, there has already been "a considerable shift in thought process" at upper management levels, according to Mary Moulton,who is DMH deputy commissioner and is heading up the police-mental health work.

Initially, the discussion was focused on having mental health workers nearby for consultation but not on site. Now, the majority of the state police district lieutenants are saying, "I'd rather have you there... sitting beside me" when it can happen safely, Moulton said.

Communication between police and local mental health agencies is "just key, key, key," she said, in building the necessary trust. Police need to hear that the agencies agree that addressing mental health "should not be a situation you're left with" without support.

Flynn said that about a quarter of all law enforcement encounters are with persons with a mental health condition. Flood said frequent encounters were inevitable with "so many people in the community who would have been in a facility" years ago. It is natural that some of them have occasional crises, he noted.

"Any time that situations occur in the field [there are] ways of doing things better" that can be learned, said Major Walter Goodell, the state police director of field forces. "It was shortsighted that we didn't take advantage of some of the resources we had" in the past.

However resources such as community crisis response teams haven't been available as a result of budget cuts, and "it became a culture" in emergency services to simply bring individuals to the emergency room for screening, Moulton noted.

There are places where new initiatives have been in place and working, but the community agencies are in "different stages of readiness" to make the change, she said. Hiring new staff rapidly has also been a challenge.

The most important aspect of training police officers is in how to build rapport with someone in crisis, Moulton said.

Mourning Fox, Director of Behavioral Health for Community Connections in Lamoille County, who was at the meeting on training, agreed.

"Active listening skills" are key for those responding, he said. It is essential to know the "dos and don'ts" based on particular types of symptoms, he said, and learning that "if you say this, it's probably going to make it worse," and vice-versa.

That was a significant part of a recent new training for the Lamoille County Sheriff's office, which is piloting a transportation service that would use unmarked cars and avoid the use of restraints.

Public Safety Commissioner Flynn, in his interview, made a similar point about police response. It's "not only the physical tools they have on their belt, but also [the heads] they have on their shoulders."

Flood, at DMH, said that the vigor of the new collaborations could hardly be called a silver lining to the tragedy of a death, but "we need to take advantage of the crisis that occurred" and the public attention it has brought. "I really am putting my faith in the communications between [the police] and the designated agencies," he said.

GUEST EDITORIAL

Rethinking How Police Respond

Valley Reporter, July 8, 2012

Reprinted by Permission

Gov. Peter Shumlin and Attorney General William Sorrell didn't exactly exude sympathy in rejecting a plea last week by a coalition of civil rights and mental health advocates to place a moratorium on the use of Tasers by law enforcement officers in Vermont pending a review of policies and training. Fortunately, the State Police and the Department of Mental Health seem to recognize that there's an urgent problem that needs to be addressed and are taking steps to do so, albeit in a different way.

The call for a moratorium came as the result of the death of Macadam L. Mason after a state trooper shot him in the chest with a Taser during a brief confrontation at his Thetford home on June 20. Mason, 39, was sufficiently distraught earlier that day to have called Dartmouth-Hitchcock Medical Center in a suicidal state, and his longtime partner says he suffered frequent seizures, including one the night before. State Police and witnesses differ on whether Mason was acting aggressively toward the officer at the time he was shot.

At his weekly press conference, The Associated Press reported, the governor said he believed Tasers are an important tool for law enforcement personnel and would support their continued use even if it turns out that the Taser strike contributed significantly to Mason's death. And Sorrell said a moratorium would be "an awfully broad reaction to a single situation."

We wonder how many such tragedies would have to take place to elicit a reaction from the attorney general. Two? Three? Several?

The attorney general's view is especially interesting in light of the fact that his office has issued an annual report showing that only 73 percent of Vermont State Troopers and 46 percent of law enforcement officers throughout the state have received specialized training in how to deal with people suffering from mental illness. That in itself seems like a good argument to suspend the use of "electronic control devices" until virtually all officers have been trained to recognize the particular dangers they pose for the mentally ill and disabled and the emotionally disturbed.

While that ought to be a minimum requirement, the approach outlined Monday by Mental Health Commissioner Patrick Flood and Public Safety Commissioner Keith Flynn is more promising and carries a welcome sense of urgency.

Within 48 hours, they said, all local mental health agencies and district State Police barracks will have a designated contact person to speed and coordinate two-way communication when a call comes in involving a mental health crisis. Whenever possible, a mental health professional will join police at the scene, the two commissioners said. Additionally, plans are under way to create mobile crisis response teams once staffers have been hired and trained.

This will no doubt be expensive. And we're guessing that the protocols for how these teams operate will be tricky to write, balancing as they must the safety interests of mentally ill subjects with those of the crisis team staffers and police officers. But it seems to us that bringing to bear the insight and expertise of mental health professionals on these chaotic situations filled with potential tragedy is exactly what's needed to resolve more of them without any use of force and to get the mentally ill the treatment they need and deserve when they experience a crisis.

What Does Act 79 Require To Reform the Post-Irene System?

A. **Law provides principles for reforming mental health care in Vermont.**

B. **Requires that health care reform fully include the reformed mental health system and parity.**

C. **Creates a care management system which must:**

- coordinate how people *move between services* through the system, including least restrictive transportation;
- coordinate how *service systems work together* (corrections, alcohol and drug abuse, mental health, aging and independent living, Blueprint for Health, and health care reform)
- *monitor quality* for best outcomes;
- *include stakeholders* in oversight;
- protect client *privacy rights*;
- ensure client access to a *patient representative*.

D. **Requires that the system include**:

- comprehensive *community services*
- *peer services*
- *alternatives* to treatment with medication
- recovery *housing*
- intensive *recovery residences*
- enough *voluntary inpatient* hospital space
- enough *involuntary inpatient* space
- a *secure residential* facility.

E. **Specifically requires the start of these parts of the system:**

- **new services run by peers** ***(warm-line, transportation, and other programs to reduce hospitalization)***;
- **increased community services** ***(emergency services and adult outpatient case management; four new crisis beds; a 5-bed peer-supported residence for persons wanting to avoid use of medication; housing subsidies)***;
- **more intensive recovery residence beds**: 15 in the northwest, eight in the southeast; and eight in the central or southwest areas of the state;
- **14 involuntary inpatient beds at the *Brattleboro Retreat* and six at *Rutland Regional*** under a contract (must accept all patients who meet admission criteria as long as a bed is available, state must pay full cost of services, patient rights must be protected; peer support access and community advisory committee required);
- **a new 25-bed involuntary hospital** run by the state in central Vermont;
- **temporary inpatient beds** until replacements are in operation;
- **a 7-bed secure residential recovery program**.

F. Requires reporting and review of deaths or serious injuries to any person receiving services.

G. Requires that inpatient psychiatric staff be the primary source for emergency involuntary procedures;

H. Eliminates several outdated laws that: allowed a "conditional voluntary" patient status; required committed patients to be transported only by law enforcement; and allowed state psychiatric technicians to provide nursing care without being licensed nurses.

I. Provides funds to continue the police academy mental health training.

J. Creates guarantees about rights of employees to jobs at the new hospital, if they were working at VSH when it flooded.

Requires reports: *Every year*: about whether every person is receiving the care needed for recovery support;

Next year, about effects of care being spread out to private hospitals, including recommendations on laws that need to change to protect patient rights, statewide consistent policies on restraint and seclusion, and outcomes of housing supports;

On how planning went, including intial program outcomes and whether there was adequate system capacity and a reduction in hospitalization;

An assessment of quality, and recommendations on how to move forward with the changes; and,

On how to streamline reporting by community mental health agencies.

This year: An independent consultant to report on (1) whether the proposed system will meet needs, and (2) how to assess quality and outcomes.

What Is the Progress?

Long Waits for a Bed Continue

The crisis situation with patients on hold in emergency rooms and corrections continues across the state, despite efforts to move clients more quickly to the right level of care. In the months of April, May, June and July, there were 10, 19, 15 and 22 individuals, respectively, for whom no hospital had space available. In July, that represented half of all persons being held for an involuntary emergency exam. The average time waiting for an inpatient unit that month was one and a half days (37 hours); the longest wait was five days. This compared to an average of 10 hours spent in the emergency room among those for whom a placement *was* available. Hospitals were frequently at capacity. In those four months, the Brattleboro Retreat admitted 26 patients, but had no beds available 53 times that a referral was attempted; Rutland Regional, 18 admissions, but 59 times that no beds were available; Fletcher Allen, 25 admissions, but 50 times with no beds; Central Vermont, 16 admitted, but 45 instances of no beds; Windham Center, one admitted, but 31 times that a referral was attempted and no beds were available. [Only the first attempted referral per patient was tallied.] **See pages 7, 8 and 9:** *Shows need to continue inpatient development and alternate referrals, as well as clinical resource management.*

Quality Manager Hired

The Commissioner has announced the hiring of Susan Onderwyzer as Quality Management Director for the Department of Mental Health. There are plans to create a committee that will identify quality monitoring goals. Goes towards goal of development of quality monitoring

Hospital Advisory Group Explored

The Department is evaluating how to restore the previous state hospital advisory group. Commissioner Patrick Flood asked for input from the Transformation Council, and is reviewing the idea of an inpatient advisory group that would include representatives from each of the state's hospital advisory groups. "Consistency of care among programs" is important, said Kate Purcell, a former advisory group member. *Steps towards improving stakeholders in oversight.*

Patient Representative Role Added

The former half-time patient representative position at the Vermont State Hospital is now contracted to Vermont Psychiatric Survivors as a full-time position that serves patients at all inpatient hospital psychiatric units, intensive recovery residences, and the secure residential program. The person "shall advocate for patients and shall also foster communication between patients and health care providers," the law says. *Meets requirement.*

Experts Focus on Quality and Planning

A consulting group hired by the legislature emphasized the need for "aggressive" monitoring of quality and a detailed implementation plan by the Department of Mental Health. The consultant, "Behavioral Health Policy Collaborative," was asked by the legislature to assess the system created by Act 79, to identify whether it will meet needs of Vermonters, and to recommend how to assess outcomes. The draft report offered 24 recommendations, but highlighted five as priorities: Create a detailed implementation plan; Hire enough staff to effectively monitor the use of all of the publically funded services; Create a quality assurance unit to develop standards and assess effectiveness and capacity of services contracted by the state; Direct funds to timely and quality crisis services; establish access and quality standards that can help to direct new resources to gaps in the system; and Create system objectives to ensure that inpatient and community services align. *Meets consultant review requirement.*

Progress Reports Detailed in This Issue

Work in Progress; Reports in Next Issue:

Uniform hospital standards on restraint and seclusion.
New services addressing least restrictive transportation requirement.
Corrections report on addressing inmates' mental health issues (separate new law.)

Moving Through Care, Better and Faster

MONTPELIER — Behind all of the new community supports and replacement hospital beds, one vision is intended to tie everything together: the creation of a system that will ensure that Vermonters can be matched with the level of mental health services that they need.

An essential part of that system is also to ensure that people can safety get to that care.

The Department of Mental Health held the first work group in late August to begin identifying how to develop what Jeff Rothenberg termed the "wide and all-encompassing" clinical resource management system required by the legislature under Act 79. Rothenberg is the newly appointed interim director of the Green Mountain Psychiatric Center and is chairing the group.

Critical early pieces, such as an electronic bed board that identifies open beds, are in place. The "intensive focus" right now is on persons who continue to find themselves "stuck" waiting in emergency rooms or in corrections for an inpatient bed, he said. Every morning there are "lightening rounds" at high levels to identify the most urgent situations, and decision-makers from DMH are on call 24 hours a day, 7 days a week.

Persons waiting for a voluntary inpatient bed have been added to the review along with those being held involuntarily, he added.

Two items on the target list for addressing the emergency room crisis are awaiting discussion with the state's emergency room medical directors group: what treatment should occur for such patients, and what the standards should be for use of emergency restraint, according to DMH Medical Director Jay Batra, M.D.

However, designated agency screeners are already playing a role in responding to those waiting in emergency rooms. "We now have a standard that screeners have to go back to see the person every 12 hours," said Deputy Commission Mary Moulton. "It's for support," but also to evaluate whether the person still needs an admission for an involuntary emergency exam.

The additional time for help from crisis staff has been resulting in some patients already under an emergency exam order being diverted into voluntary options. In June and July, two went to crisis beds, three were able to go home, one went to a residential placement and one to a nursing home. That represented diversion of almost 10 percent of patients who would otherwise have had an involuntary inpatient admission, Moulton said. For these patients, "the outcome of waiting couldn't be better when the reassessment occurs."

It is in the middle of addressing these day-by-day and hour-by-hour emergencies that DMH is beginning to develop the long-term system plan. "We're trying to build a house [the new system] while we're living in it," Rothenberg said.

The new work group began by reviewing principles that were developed in 2006 as part of the former Futures Plan. Members reacted favorably to the core ideals, which begin with, "Clients have an inherent right to choose where to live and/or to receive care. That choice may be limited by safety needs of the client and the community, and by the immediate availability of resources."

In the meantime, Moulton has been working around the state to improve ways that persons are transported to hospitals when it is against their will. Although the first law that passed requiring the least restrictive methods consistent with safety was in 2004, statistics over the years showed minimal improvement from the traditional use of uniformed sheriffs and metal prisoner shackles.

Already, the new statistics are showing change. In June of 2012, for the first time ever, an almost equal number of persons were transported by non-secure means as those in secure transport, and among those who were brought by secure transport, more than half had soft restraints used. AD *[More on new programs that are reducing secure transport and shackling will appear in the winter Counterpoint.]*

Residences in Planning Phases; First Opens

The first new 8-bed intensive residential recovery program under Act 79 has begun admitting clients, and a second is under development in Chittenden County. The new law requires the creation of 31 total beds.

Hilltop House opened in Westminster, near Bellows Falls, on July 31, and served its first three clients in early August.

In Chittenden County, Collaborative Solutions Corporation has identified a home in a rural area in Westford for an 8-bed program. Floor plans are well underway, and a certificate of approval application has been filed, according to Todd Centybear, Executive Director of HowardCenter, which is a member of CSC. CSC also includes Washington County Mental Health and Clara Martin in Orange County.

If all proceeds as hoped, an opening date could come by the first of the year. So far, community response has been "very positive," Centybear said. A public hearing will occur as part of the approval process, along with a recommendation from a stakeholder panel. CSC currently operates Second Spring in Williamstown, and "we will have integration... in terms of leadership, training [and] protocols," Centybear said.

Second Spring opened five years ago as the first program designed specifically to help state hospital patients transition to the community more rapidly. The 14-bed current program is serving up to 22 residents as part of the current crisis response to the sudden loss of the state hospital after severe flooding from tropical storm Irene.

Plans for Second Spring are to build an expansion to the building, and, after the other new residences open, to run with an ongoing new census of 16 plus two crisis beds. During the current emergency, the program has doubled up bedrooms and offices, and has lost its second living room.

The new Hilltop House was created through a partnership between Health Care and Rehabilitation Services of Southeastern Vermont, Rutland Mental Health Services and United Counseling Services. The partnership is called the Vermont Southern Alliance for Community Care.

The program has been actively identifying additional appropriate referrals since opening, George Karakabakis of HCRS said. According to the Department of Mental Health, it will need to balance between its vision of a "setting where young adults can recover from their first experience with mental illness" and being under contract as a part of the "no refusal" system of care that will include the highest level of inpatient care and a total of 24 new intensive residential beds.

"They [will] need to be more open" to system needs beyond their specific vision, said Patrick Flood, Commissioner. Deputy Commissioner Mary Moulton added that "we're going to work with them with each person."

A third 7-bed program, planned for the northwest part of the state, is on hold until the others are further developed, DMH has said. Rutland is adding two intensive residential beds to a center that will also include its two crisis beds.

The law requires 15 new intensive residential beds in the northwest, eight in the southeast and and eight in the central or southwest areas of the state. The Westford program represents eight of the 15 in the northwest and Hilltop provides the eight in the southeast. Central/southwest are currently represented by the two added Second Spring and the two new Rutland beds; the other four are not yet clearly identified. AD

AT HOME BY THE HEARTH – Mary Emery, RN, Hilltop's new nurse manager, and Rich Wrase, MSW, residential coordinator, share a moment in the living room at the new Hilltop House during its open house in July. (Counterpoint: Anne Donahue)

Soteria Contract Awarded

BURLINGTON — Pathways Vermont has been awarded a contract to develop a Soteria-VT residence in the greater Burlington area utilizing principles from a program from the 1970s that was started with a National Institute of Mental Health grant.

Project Director Steven Morgan explained that the Soteria model "differs from traditional hospitalization in its focus on 'being with' instead of 'doing to' individuals, its tolerance and flexibility to adapt to one's process, its cautious use of neuroleptic medications, its creative and non-professionalized environment, and most importantly, its belief that psychosis can be a temporary experience that one can work through as opposed to a chronic mental illness that needs to be managed."

The model was authorized as a new, 5-bed program in Act 79. Morgan said it is scheduled to open in mid to late 2013. Based on data available, stays at Soteria-VT are expected to average three to four months, he said. AD

CELEBRATING THE ADA — The Vermont Center for Independent Living hosted the annual celebration of the Americans with Disabilities Act again this summer in Montpelier. Alex Gallagher (left) gives the audience a joyful wave after receiving the Deborah Lisi-Baker Leader of Tomorrow award from past Executive Director Lisi-Baker. Gallagher, 11, is a member of Little People of America and was recognized for his outreach work to combat stigma in the Milton elementary school. Laura Zeigler (right) of Plainfield shares stories after receiving the annual advocacy award for her work on mental health rights.
(Counterpoint: Anne Donahue)

Peer Expansion Grants Approved

MONTPELIER — New programs developed and run by mental health peers have received funding over the past several months, and more are expected to be approved this fall.

One of the significant projects recommended by a peer services work group was to create a network of peer organizations across the state.

The Vermont Center for Independent Living received the grant to coordinate and support the development of a Vermont "peer network" for organizations offering peer-based services and supports to individuals with mental health and other co-occurring challenges, according to Nick Nichols at the Depertment of Mental Health.

Under the grant, VCIL will facilitate the development of the network to support the expansion, coordination, and quality improvement of peer services in the state.

In addition, Pathways to Housing, in partnership with Alyssum and the Washington County Peer Warmline, will develop plans for state-wide access to a non-emergency telephone response line ("warm-line"). The warm-line will be operated by trained peers for the purpose of active listening and assistance with problem-solving for persons in need of such support, Nichols said.

Pathways will work with existing peer organizations and services, including locally-operated warm-lines, to develop a plan to ensure statewide access to warm-line peer support.

Nichols said that the grant requires that the plan describe the specific goals and tasks necessary to develop sufficient infrastructure to ensure state-wide access through direct response and coordination with and referral to existing telephone support lines.

Other grants went to existing organizations to support their programs, Nichols said.

Another Way has received additional funds for increasing its staffing and infrastructure, which will increase its capacity to perform outreach and provide peer support.

DMH will also be giving funding increases to Alyssum and Vermont Psychiatric Survivors to expand their infrastructure and capacity to provide peer support. Increasing access to peer-run transportation has also been built into some of those expansion and development projects, Nichols said.

DMH is also in the process of negotiating with several peer organizations to develop new services to prevent and/or reduce the use of psychiatric hospitalization, he said.

Under Act 79, a peer is defined as "an individual who has a personal experience of living with a mental health condition or psychiatric disability." The newly funded projects were all authorized under Act 79. AD

Secure Program Plan Drags

MONTPELIER — The Department of Mental Health continues to struggle with locating a site for the 7-bed secure residence that is intended as an alternative to long hospitals stays for those who require high security and ongoing treatment.

"It has been frustratingly slow" to put a plan together, DMH Commissioner Patrick Flood said. The most likely outcome in the short term will be the interim construction of a modular unit.

Five patients fitting the profile for that program have remained in a wing of the prison in Springfield that has been designated as a hospital under an emergency executive order since tropical storm Irene.

Flood said that currently, "we have plans for every one of them," and that all should be out of that facility by mid-September. Other patients who meet eligibility for the secure residence are currently at the Brattleboro Retreat.

A barrier for community placements can occur if it requires a criminal court approval because the criminal charges remain pending. One patient currently in the Springfield prison unit is waiting for such a court decision before his plan can move forward for an order of non-hospitalization and placement at Eagle Eye Farm in West Burke.

Judge Cortland Corsones took a half day of testimony in mid-August in Rutland about a proposed placement for Mark Sailor, who had been at the state hospital since 2005. Dr. Jay Batra, Medical Director at DMH, said that Sailor has responded to treatment and was now able to control his impulses and seek help when needed.

Under the plan, Sailor would reside in a residence with alarms on all doors and windows and 24 hour and seven day supervision by two staff, including an awake staff person overnight.

Sailor would be under an agreement to a "quick return" ONH that would allow him to be returned to the hospital immediately if he violated any part of his treatment plan.

The plan was opposed by the Rutland County State's Attorney, Marc Brierre, who argued that he needed to remain in a locked hospital. Sailor was charged with attempted murder in a knife attack on a hotel desk clerk in Killington in 2005. Police said that the attack was unprovoked. Brierre expressed particular concern about the security of the victim.

Sailor has been found not competent to assist in his defense, and thus cannot be brought to trial or held in corrections unless he is found to have regained competency. He has been found to be a "person in need of continued treatment" under mental health law, however, which means he can be held in a locked mental health facility that is the "least restrictive" setting that maintains safety.

Eagle Eye Farm founder and Executive Director John Alexander testified that it provides care for about eight clients, most of whom will be there for the rest of their lives as a result of their disabilities. The majority have developmental disabilities or traumatic brain injuries, but the farm has also worked with mental health diagnoses, he said. Prior clients have included some with "pretty extreme" behavior involving harm to others. State hospital staff might initially accompany Sailor if Eagle Eye did not yet have the new staff in place for him. AD

Join the Discussion

All work groups on the reformed system and programs are open to the public. Meetings are listed on the Department of Mental Health web site [http://mentalhealth.vermont.gov/] and direct notice can be received by signing up for the Commissioner's weekly update by contacting: Judy.Rosenstreich@state.vt.us.

Hospital To Break Ground This Year

Regulators Promise Public Hearing For Input on Final Plan in the Fall

MONTPELIER —Architects and engineers are going at full speed since Governor Peter Shumlin announced this summer that he wanted a "shovel in the ground" this fall and an opening by the start of 2014 for the new psychiatric hospital being built by the state in Berlin.

The hospital will be located on Fisher Road, between the Central Vermont Medical Center hospital and medical offices and the boundary of Paine Turnpike.

Patrick Flood, Commissioner of the Department of Mental Health, said he was "very pleased" by the progress thus far, and that the next step was "to get [the] program workgroup up and running."

The urgency of the timing, based on a critical inpatient bed shortage after Tropical Storm Irene forced the closing of the Vermont State Hospital, means that the approval process for the construction will be filed under an emergency process.

That process does not require a public hearing, and no one can obtain "interested party" status, which permits special access to the process and the right to appeal a decision by the Commissioner of the Department of Financial Regulation.

However, DFR Commissioner Steven Kimball made a commitment to legislators that he will hold a hearing and take input once the application has been filed. Flood said that DMH will make plan documents available even before they are final to enable stakeholders to have enough time to review them before the hearing. Some materials will be posted on the department's web site [http://mentalhealth.vermont.gov/] by early September, Flood said.

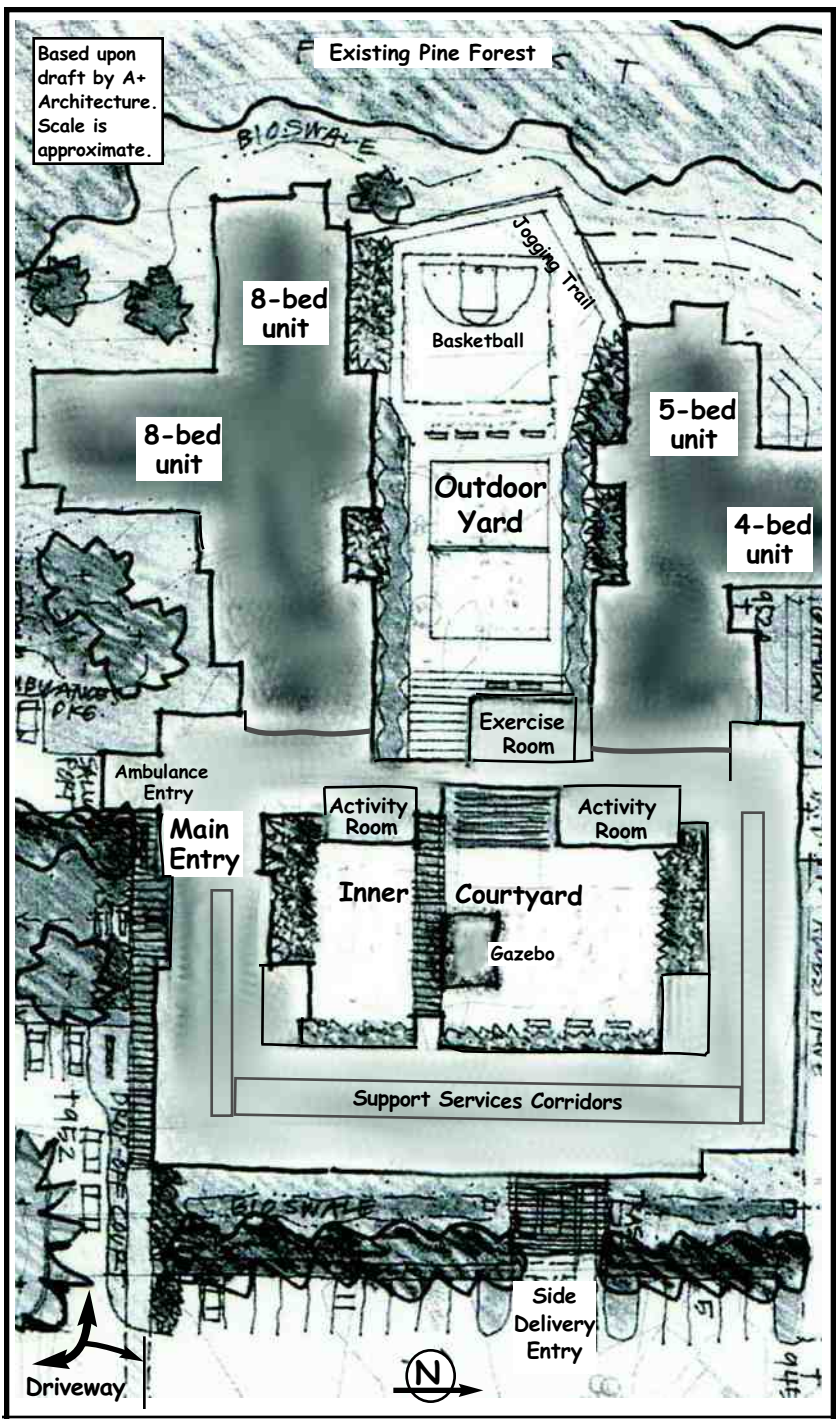
The stakeholder workgroup has spent all-day meetings in July and August with architects to help design the building plans, and a new group has now been formed to begin program planning.

Key design decisions included an emphasis on light and outdoor access, with both an inner courtyard and an outer activity area with enough room for sports activities and jogging. A greenhouse and gardening area are included in the draft plan.

The 25-bed hospital will have a 16-bed wing that is divided into two 8-bed units that share staff, and a 9-bed wing that is divided into 4- and 5-bed clusters. A separate area, accessible to all the units, will include an exercise room, a multipurpose library, computer and recreation room, and another multipurpose arts room.

In the early summer, the administration debated about the better of two sites in Berlin: the corner adjacent to the medical center, or a more spacious field that was nearby.

Advocacy groups, consumers, physicians, town leaders and residents of Berlin, and legislators successfully prevailed upon the governor's office to choose the Fisher Road site. Berlin officials said the community did not oppose hosting the hospital, but believed it belonged adjacent to other medical services rather than on property they felt was better suited for future economic development. AD



A preliminary draft of the site plan for the new 25-bed hospital in Berlin shows the clinical and staffing core of the building (lower end) with a central courtyard, and the two inpatient wings (upper end) with a yard between them. The entrance faces Fisher Road, along the left side of the plan. Detailed floor plans can be seen on the DMH web site.

Acute Bed Units In Construction Around State

MONTPELIER — Target opening dates began to take shape late this summer for three specialty inpatient units that will address some of the bed shortage since tropical storm Irene closed the state hospital a year ago. State regulators gave emergency approval to begin construction on:

Morrisville: November. Named the Green Mountain Psychiatric Care Center, this 8-bed unit is a temporary one to help provide space until the new hospital is built in Berlin.

Brattleboro Retreat: February. This 14-bed permanent unit will replace the unrenovated 15-bed unit that is currently providing this care.

Rutland: March. The 6-bed new unit will add to, but be separate from, the existing psychiatric unit at Rutland Regional Medical Center.

In late August, the Department of Mental Health announced that Jeff Rothenberg, a longtime community mental health leader and recent special assistant in the Commissioner's office, had been named as the Interim Executive Director for the Green Mountain Psychiatric Care Center.

DMH had hoped for a September opening date there after renovations in the rented space at the Lamoille Community Connections offices in Morrisville. As work began, however, asbestos was discovered in some areas. Although it had existed from the time the building was a nursing home, Lamoille Community Corrections was permitted to seal it in during its previous renovations because it was being used for offices, rather than a residential use.

The asbestos abatement took a number of extra weeks, and will likely add to the $2.6 million cost approved initially. As of late August, however, hiring and program design planning was underway.

At the Retreat, renovations to the fourth floor of the Tyler building have begun, according to spokesman Peter Albert. That unit will not actually add Vermont State Hospital replacement beds, since the Retreat has been providing those services on another unit since the flood. The state approved $5.4 million for the renovations. An outdoor courtyard is also under construction and the target date for completion is mid-September, Albert said. It will be the first space at the Retreat that allows for secure outdoor access for patients.

In Rutland, a slight delay occurred after the news that federal emergency funds might not be available to create the new unit to be added on the fourth floor. However, Jeff McKee, the unit director, said they hope to make up the time and stay on course for an opening date of March 1. That project includes a large rooftop recreation area that will be available to all the inpatient psychiatric units. As with the Retreat, it will become the first secure outdoor access available to patients.

Commissioner Patrick Flood said that DMH expects to file an amendment early this fall to reflect at least three changes from the construction certificate of need that was approved in June:

- revisions to the Retreat floor plan to include one seclusion unit, and a clarification that other recommendations for safey changes were used with adaptation, not in full. The Retreat relies on avoiding use of seclusion through "low stimulation areas"— sub-parts of a unit that create separated space that can be locked for a smaller number of patients who might otherwise be too agitated. A complaint about whether these "ALSAs" fell under the federal rules as "seclusion" was assessed during a site review by regulators in June, and they found no violation of seclusion rules.

- revisions improving the original draft of the Morrisville unit floor plans; and

- a reduction in cost for the Rutland renovations. Rutland is closing its physical rehabilitation unit for financial reasons, so the cost of moving it to another floor to make way for the new psychiatric unit is being eliminated. The initial approved cost was $6.3 million. AD

Dan Fisher Speaks at NAMI Annual Meeting

Further View on the Medication Debate

Several issues ago, Counterpoint published the comments of Sandy Steingard, MD, Medical Director at HowardCenter, as shared at a panel presentation on the work of Robert Whittaker regarding the risks and overuse of medications in psychiatric treatment. This spring, Steingard shared a discussion at the NAMI-VT annual conference on the subject with psychiatrist Dan Fisher, director of The Empowerment Center and a national speaker on the misuse of drugs in contrast to other, more recovery-oriented paths to healing. This article presents some of Fisher's perspectives from that presentation, along with some of Steingard's commrntd. Ed.

by ANNE DONAHUE
Counterpoint

MONTPELIER — "If it's all due to the chemicals, that's all you have to do."

That was one way that Dan Fisher illustrated the risk of relying on a biological interpretation of mental health distress that can be solved by medication — in contrast to a holistic view that recognizes that thoughts, beliefs, environment, body, and soul are all aspects of health.

Fisher did not say that medication had no value, but described the concept of "recovery-based use of medication," and identified two key principles to guide it.

First, he said, when considering whether well-being can be facilitated by medication,the input provided by doctors should be supportive, non-judgmental, and based on shared decision-making. The risk comes from the fact that "doctors are taught to be certain about what they are not certain about," leading to imposing a judgement about what is best for a patient.

The second principle is that there be an ongoing informed choice, which is essential to determining the pros and cons of using medication, he said. It is important to be searching for the ways to describe the difference between an illness-oriented model of mental states, versus one based upon experiences.

> *Often, what a person needs most is "someone just to be with me" at a time of emotional distress.*
> *— Dan Fisher, MD.*

"We're all basically whole. We're all basically healthy, deep down," Fisher said. A person's focus needs to be on "why am I here? What's the meaning of my life?"

"If all my life has been an illness... [it can be seen] as life ending." Instead, times of altered thinking "can be an opportunity for new learning" about a person's life, instead of fear of the reactions of others or labels such as paranoia or psychosis. *[See the commentary by Steven Morgan, pages 10-11, exploring this subject in depth. Ed]* Recognizing the presence of "unusual thoughts" rather than "delusions," for example, opens up options for collaboration on "a variety of choices beyond medication."

It is always an either/or, he said. Essential elements for support can include:

- medication with a goal of tapering its use;
- developing a therapeutic alliance that creates trust with someone through communication and dialogue;
- approaching issues from the views of recovery and wellness rather than a disease model. The brain is not the same thing as the mind, Fisher said; the mind is much more;
- keeping a record of medication uses and the response to them;
- recognizing that the use of medication can interfere with grief and addressing major life events that can be crucial to recovery.

Fisher identified a number of important tools in the recovery-based use of medication.

Individuals should have "wellness coaches" that help prepare them for discussions with doctors, and should recognize that medications need to be very individualized when used.

Tapering should always be gradual, he said, with a crisis plan as a back-up. Individuals should learn "self-soothing" stress reduction skills, and have a social well-being network of supportive people.

Mental wellness needs to be recognized as bio-psycho-socio-spiritual, Fisher said.

Sandy Steingard observed that it is a time of opportunity in Vermont as a result of new program development. Training in "open dialogue" — a model from Finland — can "integrate some of these alternatives."

She cautioned that because doctors are scarce and expensive at community mental health centers, it is others on new teams that need to have such skills developed to accomplish change. HowardCenter is working to create such an approach with its new START program, diverting persons from crisis through home-based outreach including the use of peers on the staff teams, she said.

Residential programs often have a bias against individuals getting off medications, and staff need to become aware of the subjective nature of such biases, Steingard said.

Fisher noted that an important element was greater public awareness through programs such as "Emotional CPR." Otherwise "it can be upsetting" when someone comes across a person who is hearing voices, for example.

Fisher also discussed the harm caused by belief in the need for "professional distance" that created anger and frustration for individuals because they receive no reaction or affirmation about their distress. It may be based upon fears of liability, but it means that concerns of others trumps the autonomy of persons seeking support.

Often, what a person needs most is "someone just to be with me," rather than being labeled or controlled. There is a need for people who can be "comfortable with others in distress."

Steingard agreed, and said that HowardCenter is looking for a place to develop a program where "disruptive behavior that is not dangerous can be tolerated."

Another Big Pharma Payout: Risperdol Was Mismarketed

From a press release by Attorney General William Sorrell

In the largest multi-state consumer protection settlement with a pharmaceutical company ever, Attorney General William H. Sorrell announced today that he and 36 other Attorneys General reached a record 181 million dollar settlement for the mismarketing of Risperdol by Janssen Pharmaceuticals, Inc., a subsidiary of Johnson and Johnson.

Attorney General Sorrell alleges that Janssen used unfair and deceptive practices when it marketed the antipsychotic drugs Risperdal, Risperdal Consta, Risperdal M-Tab and Inveg to children, elders, and those with depression or anxiety, when they are not FDA approved for the uses.

This is the fourth multi-state settlement to address off-label marketing of atypical antipsychotics. In March 2011, Vermont settled with AstraZeneca for $1.4 million relating to off-label marketing of Seroquel; in September 2009, Vermont settled with Pfizer Inc. for $432,000 relating off-label marketing of Geodon; and in October 2009, Vermont settled with Eli Lilly and Company for $1.5 million relating to its off-label marketing of Zyprexa.

"The marketing of drugs for uses for which they are not FDA approved can be extremely harmful to consumers, and this office will continue to aggressively pursue those companies that violate our Consumer Protection Act," said Attorney General Sorrell.

The settlement agreement restricts Janssen from promoting its atypical antipsychotic drugs for "off-label" uses that the FDA has not approved. Additionally, for a five-year period, Janssen:

Must clearly and conspicuously disclose in promotional materials the specific risks identified in the black-box warning on its product labels;

Must present information about effectiveness and risk in a balanced manner;

Shall not promote its atypical antipsychotics using FDA-approved diagnoses unless certain disclosures are made regarding the approved diagnoses;

Shall require its scientifically trained personnel, rather that its sales personnel, to develop the medical content of scientific communications to address requests for information; and

Must have policies in place to ensure that financial incentives are not given to marketing personnel that encourage or reward off-label marketing. Federal Law prohibits pharmaceutical manufacturers from promoting their products for off-label uses, although physicians may prescribe drugs for those uses.

The complaint alleges that Janssen promoted Risperdal for off-label uses to both geriatric and pediatric populations, targeting patients with Alzheimer's disease, dementia, depression, and anxiety, when these uses were not FDA-approved and for which Janssen had not established that Risperdal was safe and effective.

LETTERS

Left Out of Democracy

To the Editor:

The current democratic process for elections is really not as "democratic" as one might think. Just as women and African Americans were unable to vote for decades, there are now other large groups who find themselves simply removed from the process.

There are three groups in particular that we should be concerned about. They are handi-

Will Reforms In Health Care Include Mental Health System?

MONTPELIER — There are no work groups for it yet in the Department of Mental Health.

There was no particular reference to it in the initial health benefits package proposed under the state's new insurance exchange plans required by federal law.

No stakeholder meetings have been called, or work groups established, by the Department of Vermont Health Access, the Department of Aging and Independant Living, or the Department of Health.

There is no agenda topic on it for the Blueprint for Health work committee on mental health. There is no agenda at all yet for the Green Mountain Care Board's advisory group on mental health, which holds its first meeting on October 2.

What is "it"?

The part of the new mental health system reform law that requires that all of those areas — health care reform, the Blueprint for Health, substance abuse services, and the health benefits package — to include the new system as part of what each is doing.

Members of the Green Mountain Care Board expressed concern at a late August meeting about whether obstacles to access to mental health care were being reviewed by the administration's health reform staff. That sparked the first public recognition that Act 79 provided an early opportunity to at least address unequal insurance copays in health exchange benefit requirements.

That board is responsible for deciding upon the Vermont benefits packages to be required under the new federal law that creates a "health insurance exchange" for purchasing insurance. It also has the authority for further health care reform decisions.

In late August, the administration's health reform office said it was planning to propose to the Green Mountain Care Board that it require insurance products on the exchange to have equal copays for primary care, mental health and substance abuse care.

A separate bill passed last spring directed a report on the copay issue, which appeared to force the question to wait for further legislation. However Act 79 had stronger language about parity specific to health exchange products.

DMH Commissioner Patrick Flood told the Mental Health Oversight Committee in July that it is "defining the concrete steps that need to be taken" to integrate with health care reform.

However Sen. Jane Kitchel, chair of the Health Access Oversight Committee, identified one of the possible gaps at a meeting of that legislative group in May. "Are we overlapping a care management system" that fails to address integration of care for clients on the day-to-day level, and not paying attention in terms of "where we want to go in the long term?"

Consumers and advocates identified other questions about integration as well in various meetings over the summer.

Linda Corey of Vermont Psychiatric Survivors observed that psychiatry and primary care continue to provide poor follow-up, ignoring physical health issues, for example, when looking at symptoms and medication problems.

Ed Paquin from Disability Rights Vermont said that the positive emphasis on community services in the reformed system meant those still receiving inpatient care would represent "people with the highest medical needs."

"They should be down the hall from a cardiac unit... or a neuroimagery unit," he said. That will not become a reality for most of the new inpatient beds being developed. Of the 45 new inpatient "Level 1" beds under development in three locations, only six — those at the Rutland Regional Medical Center — will be within a medical center. AD

Retreat Apologizes to Legislators

by ANNE DONAHUE
Counterpoint

MONTPELIER — The Brattleboro Retreat's Chief Executive Officer told a legislative committee in June that "I am very sorry for my mistakes during my [earlier] testimony" about a patient's death from a drug overdose that occurred in January.

Robert Simpson's statement to the Health Access Oversight Committee differed in the regret he expressed about mistakes, in contrast to when he was first questioned by news media about denying that the Retreat had any violations cited by the Centers for Medicare and Medicaid Services related to the death.

That testimony was provided to the Senate Health and Welfare Committee in February when the death was still under review by CMS.

The patient had stolen methadone from a nurse's medical cart, and was found dead two nights later. CMS found that he received no nursing reassessment that night despite the fact that staff noted unusual noises and yelling from him during sleep, and were unable to wake him up.

Simpson did not disclose the facts surrounding the death or the ongoing CMS review, and testified that the cause of death was unknown and possibly from natural causes. A day after that testimony, CMS found the Retreat to be out of compliance, and it lost its "deemed status" that allowed CMS to assume compliance as long as it was in compliance with the Joint Commission.

CMS conducted a further review in June, and informed the Retreat that it was at risk of losing its Medicare funding as a result of deficiencies.

After a re-survey in July, CMS informed the Retreat that its "termination notice" had been cancelled and it was back in full compliance with CMS conditions, the Retreat said later in an update to legislators.

Simpson told the HAOC in June that the Retreat had suspended new private admissions in order to "stop and take a breath" after a period of very rapid growth. It was addressing education in every unit,and meeting with leadership teams.

Counterpoint was the first news organization to contact Simpson in May to question his February testimony. At that time, he said that he still believed it was accurate to say there were no violations, because there had been no notice from CMS yet. He acknowledged that he failed to update the committee when he learned of the violation report just days later.

Simpson later denied the loss of its "deemed status" when interviewed by the online news organization, VTDigger. The VTDigger article pointed out that the testimony in February came at a time that the administration was proposing a major contract for inpatient care of patients in state custody with the Retreat. The legislature also approved several million dollars to renovate a unit at the Retreat for that care.

"It was not my intent to be deceptive," Simpson told *Counterpoint* in his May interview. In his statement to the HAOC, he said he regretted being "unclear," and "if I could do it over, I would... I also did not report back to the Committee after receiving the report [from CMS] and I should have. I deeply apologize for this oversight." He said the inaccurate statements to VTDigger about "deemed status" were a result of the Retreat's own "confusion" about the message from CMS.

Patrick Flood, Commissioner of the Department of Mental Health, also testified in June and said that "I accept that responsibility" for failing to volunteer the information about the violations and the facts of the overdose when he was aware of them in February. He had told *Counterpoint* that in February, he didn't have clarity on the types of information the legislature should receive. In June, he told the HAOC that "we stand ready to provide that [type of] information in the manner you see best."

CMS Restores Hospital To Full Compliance Status

capped veterans, the aged that are confined to nursing homes, and the institutionalized mentally impaired.

These are citizens that find it difficult to reach the polls on election day. We must ensure that these people register and are provided with absentee ballots.

As we are told, every vote makes a difference. Why not encourage and assist all individuals to participate in the process of representation? Why do we neglect these populations? They are entitled to the same dignity and respect as anyone else. Instead, they are discredited. This is clearly a form of hidden discrimination.

These individuals are not incompetent. They have issues like the general population. Among them are health care, housing, and employment. In addition, these are individuals of normal intelligence and can make rational choices. Consider the outcome if an effort were made to solicit their votes all across the nation.

KELLEY L. MURRAY, Brattleboro

Point →

Reviving the Myth

by Steven Morgan

What do we mean when we say someone has a mental illness? If we are to take the phrase literally, we mean that someone's mind is ill. But can a mind be ill with disease?

To believe so, one must make two serious assumptions: one, that the mind is a tangible object with discrete boundaries, and two, that the health of that object can be measured. Both of these assumptions are wrong. Since nothing called a mind exists that can be looked at under a microscope, the former assumption is wrong. The mind is not an object. It follows that the latter assumption is also wrong because only objects with discrete boundaries can be objectively measured.

Thus, it is important to note that mental illness in itself – the idea that a mind is ill, is actually a categorical error, like saying the sky is ill or the color green is healthy. There is no such thing as mental illness except by metaphor.

It may seem like trivial semantics, but the mistake that mental illness is something concrete has led to an epidemic of mythology. Every day, someone is told they have a thing inside them called mental illness that must be contended with long-term in order to achieve health. What follows is people learn to see themselves as having ill experiences and well experiences, unlike the normal population who somehow manage to live without sick feelings and thoughts.

This attitude can have devastating effects psychologically, as it assures a person that something is wrong with them at their root – their mind, and that they cannot live confidently in their understanding of the world. Physically this attitude can lead to injury, as it assumes and often persuades anyone diagnosed with major mental illness to take risky medications indefinitely as opposed to selectively, which can lead to long-term addiction and a wide range of disabilities, bodily dysfunctions, and disturbing behavior. And socially this attitude can create alienation, ironically reinforced by the attitudes – "You are chronically mentally ill" – of the very people who are supposed to be helpful.

Of course, many psychiatrists, mental health experts, and pharmaceutical companies do not see it this way. Nor do the National Institutes of Mental Health and most of the National Alliance on Mental Illness. They claim that each mental illness correlates to a specific neurological disease. Yet you do not need to read studies or have a medical degree to rest assured that mental illness does not correlate to specific neurological diseases. You need only know that there is not a single reliable test for any of the 297 disorders listed in the current diagnostic manual, and not a single reliable test for any of the disorders being proposed for an expanded manual. Not one.

Biopsychiatric researchers proclaim they will soon be able to find these disorders once more nuanced medical technology develops ("We're in the middle of a revolution," said Thomas Insel, head of the National Institutes of Mental Health, in 2010. "We have the chance to change the world — not tomorrow, but by staying on course"), but really, how long have we been hearing this? Here's a Pulitzer Prize winning article from twenty-five years ago:

"…[P]sychiatry today stands on the threshold of becoming an exact science, as precise and quantifiable as molecular genetics. Ahead lies an era of psychic engineering, and the development of specialized drugs and therapies to heal sick minds."

We are still waiting. Besides, several aspects of what we do know now about the brain – that it is complex beyond comprehension, that it is capable of producing the same results through multiple pathways, that it is inextricably connected to and influenced by the body, that it is ever-changing in response to the environment – all suggest that finding a neat and discrete pathology in the brain called schizophrenia is simply never going to happen.

Attempts to find even general similarities in brain structure and in genes between people diagnosed with mental illness have produced remarkably unconvincing results. You may not know this, because the media often publishes optimistic headlines like "Study Hints of Gene Link to Risk of Schizophrenia" (New York Times 2008), but fails to cover an analysis that same year called "No Significant Association of 14 Candidate Genes With Schizophrenia in a Large European Ancestry" (American Journal of Psychiatry 2008), which was published in the world's most authoritative psychiatric journal and demonstrated that all of the genes presumed to be associated with schizophrenia thus far are not actually associated with schizophrenia at all.

Or, you may not have had $45 to purchase a recent review called "A systematic review of the effects of antipsychotic drugs on brain volume" (Psychological Medicine 2010), which concluded that while "there seems to be enough evidence to suggest that antipsychotic drug treatment may play a role in reducing brain volume and increasing CSF or ventricular spaces…", "Most studies of drug-naive patients examined here did not report or detect differences in total brain volume, global grey-matter volume or CSF volumes between patients and controls…"

There are plenty of studies that show differences between the brains of people diagnosed with serious mental illness and the rest of the population, but almost all of those fail to control for the effects of medication on the brain. When you look at studies of the brains of people diagnosed with serious mental illness who have not taken medication, you find most often that there are no observable differences.

Let us not forget that psychiatry once proclaimed homosexuality a disease. And let us not doubt that if the cultural zeitgeist was still against homosexuality, that biopsychiatry would be hunting for it in the brain and proclaiming it as a legitimate, diagnosable brain disease. What has changed are social values, not scientific evidence.

Even if one day a psychiatrist can show you that a part of your brain is different than everyone else without your

Counterpoint

of Mental Illness

particular psychiatric diagnosis, that still does not mean that your brain is diseased. Since the brain is the primary physical house of the mind, it's likely any conscious experience correlates to it.

For instance, the experience of love could hypothetically be correlated to biology in your brain just as much as the experience of hearing voices. But what constitutes disease is culturally-defined, so we don't isolate love in the brain and diagnose sufferers of love as having Love Disorder. Now, if you're excessively hyper…

Of course, there is a difference between feeling elevated and thinking the CIA has installed cameras in your mind. The latter can cause much more functional disability within our society. In some contexts, it may be useful to view breakdowns as part of an illness, as long as we recognize that we are talking in metaphor. Some people find great relief in believing they have a brain pathology, and some folks feel invaded and possessed by their experiences to the extent of losing control over their selves. That can certainly feel like a disease taking over. These viewpoints are valid and important if one chooses to make meaning of their experiences in such a way. But let's not pretend this perspective is empirical – "just like having diabetes" – and therefore applicable to all subjects who have similar experiences. Nor should we ever build far-reaching policies and laws upon such a porous foundation.

Let us instead call the brain disease hypothesis what it is: a world view, a theory with contradicting evidence, and a cultural bias. We can then make room for other perspectives, for one person's shrunken amygdala is another's child abuse is another's combat experience is another's religious mission is another's salvation.

What is important is how we build the most connection between people. Talking about experiences in non-clinical, everyday talk provides a bridge between people that is otherwise drowned by psychiatric jargon. I cannot relate to someone who is having a symptom of schizophrenia called paranoia, but I can relate to someone who is really scared. And if I can relate, maybe I can align, be real, and open up with my own learned wisdom instead of parroting prescriptive treatment modalities.

Unfortunately, such alliances are difficult to nurture in a mental health system that assumes clients and staff are fundamentally different. In this system (save progressive organizations and conscientious workers), you're likely to hear professionals at the water cooler talking about how manipulative those Borderlines are, how John just needs to take his meds, and a range of observations in language usually reserved for machines: "John is decompensating. Amy is below her baseline." I know: I've been at that water cooler. And back in my day, I was the subject of such chatter.

Such chatter is not harmless, as I recently relearned when obtaining my own hospital records. The notes declare me "very paranoid" and make observations that "Steven curls up in a ball and cries uncontrollably whenever anyone enters the room" and "Steven is paranoid that others are watching him," which is of course true, and may I suggest a valid response to being in a white concrete-wall institution where you are the subject of relentless observation despite unfathomable shame?

How is this remedied? A shot of Haldol, multiple Ativan, and Symbyax. No more "smiling inappropriately" after that.

Psychiatrists and prescribing doctors wield enormous authority over their patients. At the very least they should maintain an informed level of skepticism when explaining the nature of behavior to someone who feels out of control. Such caution is an ethical responsibility, but one with rewards, for people in distress will value genuineness more than certainty.

Patients should remember that a medical degree does not denote an understanding of consciousness, that people of all stripes have been trying to make sense of the mind forever, and that however unfortunate for industries that stand to make record-breaking profits otherwise, we cannot yet siphon the Great Mystery down into neuronal patterns and genetic variants.

Steven Morgan, former Executive Director of the Another Way drop-in center in Montpelier, is now the Project Director for a Soteria-Vermont residence. *See page 7.*

***Point → Counterpoint* is a regular feature which presents vantage *points* on a mental health topic, and encourages responses by readers who suggest *counter*points.**

***Counter*points should be sent to *Counterpoint* at 1 Scale Ave., Suite 52, Rutland, VT 05701 or at *counterp@tds.net*.**

Views expressed do not necessarily represent those of *Counterpoint*.

Editorial Page

Letters and Opinions

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

Editorial

Toilet Training

Sometimes, progress comes one bathroom at a time. Sometimes, people really do listen and understand. Equality can begin with toilets.

As discussions began on the design for the new state psychiatric hospital in Berlin, the architect began to do a head count for how many bathrooms would be needed. Total staff? Total patients? Visitors? Numbers were being listed on a chart. Total number of staff bathrooms. Total number of patient bathrooms. Total number of public bathrooms for visitors and others.

Then one person at the table spoke up — a consumer member of the committee. She asked why toilets would be separated when they were in common areas. Why couldn't a visitor use the same toilet a staff person uses? Why couldn't staff use the same toilet that patients use?

Activist Laura Zeigler later recalled this poem published in *Phoenix Rising*, vol.6 no.2, October 1986 (a Canadian magazine issued from 1980-1990 as "the Voice of the Psychiatrized.") (Reprinted by permission.)

*****

When asked
where the nearest washroom was
the lady behind the desk
at the "mental hospital"
advised that I go to the far end
of the hall because
the washroom only a few steps away
was used by "The Patients."

*****

Quietly and oh, SO politely
I asked if she felt that
having trouble coping with
some of the shit
life can dish out
was caught off a toilet seat.

*****

She was perfectly flustered;
however, the sweetest aspect
of victory was in the knowledge that
she never realized
I was one of the
people
whom she so greatly
feared.

*****

yvonne-marie

*****

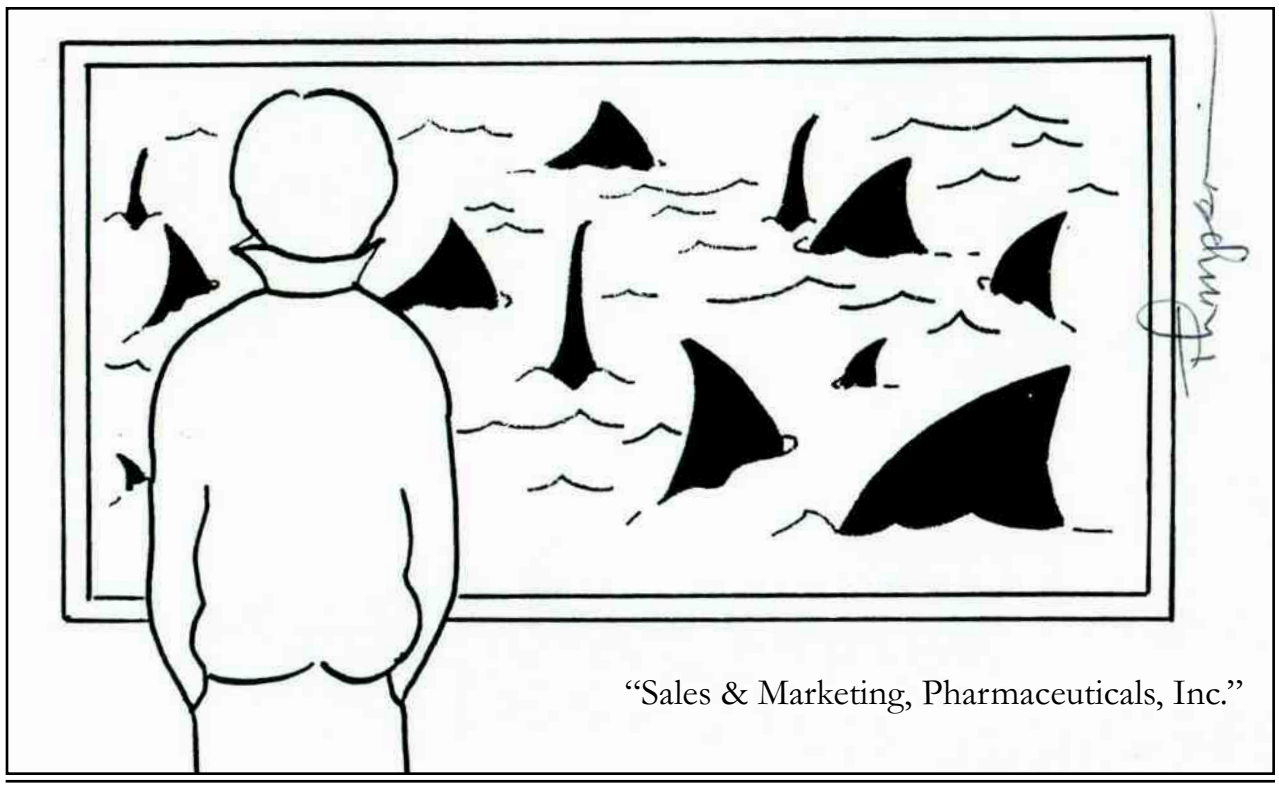
That was 1986. Now we are in 2012, and a consumer asked why we can't all be using the same bathrooms.

So what happened?

No one objected. *No one thought it was a crazy idea.* The architect wrote it down in his notes. He asked for a new number: how many people in total, and how many bathrooms needed for all of them to use in common areas? The final project core assumptions say: *"Common area toilet rooms shall be available to all. Separate toilets for staff, patients and visitors are not needed when located in common areas."*

Perhaps that is a real bright spot of hope for a new culture when the new hospital is built. Some of us may be struggling to cope with the world around us. Some of us may be helping others to cope. But we all remain individuals with dignity and worthy of respect.

In the new hospital, we will all be worthy of using the same bathrooms. Equality, one toilet at a time.



"Sales & Marketing, Pharmaceuticals, Inc."

COMMENTARY

One More for the Med-Sellers?

by ELEANOR NEWTON

Aha! One more target group and selling point for Big Pharm, as some of us like to call the psych-med producers and promoters: Post Traumatic Stress Disorder.

Well, beware. Psych meds are not always the most appropriate and most helpful treatment for *any* particular mental health problem. And whereas PTSD may not be an actual disease, it is a mental problem, evidenced by behavior, which affects both the sufferer and others around him. Or her.

Psych meds may help some, especially the most affected and those who already want help, but are not yet ready for intensive talk therapy, such as cognitive behavioral therapy (CBT) or exposure therapy. Some might, in fact, need the support of medication as they embark on such therapies, formally or not.

The greatest concern, with or without treatment, is that there are and can be, no guarantees about outcomes, but there are strong indications that only med-free treatments like CBT or exposure therapy can effect a cure or permanent improvement. If sufferers can get off meds, they can often be considered "cured." And this seems to be true for paranoid schizophrenia, as well.

My diagnoses included both paranoid and catatonic schizophrenia. I've been off meds for twenty or twenty-one years, without relapse. And although I've never been violent, some people are still freaked out by those diagnoses and by the fact that I'm off all psych meds! Now, *that's* scary!

Think Before You Vote

Presidential candidate Mitt Romney's stories of successful women are impressive examples of strength, determination, and creativity, They are to be admired as survivors. And they had previous successes, education, and experience. That helped, too.

But why make it more difficult for those less fortunate? The catastrophe of the Great Depression of 1930 brought on many suicides among the previously wealthy, who had lost everything. The poor huddled together and shared what they had.

Further back in time, many historical figures lost their wealth and died in poverty. Think of Ethan and Ira Allen, businessmen, heroes, and (lra) a founder of the University of Vermont. They had no safety net, no Social Security. Back then there were terrible "poorhouses," and some towns shifted their poor to other towns in order to avoid responsibility for them.

That was then. Now is now.

Yes, it costs money to "save" people, to help them survive and recover. But people are valuable, — and "equal" — aren't they? And some can not only recover, but become taxpayers again, with a little help. Nothing is as simple as it seems.

Franklin D. Roosevelt got it right, with the Civilian Conservation Corp boys repairing roads and bridges and working on our national parks, helping even little Vermont, one of the only two states that voted against giving him a second term. He also created Social Security, which has saved many senior citizens from painful early death from the cold, starvation, and neglect.

The safety net is in jeopardy. Good jobs are too scarce. The deficit poses a major problem.What next?

We do need to cut the deficit, but in the proper time frame, as the economy allows. It will take time, is taking time, to recover from the damage already done to the economy, the environment, and the people. We had better get it right this time.

Think before you *vote!*

Eleanor Newton lives in Burlington and is on the Editorial Board of Counterpoint and a frequent commentator.

Op-Ed Page

Letters and Opinion

Silence About Suicide Hurts All

To the Editor:

I found out that I knew the woman who recently died by suicide in Burlington a half mile from my house the day after a gathering of friends and others.

I do not understand exactly why, but her name was never announced to the community. Had I known, I would have gathered a few of us together who have been in treatment with her and drove up. When one connects peer to peer in a place of mutuality there is often a different shared experience and sharing that happens, sometimes different than with our closest friends or family... just different!

There needs to be a way somehow, for stigma of death by suicide to be faced. It is a fact of the consequences in which we face in this life with all of the pain that 'our illnesses' and 'what happened to us' and how much we lose as a result of that pain, adding to our pain! Sometimes, I feel there can be a certain sense of empathy putting a face to a name to a situation, to a reality.

In that, for me death by burning has never been a thought, until hearing it on the news. The news articles brought an uncomfortable awareness of a very quick, painful, public way to die. I realized it is a solution to ending the pain should that pain ever again become heightened for me. Having a new solution scared me and I have talked about this with supporters to make better sense of this in my mind.

I am able to create comfort in my apartment in time of heightened emotions by locking up any medications available to me and clearing out sharps from my home, giving key to lock box with them, along with conversation around wanting to live and desire to get through the emotions and committing to myself not to purchase rope or other items. This is a healthier way for me to engage in life around the fear of feeling my feelings. Death by burning never occurred to me as a way out and hearing this scared me. Now knowing it was someone I knew who died by burning puts a different energy in it for me. It simply is not an option for a way out for me. Period! I understood her pain well in her sharing in the different times we spent together.

Had she been in a car accident and landed in a coma, maybe her name would have been shared immediately and Win and I would have visited. Stigma is a continued challenge for many situations in life.

While I understand that the family might have wanted to keep her name private, I also understand that each of us as individuals away from our family connect to others in many different, meaningful ways.My immediate family today consists of a grand total of three who most of the time, I feel barely know me. The people who know the me I know best today are in my community, to those who I connect with in tiny ways and in big ways.

I don't know what is right here, I don't think any of us do, but I think conversations around suicide are needed. How can we live in a state where there is around 100 deaths by suicide annually, without discussion in our towns?

I feel great discomfort as a community member in Burlington where half a mile from my house a woman publicly burned herself, resulting in her death, seeing it in the newspaper on two different occasions with no knowledge as to who.

As a credentialed peer support specialist in Vermont, in the community where I work and reside, should there ever again be a very public suicide, I feel it would be helpful if there were closure for our community to grieve. In other areas we talk about suicide, we have suicide prevention workgroups, we have campaigns, we have hotlines, but when a suicide happens we have silence.

"Silence feeds shame." Suicide is a public health concern; silence is telling. The stigma around it is certainly a challenge we have barely touched upon, but we need to face with a presence of perhaps "it is what it is" and "so it is."

Taser Moritorium Petition Available Online

To the Editor,

MacAdam Mason, 39-years-old, was a talented artist as well as a person with disabilities, including epilepsy. He was shot by Vermont State Police with a Taser stun gun while unarmed outside his home in Thetford and died immediately thereafter.

A week to the day following his death, various advocates, state legislators and concerned citizens held a press conference and issued a statement calling for a moratorium on the use of Tasers by both local and state police across Vermont.

The statement urges that the moratorium be kept in place until standardized, statewide and state-approved policies as well as more extensive police training, including about how to better deal with people experiencing mental health crises, than is now currently available, are put in place.

An online petition had also since been created. To date nearly 1200 signatures, the vast majority of which are from Vermont residents, have been collected thus far.

Those interested in signing onto the online petition are strongly encouraged to do so. The Web address for the petition is: signon.org/sign/call-for-moratorium-on

The Taser moratorium and related action should not have to wait until either the results from an autopsy and subsequent reports are finally made available or, even worse, for another tragic incident along these lines to occur.

The time for prudent leadership as well as political courage to be exercised at all levels concerning these urgent matters is sorely needed sooner rather than later.

MORGAN W. BROWN
Montpelier

Work on Civil Rights Is Urged

To the Editor:

The Vermont Center for Independent Living marked the 22nd anniversary of the signing of the Americans with Disabilities Act on July 26, even as the civil rights of many Americans are under attack.

Women's rights are being challenged again. Low-income Americans don't have equal access to health care. New Americans face profiling by police. The hotel industry is lobbying hard to roll back the ADA on swimming pool access.

Now, more than ever, it is imperative that civil rights organizations work shoulder-to-shoulder to beat back the current attacks on our collective civil rights. Social responsibility has many faces.

It's discouraging that today, after all the decades of progress made in the disability rights movement and other social change movements, we need to fight harder than ever in 2012. We need everyone on the front line.

Together with our community partners' campaigns, VCIL believes the civil rights of people with disabilities will be won, in time. VCIL, arm-in-arm with its sister and brother organizations, will see everyone's civil rights honored. We will see the Violence Against Women Act passed, the Convention on the Rights of Persons with Disabilities ratified by Congress, healthcare as a human right achieved in Vermont, and compliance with the ADA met.

VCIL calls on Vermonters to continue to push for access improvements. Complying with the ADA produces a community that works better for everyone. The ADA means curb cuts, ramped entrances, and kneeling busses. The ADA means equal rights, job accommodations and large print meeting agendas. The ADA means bigger bathrooms, assistive listening devices at the movies, and eating out at restaurants with family. The ADA means swimming at the public pool. The ADA means diversity and equality in our communities.

SARAH LAUNDERVILLE

Sarah Launderville is executive director of the Vermont Center for Independent Living.

Shout it Out!

Have an Opinion about Things Going Right or Wrong?
That's What the ***Counterpoint*** Letters Page Is For!

Send comments to: ***Counterpoint***, 1 Scale Ave., Suite 52, Rutland, VT 05701, or to counterp@tds.net. Names may be withheld on request, but must be included in letter. Letters do not represent the opinion of the publisher, and may be edited for length or content.

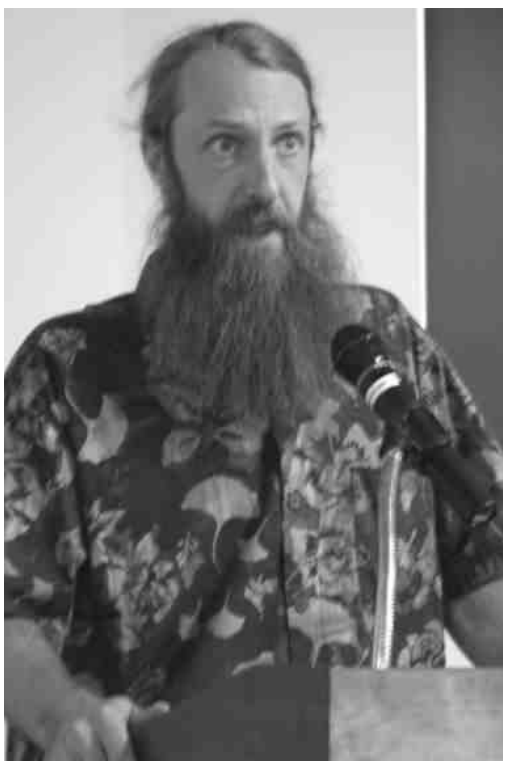
Vermont Psychiatric Survivors Annual Meeting

Telling Your Story:

Actress Shows How To Share with Public

by ANNE DONAHUE
Counterpoint

MANCHESTER — "Everybody can learn to do this."



NEW PEER ROLE — George Nostrand addressed the conference audience to identify himself as a new Vermont Psychiatric Survivors staff member being funded under the expansion of peer services in the budget of the reformed mental health system. His role will be to work with both existing VPS support groups and work on places to develop new ones.

AN HONORED PEER LEADER — Marty Roberts, shown here addressing the members of the Vermont Psychiatric Survivors conference, has a long history of recovery leadership, including as current VPS board president. She was recently honored at her retirement from the Department of Mental Health Adult Standing Committee, and she explained she wants more time to pursue her many other interests, which include conducting recovery workshops and singing. She was a founding member of the Standing Committee in January 2000 and has been its co-chair since the beginning. Commissioner Patrick Flood and Deputy Commissioner Mary Moulton presented Roberts with a certificate of appreciation and plaque recognizing her contributions to the work of the State Standing Committee at a meeting earlier in the summer. (Counterpoint Photos: Anne Donahue)

That was the encouragement that playwright and actress Elizabeth Kinney shared in a workshop on "Telling Your Story" at the Vermont Psychiatric Survivor's annual conference, which had "Recovery through the Arts" as its theme.

Kinney's one-woman play, "Sick," was the culmination of a day that also included workshops on creating vision board collages and how food affects wellness. It was held at the Burr and Burton Academy.

Kinney engaged a group of about 20 peers in a discussion about why and how a person can share the story of a lived experience with a mental health condition, stressing the importance of creating a message that will be heard.

"How do you achieve true listening?" she asked the group. It is essential to "know who our audience is... and what do I want them to hear, feel, think and do after they've heard?"

"A big part of being heard is who is your audience."

Kinney said that she has learned that the most important part of sharing a story is to give the audience an action story of events, and let the audience come to an understanding of the feelings that the events must cause.

That becomes "so much more powerful" than to talk to an audience directly about what one was feeling.

Why share personal stories?

"To empower other people to change ideas" about mental illness "into the larger culture," she said. She wrote her play for an audience without any lived experience, who knew her but had no idea what had happened to her, and held misperceptions, she said.

Stories communicate to an audience of people "who don't know the experience, [who] don't get the impact of the loss of control."

What is obvious to us is "not obvious to them," so it is important to "put the person who's listening into your seat" in order to understand how you were responding to the events.

Kinney began the workshop by drawing from participants ideas on what a "story" was: what a person has been through; feelings; history; what's been learned through recovery; hopes and dreams; and finally, her own summary: "a way to organize the information that has been our life."

Her play compacts what happened in a two to three year span of her life, "trying to tell the story of when I went crazy" but through events, not through direct description of the pain being experienced.

"It is unbearable to listen to so much pain" on the part of an audience, she said, and so "it won't be listened to." An audience will shut off the message.

Kinney drew from workshop participants the obstacles that individuals face when they consider sharing their stories: stigma; trauma; the fear of being boring or offensive; the emotional impact on oneself; and coming across as too vulnerable.

By identifying one's story as an action/adventure, "it becomes liberating" because the focus turns to the telling of events instead of a focus on feelings.

"I let the audience fill in the blanks of how I must have felt" as they hear the events she was experiencing.

A workshop participant summed up Kinney's message: "you're not trying to tell them what to feel," but instead, to let them discover that for themselves.

Kinney said that the telling of a story requires a beginning, middle, and end. Those three steps need to also be included in "each step along the way" of describing the events that make up the story.

A person must evaluate: do these things — the events — match up to the point one is trying to make?

The beginning, middle and end need to tell the story in a way that leads the audience to recognize the point being made.

A person discovers that "you don't need to tell as much if you are telling the right part," Kinney said. Practicing with a timer "forces you to get to the point sooner."

Kinney also suggested to participants that by not telling too much detail, a speaker is "inviting curiosity" and holding attention, because "the audience doesn't know what's going to happen next."

That does need to be balanced with being too confusing by not providing enough information, she noted.

Kinney encouraged participants to "find a story telling partner" to practice in advance. Those who are prepared and show that effort will be invited to more audiences to share their message, she said.

The Production of 'Sick'

In the afternoon of the conference, Kinney put her advice into action by performing the play that she uses as the way to tell her story.

In segments of dialogue that were interrupted by a bell, she shared snippets of events that began with a physical, hormone problem and depressed feelings that led her to a psychiatric referral.

One episode was her first psychiatric contact, where she was asked to answer "scale of 1 to 10" questions, found to be depressed, and placed on medication.

"This light that I had been promised" — the relief from medication — "was a little late in coming," and further episodes described the addition of other medications. Her symptoms began to include whispering voices, and a diagnosis of major depression escalated to "with psychotic features" and new medications were added.

She then found "the magic combination" of temporary relief with alcohol and then cocaine.

Sick?

Elizabeth Kinney of Seattle, Washington, presented her one-person play, "Sick," after a workshop on "Telling Your Story" at a Vermont Psychiatric Survivors conference in August. As a playwright and actress, she uses the play to tell her own story of a depression and psychosis that appears to have been brought on — or at the very least, exacerbated — by the treatment the mental health system provided. The play communicated the horror of the symptoms she experienced, the ways in which a degrading system of providers failed to listen and respond to her needs, and how her family's support in detoxification from psychotropic medication led to her recovery. She used short episodes of dialogue to show different pieces of her three year struggle. The play was presented on stage at Burr and Burton Academy in Manchester. (Counterpoint Photos: Anne Donahue)

Many episodes drew the laugher of recognition and sympathy from the audience.

Her first hospitalization was a voluntary admission, but she discovered as two doors clicked behind her that she no longer had the ability to discharge herself.

In another episode, she is confronted by a nurse who tells her that her bloodwork was "suspicious" and that she was clearly not being honest about herself.

Her play vignettes showed her in desperate confrontations with an evil presense in her head and with nightmare visions.

Kinney then portrayed the help received from her family in seeking other answers, leading to a meeting with a psychologist with a "hypothesis" that her symptoms were a result of toxicity: "medication has been poisoning you."

After a challenging search for a psychiatrist even willing to guide her through coming off the medication, Kinney went through an agonizing period of withdrawal. However, as her despair finally lifted, she saw she no longer had ro feel that "this was just what life was going to be," living in her mother's home without an independent life, .

Her points were clear: having an audience understand what the experience of "being crazy" was like, how the system treats persons who are "crazy," and identifying major issues about the role medication can play in provoking symptoms.

Kinney said she was not judging whether medication might be the right answer for some individuals, but that there was a critical issue about informed consent. Any treatment has pros and cons, she pointed out, but patients aren't told what the risks are when they are advised to take certain medication.

Some of her play episodes referenced the huge weight gain she experienced on one anti-psychotic: a drug first marketed for the scary diagnosis of psychosis, but then exploding in sales as it became a treatment for all sorts of conditions.

It took more than five years of recovery to rebuild her life in the arts. Returning to acting did not initially bring on any thought of writing about mental health or her experiences. It can take years to develop the desire, and then the courage, to take it on, she said. Her play opened in Seattle in the spring of 2011.

"Stay with it" even if it takes time, she told the conference members.

Message from Commissioner

Before the start of the play, the Commissioner of the Department of Mental Health, Patrick Flood, addressed the conference members.

"I'm humbled to stand in front of you folks," he told the group of mostly consumers and peers.

Although not someone with a "lived experience" himself, he "learned the importance of peers in shaping the public policy response" to the mental health system during the spring legislative session. He said he saw during testimony in the legislature by consumers that legislators "really didn't know a lot" and had many questions, but "showed a lot of support" thanks to what they heard.

Telling Stories Through Art: Although some people think of "telling one's story" as only meaning a speech to an audience, Elizabeth Kinney uses a play to express what it is like to cope with a mental illness. Others use poetry, such as this example, sent to *Counterpoint. Counterpoint* includes a section every issue for sharing through art.

What's the Difference in 'Different'?

What's the difference in 'different'? Aren't we all the same?
"She's odd!" "She's weird!" "She's queer!" they'd say, never calling me by name.

If I am so very different, then why does this heart beat?
I'm just like all of the rest of you; I have two hands, two feet!

So, I happen to love the underloved or pick up a stranger or two?
I still pray to God, alone at night, supposedly like you.

What is the difference in "different?" I know I'm not a freak!
I'm surving in a world like yours that zeros out the weak.

I'll hide for now and pretend it's all make-believe,
As I wait to dodge the bullet that's busting out your sleeve.

No difference in this, different. A bond this kinship makes.
To admit our hearts beat quite the same is all it really takes.

by Jill Tuttle, Putney, Vt and Charlestown, NY

Louise Wahl Creative Writing Contest

2012 Second Place Tie, Prose

The Visit

by Randy Peters

Randy paces his small cell. The white enclosure feels cramped by its few furnishings. Two metal bunks lie stacked on the left-hand wall, covered with thin hard puke-green mattresses. One tiny blue steel table rests bolted into the floor against the right side wall with a green plastic chair slid partially under it. In a corner by his door sits a stainless steel toilet, molded into the sink behind it, forming a single futuristic-looking conglomeration. The polished metal mirror over it catches distorted reflections as he trudges by. Even at 5'6", he comes flush with the blue double steel door in only four short strides. He opens it and peers through its narrow rectangle of plexi-glass that serves as a window. He checks a clock on the dayroom wall for the third time in as many minutes.

"She should be here by now." He mutters as he spins on his heel, and pulls the door shut behind him. Randy steps toward a recessed window buried in the concrete wall overlooking a large blacktop parking lot separated from the building by a ten-foot chain-link fence topped with razor wire. He bounces his head off the heavy metal screen while scanning the macadam, "I wish I knew what she's running now." Sunlight flashes off a moving windshield; his heart leaps, "Is that her?" The fence breaks up his view of an old Ford pulling in. Depression slaps him, "Nope, not her. She wouldn't drive a Ford on a bet."

He resumes pacing; stomach twisting and gurgling. Meager food portions coupled with anxiety make for a bad mix. He grabs his gut and winces as nausea threatens to overtake him. A low growl rumbles in his throat. He rides this wave of sickness until it calms. The battle leaves him breathless.

While he stands panting, hands on knees, the guard calls him, "Peters, let's go, you got a visit."

Randy straightens and struggles for composure. He strolls to a sallyport door beside the officer's chest-high podium and waits to be let out. The C.O. ignores him, just for fun. Randy bites his tongue; he's been through this before. Any comment on his part will bring on a confrontation. Inmates always lose confrontations with C.O.s, right, wrong, or otherwise. The guard finally realizes he can't goad Randy into a fight, then pushes a button on his console. The lock pops with a loud snap. Peters steps through, closes the door, and waits for a second one to open. Once that obstacle gets cleared, another door stands at the exit. He pushes a call button mounted on the wall to his left and waits, tapping his foot, chewing his lip. His actions must be measured and nonaggressive. A camera on the ceiling behind him feeds a screen in the main control room while a speaker in the call box picks up every sound. Any word or movement considered improper by either of the two officers manning their operational panel will result in Randy being locked in his cell, missing precious visit time. This barrier releases and he walks into the yard, a glob of grass dropped in the middle of four concrete buildings and peppered with three round picnic tables anchored by buried cement tubes. Forgotten balls lie scattered across this vacant lot. A sense of loneliness and despair hangs in the air.

At the end of his fifty-yard hike awaits another sallyport guarding the main building. Randy gnaws his lip once more as he waits for admission. Two adjacent steel barricades open simultaneously and he enters the hall. A guard waits at the far end; a vicious pat-down ending in a swat to the crotch leaves him limping toward the visiting room. He looks through the large entrance window and his heart soars. Donna smiles and waves; long thick auburn hair frames her face in a perfect complement to her blue eyes. She let it grow to the middle of her back because Randy loves it that way. The very sight of her melts away the pain of prison. He bounces on his toes, impatient for her embrace. His heart rate triples when the final blockade gives way. He rushes for her open arms.

They lean over one of several octagonal green Formica-topped tables lined in a half circle intended to separate them. A C.O. nestles in a wrap-around counter, like a receptionist. He jumps up from his post close by the visitors' entry and

(Continued on page 20)

2012 Second Place, Poetry

Lying on the Bed...

by Ocean Chance

"Lying on the bed writing in the State Hospital while others laugh in the hallway, and thinking about Bergman's `The Seventh Seal' and why the mute girl and wife were missing from the final scene where the others dance with death..."

It occurred to me — only recently —
that the mute girl's only
words were, "It is finished."
(These words were the last words
of Jesus as he was on the cross.)
She smiled and seemed
to await death with pleasure.
Her life: (must've been) a great
hardship.
And thinking thus I thought.
"These mental health workers are/
must be attracted to tragedy.
Why else would they work here?"

Being raised in a "male world"
It is no surprise that I cannot
and do not (really) love men.
A father who was never there
really, even when he was.

Mother seldom came home
Tupperware parties at
Barbara's or Susy's house.

I hid out in the cemetery
or played with tadpoles
in the pond.
Sometimes even in trees
by the old lumberyard
or the woodsy hills beyond.
Following railroad tracks
for what seemed forever
and running away to the park
where old men
would follow me around
flashing money out of cars
with baby seats in back.

The basement was dark
and musty. A scary place
where spiders crawled
and snakes slithered
across a dirt floor.
Daddy kept all his
tools there though
hammering and sawing
away the night
even when Mother yelled,
"It's time for supper."
I ran, ran, and ran
around the yard.
My little heart beating
like a blue jay.
Climbing trees when
the hawk cried out my name.

Daddy took me on trips
to Harlem and sold
cigars.
He loved to go to what
he called "The Witch Shops"
where women with
bone-like fingers,
and clothing
blacker than
a moonless night
would smile at me
saying, "Isn't he the one."

Mother took me to her
elite parties in Long Meadow
where she would give
Mark and I a quarter
apiece to "keep us out of her hair."

When too unruly I stayed
at home with a babysitter
who sat me naked in the
tub with the hot shower
pouring down so the
smell of pot wouldn't linger.
Sometimes though
laughing she blew
smoke in my face.
"Why?" I asked.
"To calm you down,"
she replied.
I still remember her name
Stephanie
Now I know who
little Anna's Frankenstein
was in one of my
favorite films, "Spirit
of the Beehive."

My head always "in the clouds."

For I wanted so much
to be loved by a woman,
or any woman
Still laying here
in this State Hospital
surrounded by men.
I close my eyes
to the darkness
and sing, "Where's
the witch, black
as pitch."
Always behind me
Always...

Ocean Chance formerly resided in Waterbury.

Louise Wahl Creative Writing Contest

2012 Second Place Tie, Prose

Esmeralda

by Sandy Snyder

I, Esmeralda, am beautiful. Even the extension agent thought I was beautiful when he saw the lovely new feathers I had grown for winter wear. Although I was a bit hurt when he exclaimed, "She has a crooked beak," when I turned around. You see, I have a disability.

My egg-laying Mom didn't have good nutrition when I was born. That's right. She was a picky eater and didn't eat all of the good stuff the farmer fed her. My egg-sitting Mom, the one who raised me up, never minded my disability. She said, "Esmeralda, you just peck a little longer than the others so you'll get enough to eat." And I have. She said, "Esmeralda, you scratch a little harder and find those rich in enzymes and proteins worms, instead of eating too much stale bread." And I did.

Well, enough of that!

Did I tell you I am cultured? That's right! I hid in Farm Woman's purse the night she and Photographer Guy planned to go to the ballet. (Farm Woman calls her son Photographer Guy.)

I had just settled down all comfy under the scarf in Farm Woman's purse when Tilly stuck her head in and said, "Esmeralda, you forgot to poop. People just don't like the smell of chicken poop."

So I struggled my way up and out and headed for the bushes.

And none too soon, for I had barely gotten back in the purse and under the scarf when along came Farm Woman and Photographer Guy.

I could feel the motion of the purse as she picked it up and sat it in the truck. Then there was that noise the truck makes before it moves. Next I felt jiggles and joggles as we went down the big stone hill. After that we were still moving but not so bumpy. It seemed like we moved for a L O N G time... Just then I burped.

"For heaven's sake, see what's going on in my purse," Farm Woman said.

"It's Esmeralda!" Photographer Guy almost shouted.

Well.... of course it's me!

"Esmeralda, what ever do you think you are doing?" her voice also said, a bit exasperated. (My mother used to sound like that.)

I cluck, cluck, clucked. But of course she had never learned to translate chicken talk.

Why, I remember the night she was shouting at Lovely. "Lovely, what are you doing up that high? Where are your babies?" Well, Lovely just looked at her as one little chick came in and hopped up each step of the ladder before fluttering over and snuggling next to Mom. Next came the other two who did the same thing. Then...and only then...did Lovely scold Farm Woman.

Did I tell you we get flutter privileges? That's right. Most chicks just have a floor and have to stand around all of the time. But Farm Woman gave us high perches so we would have to exercise our wings. She sticks a twig here or there so the little ones can get up to the lower roosts.

Of course, there is June Bug, who decided to sleep in an odd spot. She called and called, but her chicks were still too little to figure it out. Farm Woman elevator-ed them up to Momma every night. Well... June Bug was a "casual" Momma. So every night when those youngsters got lifted into the nest they had a pajama party and would twitter and tweet until they had told June Bug about all of the adventures they had that day.

And there was the day that fluttering privileges saved Miracle's life. Farm Woman was standing there puttering, and not ten feet away an owl swooped down over Miracle's back, grabbed her and headed skywards.

Farm Woman saw it and ran after that owl screaming "Drop my baby!" (Of course it was really Biddy's baby.) Farm Woman shouted again and again as she ran.

…. and.... the owl did drop the baby. But because we had flutter privileges, Miracle just fluttered to the ground instead of falling to her death from 30 feet up in the sky. How she scurried for cover. (That means she hid under a bush.)

Oh yes! ….where was I?...There were some bushes near where Farm Woman stopped the truck. I headed right for them

"What shall we do with her?" Farm Woman asked Photographer Guy.

"Take her along," he said. "It's too hot for her to wait in the truck."

So Photographer Guy put a piece of newspaper on his lap (just in case) and for the 1st time I got to see out the window and know what it's like to ride in a truck.

They stopped at the Bee's Knees for something they called supper. Farm Woman had bacon that came...would you believe it...from the town next to ours. There was a "menu" that told all about it.

She did *not* have chicken. She says those chickens that grow so fast give people the wrong kind of nu...ah...nutrition. Wow, that is a big word. *Nutrition, nutrition, nutrician.* That word's so big it's almost a song by itself.

I got to sit under the scarf in her purse...which she put under the table. Why, yes, I did take one little peek to see what a restaurant was like. But all I saw were legs and jeans and shoes.

Then it was time to go and I got to ride on Photographer Guy's lap again. I was dozing off when suddenly the truck stopped.

"Let's let her poop again," Photographer Guy was saying. "We don't want to be put out of the movie." (That's when photographs move.) And so I headed for the nearest bush once more.

We waited until the last minute. That means just before the show started. Farm Woman warned me to stay under her scarf, but said she would set her purse so I could see out.

Well...let me tell you...there was music. Many instruments of all kinds making sounds. Photographer Guy only plays one instrument at a time. And then the Ballet, my ballet, "Esmeralda" danced by the Russian Bolshoi began.

There were beggars and a poet... and then ME, Esmeralda, ever so beautiful. (But I wasn't wearing a tu-tu like I thought I would.) I had flounces and something called "toe shoes." And I danced and danced. And there was a prince. Oh, how he made my heart flutter. And boy could he flutter up when he danced.

Oh, I was excited. And in the end when everyone clapped, I couldn't help it... I squawked.

"Shush, Esmeralda," I heard Farm Woman say as she gently pushed me under her scarf.

And so that's how it was and I rode the truck home while I slept on Photographer Guy's lap, the whole time dreaming of how I would dance "Esmeralda" for the flock.

Sandy Snyder is from Westfield.

2012 Second Place Tie, Prose

The Newborn Boy and the Obstetrician

by Patrick William Bradley, Jr.

It was Christmas Eve in New York City and the night sky was strangely ablaze with stars. Normally, light pollution and the usual city haze dimmed the night sky but tonight was bizarrely different. A sharp brilliance was in each star and you could see its vivid color easily. The universe literally shimmered in rare beauty.

The obstetrician scrubbed his hands roughly over the sink. Some flecks of blood from his final and fifth abortion for the day had spattered on him. He felt tired. It had been a long day, this day before Christmas, or so it seemed, and he was in a hurry to get home. Night had arrived because of a plethora of tasks and paperwork, besides his abortions, that had eaten up his hours.

Quickly taking off his scrubs and putting them in the special biohazard basket for cleaning, he put on his heavy winter coat and fur hat, picked up his small medical valise — he would take the valise home because of great numbers, recently, of burglaries — and stepped out in the cold, crisp night.

As he walked on the crackling snow to the parking garage, images of the bloody feti, some

(Continued on page 20)

Winners of the 2012 Louise Wahl Memorial Writing Contest

First Prize, Prose: The Snow Hunter by Vesna Dye, $100 [published in the summer Counterpoint]
Three-WayTie for Second: Esmeralda by Sandy Snyder, The Visit by Randy Peters, The Newborn Boy and the Obstetrician by Patrick William Bradley, Jr., $20 each
First Prize, Poetry, Tie: I Am Lost by Sharon Young and Listen Closely by Jill Tuttle, $50 each [published in the summer Counterpoint] Second Prize: Lying on the Bed by Ocean Chance, $20
The Louise Wahl Memorial Writing contest is named for a former Vermont activist and encourages creative writing by psychiatric survivors, mental health consumers and peers, and their families. The annual deadline is March 15. Only one entry per category; 3,000 word maximum. Repeat entrants limited to two First Place awards. Send submissions to: Counterpoint, Louise Wahl Writing Contest, 1 Scale Ave, Suite 52, Rutland, VT 05701 or to counterp@tds.net; include return address.

Louise Wahl Creative Writing Contest

The Visit

(Continued from page18)

runs to stop them. Noise from the children's play area on his left leaves him barely audible, "Hey, hey, none of that. There's no more contact during visits."

Randy's voice holds a hint of anger, "Why? I didn't do anything wrong."

"New policy. Last week we caught a grandmother in a wheelchair smuggling in drugs for her grandson."

"What's that got to do with me?"

"Like I said, no more contact."

"So, because some asshole I don't even know tries getting drugs, I gotta suffer?"

"'Fraid so."

Randy clamps down on a biting reproach. His eyes smolder and a growl builds in his chest.

Donna's nervous response douses his fire. "It's okay, Honey, let's just visit. We don't get much time together, I don't wanna lose any."

Randy pulls out a black-on-chrome metal and plastic chair, "You're right, Baby, let's visit." As the guard returns to his desk, Randy's glare burns holes in his back. Donna chances a brush across her husband's hand.

"How you been, Honey?"

"Miserable, you?"

"Depressed, lonely, broke, sad, angry, did I mention lonely? I've come to terms with the fact that you can't come home, but I wish you were closer. Seeing you once every six weeks sucks."

"Yes, it does. D.O.C. preaches they want us staying in contact with our families, then they drag us as far away as possible."

"I'm not sure how I'm going to handle another year of this."

"I know it's hard on you, Babe, I don't like it either. I can't sleep. I toss and turn from missing you. I try to keep a positive attitude, but it's damn near impossible." Randy looks into Donna's eyes, he can see the depths of her loneliness. It drives a corkscrew of pain and guilt into his heart, "Have you tried getting out and seeing friends?"

"I did go up to Eddie and Lisa's."

A storm cloud rolls across Randy's face, "I really wish you wouldn't go up there."

"You just said you wanted me to see friends. I don't have that many you know."

"I do know. I just wish you'd stay away from Eddie. I know how he is. He'll use your loneliness to try and get in your pants."

"Thanks for the vote of confidence in my virtue."

"I don't mean to insult you, Honey. The loneliness really gnaws at me, all the time, and I know you hate being alone even more than I do. Eddie's a fucking predator; he'll jump on that in a heartbeat."

"So I should stay home and not talk to anybody?"

"I'm not saying that. I just wish you'd find some new friends is all."

"I can't find new friends. I'm no good with people, I don't trust them."

Randy's head drops to his chest, he draws in a long slow breath. "I love you, Baby. I love you with all my heart. I want you to be happy, but I worry every day about losing you."

"You're not gonna lose me, Honey."

Randy's voice trembles, "I try to believe that; I really do, and I know you mean it, but I also know that everybody has a limit, a breaking point. I'm scared to death you're gonna find yours before I get out."

Donna's soft blue eyes hold his in a comforting embrace. She longs to wipe away the tear sneaking down his cheek, "I'm not gonna find my breaking point. I'm too tough for that."

Randy forces a smile, "Will you at least do one thing for me?"

"Anything"

"Don't hang around Eddie unless Lisa's right there, and for God's sake, don't let him get you drinking."

"That's two things, Honey."

"I'm serious, Babe. This shit scares the hell outta me. You're the only reason I got for living."

"Okay, Honey, I'll do what you ask."

"Thank you."

The guard's bellow echoes across the room, "Time's up, visit's over, everybody out, c' mon, let's go."

Donna slumps under the weight of the words, "These things never last long enough." She sighs and puts on a brave face, "Are you gonna call me tomorrow?"

"Definitely."

"Good. I can't wait. I love you."

"I love you too, Baby. I love you with all my heart. Try to remember that when things get tough."

"I will."

The officer lands a disgusted look on Randy. "Peters, if you don't wanna lose your visiting privileges, you'll quit yakking. Right Now."

Donna gets up and sees rage smoldering, deep in her husband's eyes, "It's okay, Honey. I'll talk to you tomorrow, just try to stay calm 'til then."

"I'll try. Bye, Baby, I love you."

"I love you too, Honey, bye."

Randy's heart withers as he watches Donna walk away. He feels as if a piece of his soul has been torn out, thrown on the floor, and stomped on. Emptiness rises in him like a fast tide. She turns; he gives her one last wink and wave. She smiles, blowing him a kiss on her way out. The slamming door chops off his happiness like a guillotine beheading a peasant.

Randy sighs and swallows his tears; there can be no sign of weakness here. He rises, getting in line for his least favorite part of prison, the strip search. It's the most humiliating thing he's ever been through. After hundreds of them, he's still not used to it. The sense of violation seems akin to being raped, especially when you're homophobic. He grits his teeth while working on clearing his mind. Pictures of Donna getting drunk and succumbing to her crushing loneliness torture his thoughts. When he pushes those away, they get replaced by his most prominent waking nightmare; Donna telling him she's had enough, she can't take the stress anymore. The pressure of facing a strip search and what he may confront in the future overwhelms him. Excruciating tightness in his chest makes him wonder if he's having a heart attack. He can't breathe, he can't see, he can't think straight. The line moves forward and it's Randy's turn to step into that dreaded room. He tries imagining himself walking through the woods in hopes a happy distraction will take him away from the degradation he's about to endure.

He runs through the strip search with mechanical motions; he barely hears the C.O.'s monotone directions: "Run your hands through your hair, lift your arms, now your feet. Raise your scrotum, turn around, bend over and spread 'em. Alright, you're good."

Randy straightens, struggling against his erratic breathing. He reaches to retrieve his clothes from the officer. The guard smiles and winks at him. Randy's shock stuns him to the point of vomiting; he almost drops his pants. Shaking and sick, Randy wrestles with the urge to fight while he dresses, as fast as possible, then scurries out the door.

Although he feels like a coward for not lashing out against that sick bastard, he knows striking an officer will add at least two years on his sentence; a long two years he can't afford. The more he thinks about it, the more the C.O.'s blatant advance freaks him out. He breaks into cold chills while walking down the hall shivering and fighting an overwhelming queasiness. His mind blacks out in self-defense.

The next thing he knows, he's back in his cell, lying on his bunk. Worried thoughts of Donna swim around in his tortured mind. A frigid hand of dread squeezes his heart. There's nothing he can do, no way he can change things. The crushing sense of hopelessness steals his breath. All he can do is sit here and wonder how long he'll have to wait before getting another visit.

Randy Peters is from Albany.

The Newborn Boy...

(Continued from page 19)

almost ready for birth, plagued his eyes and mind. Their bulging, dead eyes covered with blood, bothered him most. They had wound up in the biohazard trashcan and would never enjoy life or holidays like Christmas.

The obstetrician's ethical feelings about abortion were, to say the least, all messed up. He believed in a woman's most private choice — but to take her baby's life? He could understand her disgust at bearing the product of rape or incest: but why did the female have to get sliced and not the male perpetrator? Or should one say penetrator, who all too often laughed off and bragged about his macho score and called his female victim a whore? Sex only for unprotected orgasm and no real caring responsibilities for his mate or child completely baffled and and nauseated the obstetrician who greatly -- loved his wife and little boy. But then, he did not desire Romanian dictator Ceaucescu's outlawing of abortion imitated in the United States. Ceaucescu's stupid act resulted in cruelly overflowing of dirty orphanages and streets by abused children. And France's vicious Vichy Government guillotined women for abortion and even miscarriages right in front of their own children, horribly splattered by their headless mothers' blood!

No, you cannot legislate morals, especially sexual morals, thought the obstetrician, as he approached the parking garage. Not all the laws in the world have effectively stopped crime, either murder, sex, or property crimes. Or the horrors of war. Then there was the plague of overpopulation, promoted by many religions and cultures. No wonder homosexuals were so badly abused and even ostracized globally. They cannot breed! And the current several billion human beings, if abortions had not been performed legally since 1973 in the United States alone, would have been so huge as to have devoured the entire or most of the planet's resources by now. Already, humanity was quickly approaching the consumption of 80% of the planet's total photosynthetic product, and would soon be leaving nothing for all other species, which would be catastrophic! But then, it might not be the catastrophe to destroy the biosphere and humankind: a ballooning human overpopulation would attract lethal and untreatable microbes or a total geocidal war for disappearing resources!

Yet, the rapidly walking obstetrician surmised, there were far better ways to avoid the gruesome horrors of abortion and overpopulation: effective birth control devices and demographic growth and family planning taught globally with a resultant cultural and sexual evolution!

But the reality was that now these factors were minimal, and if abortion were outlawed, you would have again the Ceaucescu and Vichy horrors. And brutal coathanger and charlatan abortions that killed countless females in the past rather than have them bear the cruel stigmas of single-mother whoredom and bastard birthing.

The obstetrician was really confused. He preferred life over death, bringing a baby alive into the world instead of dead. But if too much life — especially human life — meant genocide, or the very possible extinction of all earthly life — and man could truly in overcrowding's sociopathy easily accomplish that by pushing a few deadly buttons: then what? When life itself becomes the enemy of life, and massively refuses to be restrained, what hope then for the biospheric future in the hands of overcrowded and sociopathically maddened mankind? The obstetrician trembled at the thought! It was the most

(Continued on page 21)

Louise Wahl Creative Writing Contest

..and the Obstetrician

(Continued from page 20)

horrendous Catch 22 enigma ever to confront the biosphere, except perhaps some astronomical accident such as a collision with a super-speed monster asteroid, rogue planet, comet, or midget star!

This latter thought made the obstetrician look upward at the brilliant, shimmering, star-bejewelled sky. His jaw dropped in awe. Never had he seen such a sky! The heavens were black velvet with shining, multicolored diamonds pinned to it!

Suddenly, one of the stars exploded in brightness! It seemed to whirl in the ebony universe! The obstetrician was petrified! Frighteningly, a tunnel-like beam shot earthward from the twisting star, now bright as the sun. The obstetrician now was in a kind of paralyzing ecstasy as the strange beam engulfed him! His valise still in hand, he was levitated into the photonic tunnel. The fiery, whirling tunnel walls shot his body into an unknown space-time at a speed that stopped time itself!

Time having stopped for him, the obstetrician did not know if he had been in the tunnel beam a second or an hour or even more than a century! Later, he would discover his wristwatch had been mysteriously smashed! In his mind as he flashed along, he wondered if he were in the tunnel of death so many people revived from the death state said they had experienced! He also wondered if the Deity — if there were One! — would be awaiting at the end and what would be his own personal judgment if he were really dead! Whatever was timelessly going on, he was in supreme ecstasy all during this timeless experience in the flaming tunnel. It was a truly unearthly feeling beyond any worldly happiness or pleasure. No orgasm, no pleasure or well-being of any kind even approached this! It was like being in some heavenly state! Why he in his own grave personal sins should be chosen for this greatest of honors totally baffled him!

Suddenly he felt a twisting motion — he was now going downwards! But all fear, including crashing, had totally disappeared in his ecstatic state. As he was enjoying his great freedom from any of his earthly dark emotions, the flaming light suddenly went out and his feet touched, very gently, the ground!

He found himself in a cave also serving as a barn! The star behind him had greatly receded in brightness but still was outstanding in the black velvet sky and actually seemed to move over the cave barn!

In the dim cave, near a pen filled with sheep, there were two figures dressed in robes — a very young woman — seriously in trouble — she was crying in great pain giving a very difficult birth! With her was a very distraught young man futilely trying to help her. The young woman was literally screaming in great suffering as she lay prostrate on the hard cavern floor. The young man was speaking loudly, in a strange language, apparently urging her to push harder with her tormented body. But it became immediately obvious to the obstetrician that she was undergoing one of the most difficult of birthing — a breach birth! The young man looked at the sudden appearance of the strangely-dressed man with a valise, and there were begging tears pouring from his eyes!

The obstetrician immediately realized there was little time to save mother and child now that he inwardly felt he was back in the time sphere again. His ecstasy had been replaced by an emotion that he was in the presence of a superior, yes, even divine, power, though he had been an atheist since childhood because his secular-humanistic parents had raised him that way. He believed in sin in a humanistic way as a transgression against humanity, but not against a non-existing being such as a god. But this bizarre night had greatly changed him! Something totally beyond his scientific knowledge now had occurred to him personally and miraculously, and he had indeed been introduced to the ineffable wisdom of divine mystery, an infinity as beyond any science as the universe itself!

The obstetrician got down on his knees beside the lamenting, very young woman, really just a girl in her early teens. He surmised then that he had travelled back to a far earlier time when young girls married and had children early in life because life spans were so much shorter. He could see the wedding ring on her trembling finger. And he had no doubt the pleading young man was her husband, as he also wore a wedding band.

The young man, who seemed only in his late teens, was quietly murmuring some kind of repetitive litany prayer as he knelt beside the obstetrician. The latter quickly opened his medical valise and injected a painkiller into the girl's willing arm.

She closed her eyes and stopped crying. A great, powerful feeling gripped the obstetrician. He had to save this child! Something told him this unborn baby was destined to revolutionize the world and aid the living and the dying, especially the hopeless, achieve the grandeur of an ultimate bliss! This child was truly from some other dimension beyond any universe, something deep in the mind of the obstetrician told him! This must be God made flesh, the strange thought insisted! Why, oh why, was he thinking this? He had heard of the Christian belief in Incarnation but never could accept it because he did not then believe in any deity, and anyway, what would so supreme a purported creator of universes be doing demeaning itself by clothing its ineffable being in the stupidly arrogant flesh of a nearly hairless mutant of tree-abandoning Miocene apes? But now he stunningly believed this great mystery! And how he *believed*! Because of the wonders he had experienced this strange, time-warping night!

With great professional carefulness, the now highly motivated obstetrician gently placed a pair of sterilized forceps around the little protruding buttocks and very carefully pulled so as not to injure the cramped position child with spina bifida or some other horrible injury! Gently, ever so gently, he pulled and for the first time was praying! Gradually, the little body moved outward, and voila! A healthy baby boy was born! The obstetrician cut the umbilical cord after skillfully tying it, gave the usual healthy spank and everyone joyfully heard the baby boy bawl his first breath! The obstetrician took off his special, sterilized gloves he had hastily put on before using the forceps, checked and treated the child's eyes and body in general, took care of the afterbirth with another pair of sterilized gloves and after he had removed those and scrubbed his alcohol-sterilized hands, he placed the baby in his mother's arms. She then wiped her baby with linen cloths, wrapped him in swaddling clothes, and began with great love to nurse him.

To the obstetrician's mesmerized eyes, it was as if a great golden light filled the cave barn — and his soul! Outside, he could hear harp-like music and the most beautiful singing he had ever heard! The music and song seemed to come from the sky, from the universe itself! He was again in a divine ecstasy, only this time more powerfully than ever! The nursing baby and beautiful mother seemed to glow in some golden celestial light!

Something deep inside his ecstatic spirit told the obstetrician it was time to leave this sacred place. The young man, tears still in his eyes, hugged him devoutly and said what must have been a prayerful "Thank you!" to the divinely moved obstetrician. The young mother came over and gently hugged the doctor who had saved her son and her; the hug was one of deeply sincere motherly love and so transfixed the obstetrician that it pierced him to the heart with the fire of divine grace!

The young mother then placed a clean blanket in a nearby manger filled with fresh hay, laid the sleeping baby boy on the fresh blanket, and then covered the child with a heavier blanket, as the night was getting cool.

The obstetrician could hear the clamor of many voices coming up the hill towards the cave barn, and the mellow bleating of sheep. Shepherds coming to see what was going on! The celestial music and song grew louder and would remain forever in the obstetrician's memory. No human composer could have written such glorious music which literally vibrated the universe itself!

Suddenly the mysterious star — or whatever phenomenon it was! — reappeared, moving over the cave barn and aligning itself directly with the startled obstetrician. He knew something marvelous was again about to happen to him! He snatched his valise, already refilled earlier with his medical equipment, and zap! The strange star blazed like the sun and a photonic tunnel time-warp beam shot out from it and engulfed the cave barn with a warm, golden light! In an instant, the obstetrician was sucked up into the tunnel beam and zero-time made everything stand still. He would forever remember the smiling, good-bye faces of the holy family he had so well and humbly served! As he whirled upwards, he caught a zero-time glimpse of three richly adorned bactrian camels and their elegantly crowned riders approaching the cave barn in zero-time stillness! In a flash, all was gone and he was descending at light speed to the Earth! The ecstasy was diminishing! The next thing he knew was a strange, slowing speed and his feet gently touching the ground. The golden light had disappeared, the bizarre star was back in its usual magnitude and set brilliantly like a jewel among many jewels in the dark velvet sky.

He was back in New York City. He noticed the local bank's huge, red-numeraled digital clock had advanced only one minute since his strange departure, and the date and year had not changed! He was back in front of the parking garage.

As he drove away, he resolved that he would do no more abortions, but find new ways like teaching safe sex — especially RESPONSIBLE sex! — to his students. Or work in Third World countries, educating men and women about what damage overpopulation was doing to them and how to practice non-abortive and humane birth control that would serve, not denigrate, nature! Or change his profession entirely, like becoming a public school teacher or college professor. His bizarre experience visiting that sacred family had changed him completely and *yes! There was a good, all-powerful, and loving God! Even in a sometimes cruel and testing universe!*

Patrick William Bradley Jr. is from St Albans.

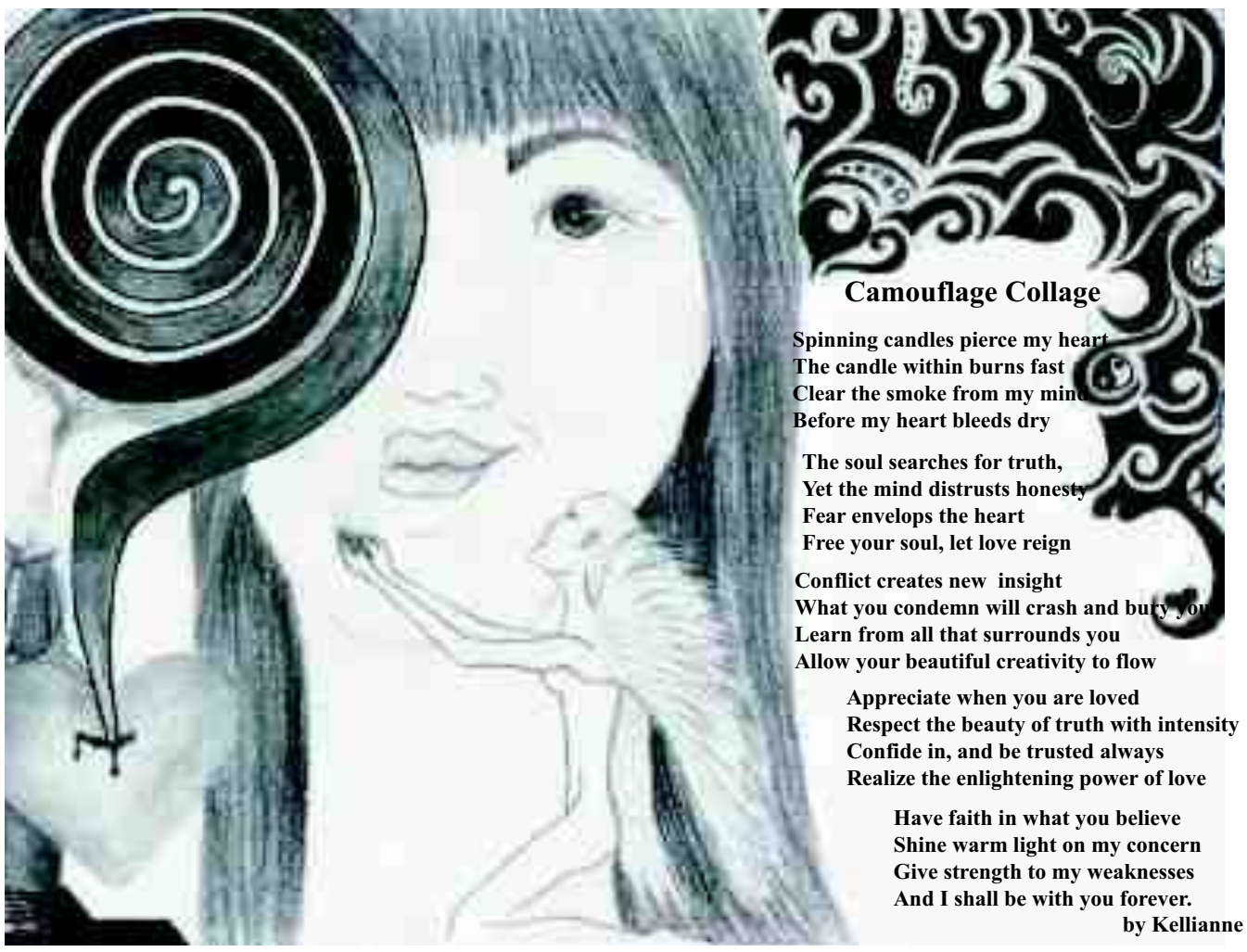
Arts

Poetry and Prose

Attention

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

by neil t schmidt
east montpelier



Camouflage Collage

Spinning candles pierce my heart
The candle within burns fast
Clear the smoke from my mind
Before my heart bleeds dry

The soul searches for truth,
Yet the mind distrusts honesty
Fear envelops the heart
Free your soul, let love reign

Conflict creates new insight
What you condemn will crash and bury you
Learn from all that surrounds you
Allow your beautiful creativity to flow

Appreciate when you are loved
Respect the beauty of truth with intensity
Confide in, and be trusted always
Realize the enlightening power of love

Have faith in what you believe
Shine warm light on my concern
Give strength to my weaknesses
And I shall be with you forever.

by Kellianne

Barb's Alarm

Something went wrong bio-chemically, but only in Barb's brain.
Not on the White House lawn
or in the nation's food belt.
Thus, no rescue mission was organized,
no clean-up
effort got underway. CNN had nothing to say to anyone
much less, exclusive images.
In fact, all the world's news gathering agencies
were caught with their pants down.
And would have been embarrassed
if not outright ashamed had they known, had they cared.
It was left up to Barb
to sound the alarm. So she set the alarm clock
in her own way. Probably never even went off.
Definitely didn't wake her up.

Dennis Rivard
White River Junction

Care

I wish I knew a kind of glue to make, as one, what's split in two.
Distaste of paste I can't disguise since preschool memory decries.
And superglue I will abhor until my fingerprints restore.

Scotch tape won't tastefully renew unless scotch whiskey clouds my view.
My baling twine and diaper pin hold up my pants and keep within.
Nor can I mend it with a laugh, at least I feel on your behalf.

by Alfred George Brier

Arts

Poetry and Prose

#49

we've travelled the whole world over
just searching for a song
and all we heard were lonely sounds
and no one would sing along

we've walked along the empty roads
just looking for a face
and all we found were lonely stares
which time could not erase

the paths were long, the wounds were deep
our pain was drowned in tears
could we go on to find our life
through crowds and all our fears

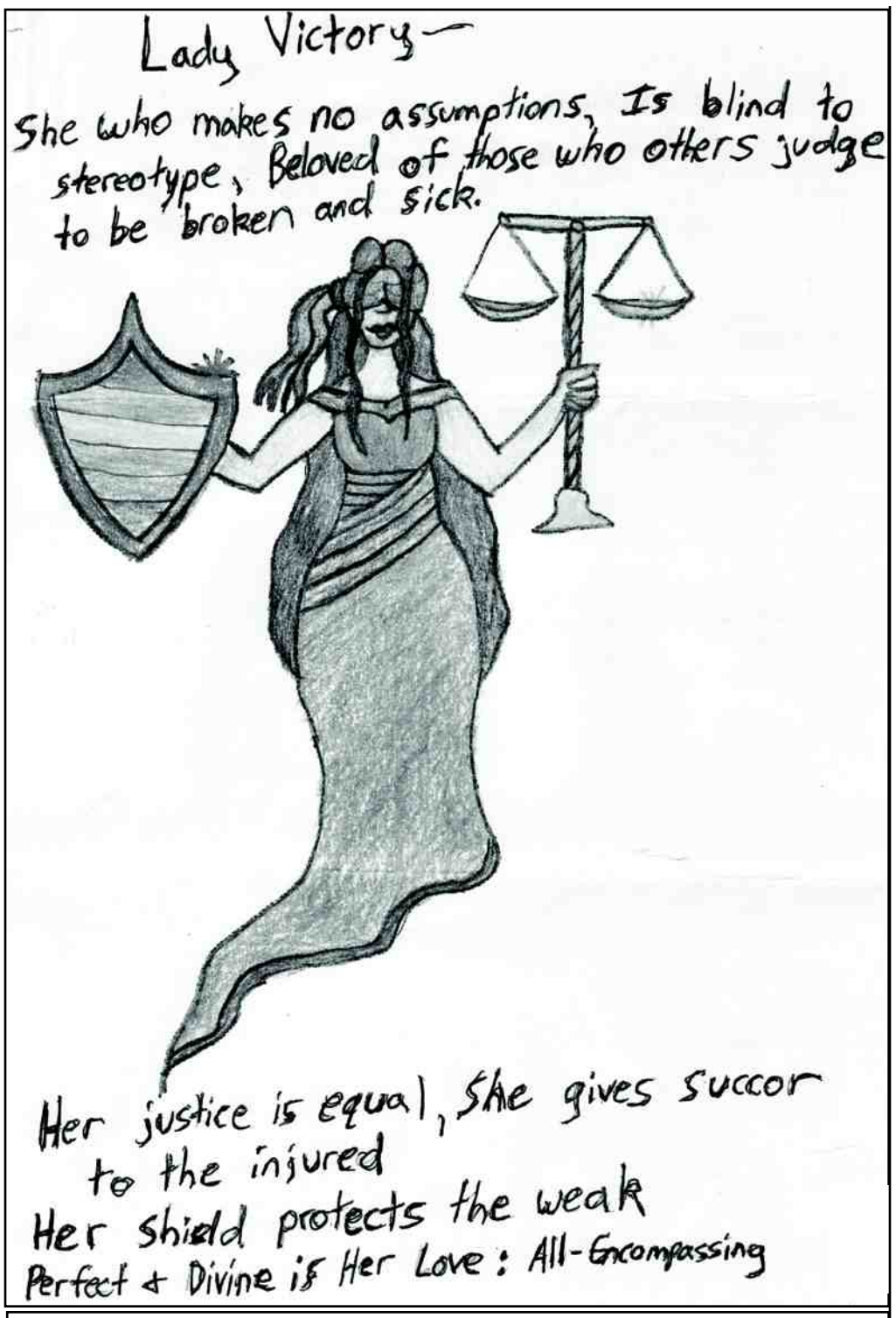
we searched beyond what we once knew
as life's accepted flight
and reached a plane where life for us
was a dream but still a fight

our life we feel was once so lost
but now has found its roots
and once when we were wandering
we stumbled on our truth

we see our face in all we do
we're a reflection of our eyes
we know our love has found a home
and our life shall light the skies

we travelled the whole world over
just searching for a song
and once we heard just lonely sounds
now we all shall sing along

by m. a. wakeman, north bennington



Lady Victory, by Kathryn 'Kat' N., Montpelier

Second Place

The rap is a star has a silhouette like a constellation is a body in space Second Place.
Rap is a dark light since one million years where people trespass.
It has a fire space as a fire place.
It has sustenance to make my heart warm. To feel the tender lips press the sky and my feet touch the ground as the world turns. Without your light my life would be an empty cell... I live in your presence all this life before I was born there it exists. Like the L train. We ride the same fair so pay your fair, pay your fair stop!

by MIKE MIKE, Barre

Counterpoint
Would Love
To Have Your Art
Right Here!
Share Your
Sketches,
Photos, Poetry,
Paintings, Stories

Send to: ***Counterpoint***,
1 Scale Ave, Suite 52,
Rutland, VT 05701 or
counterp@tds.net

The Brain

It starts in the brain
You cannot refrain
It's like a mindful cloud
Everything becomes so loud
You get such a headache
Because reality is hard to take
When you get a headache
It's time for you to take a break
Your brain starts to freeze
Which doesn't make you at ease
The brain holds so much power
As you get new thoughts hour by hour
The most powerful element
And you can't get rid of it by sellin' it
It holds so much knowledge
And what will get you through college
As the ideas emerge
You try to put your thoughts into words
Be good to your brain
Even if you're feeling drained
It's there from the time of birth
It's your job to value it, for what its worth

by Nikita Laferriere, Middlebury

Resources Directory!

Community Mental Health

Counseling Service 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
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 CALLS

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

Co-Occuring Resources

www.vtrecoverynetwork.org

Support Groups

Double Trouble
Bennington, Call 442-9700
Turning Point Club,
435 Main St., Mon, 7-8 p.m.
Bennington, Maintaining Your Recovery, Turning Point Club, Thurs, 5:30-6:30 pm; no registration required.
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 ,Thurs, 6:45-7:45p.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,191 Bank St; 851-3150;
director@turningpointcntervt.org
Middlebury, 228 Maple St, Space 31B; 388-4249; tcacvt@yahoo.com
Rutland, 141 State St; 773-6010
turningpointcenterrutland@yahoo.com
St. Johnsbury, 297 Summer St; 751-8520
Springfield, 7 1/2 Morgan St.
885-4668;
spfturningpt@vermontel.net
Wilder, 200 Olcott Dr; 295-5206
uvsaf@turningpointclub.com

Vermont Psychiatric Survivors Support Groups

Northwestern
Call Jim at 524-1189
St. Paul's United Methodist Church, 11 Church Street, St. Albans, 1rst and 3rd Tuesday, 4:30-6:30 p.m.
Brattleboro:
Changing Tides;
Call Karen at 579-5937
Brattleboro Mem. Hospital
Wednesdays, 7-8 p.m.
Central Vermont
Call 223-7711
Another Way,
125 Barre St., Montpelier
Women's Support Group
Tuesdays, 3:30 - 5:30
Another Way,
125 Barre St. Montpelier
Tuesdays, 6-7 p.m.
Bennington:
Coffee Busters;
Call Caroline at 681-5513;
daily, 12-1 p.m.
Vermont Psychiatric Survivors is looking for people to help in starting peer support groups. Funding is available to assist groups. For information, call VPS at 800-564-2106.

LGBTQ Individuals With Disabilities

Talk, connect, and find support; issues including coming out, socializing, employment, safe-sex, choosing partners, self advocacy, discovering who you are, and anything else. Tuesdays, 4 p.m. at RU12? Community Center, Champlain Mill, 20 Winooski Falls Way, Suite 102, Winooski; David (Dave6262002@yahoo.com) Sheila(sheila@ru12.org); phone: 802-860-7812.

Brain Injury Association

Support Group locations on web site: www.biavt.org or email: support1@biavt.org. Toll Free Line: 877-856-1772

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, Safe Haven in Randolph, advocacy work, *Counterpoint*. 1 Scale Ave., Suite 52, Rutland, VT 05701. (802) 775-6834 or (800) 564-2106.

Adult Protective Services

Reporting of abuse, neglect or exploitation of vulnerable adults, 1-800-564-1612; also to report licensing violations at hospitals and nursing homes.

Vermont Family Network

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. 800-8800-4005; 876-5315

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

Support, education and advocacy for families dealing with mental illness. 1-800-639-6480, 67 162 S. Main St., Waterbury, VT 05671; www.namivt.org; info@namivt.org

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

(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:office@mindfreedom. org

National Empowerment Center

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

Check it Out!
www.vermontrecovery.com
Links to just about everything... including back issues of *Counterpoint*

Warmlines

Peer Access Line of Chittenden County:
Thurs, Fri, Sat, 6-9 p.m.; 802-321-2190

Rutland County Peer Run Warm Line:
Feeling isolated? Need someone who cares? Fri, Sat, Sun, 6-9 p.m.; 802-770-4248. Call any time to leave a message for a call back, or email at warm_line2012@yahoo.com.

NAMI Connections

Peer Mental Health Recovery Support Groups

Bennington: Every Tuesday 1-2:30 pm; United Counseling Service, 316 Dewey Street, CRT Center
Burlington: Every Thursday 3-4:30 pm; St. Paul's Episcopal Cathedral, 2 Cherry Street (enter from parking lot)
Rutland: Every Sunday 4:30-6 pm Wellness Center (Rutland Mental Health) 78 South Main St.
St. Johnsbury: Thursdays 6:30-8 pm Universalist Unitarian Church, 47 Cherry St.
Springfield: Every Monday 11:15 - 12:45 pm; Turning Point, 7 Morgan St.; contact Greg at 802-855-3684.

If you would like a group in your area, to be trained as a facilitator, be a Champion for a group in your area or have questions please contact NAMI 1-800-639-6480 or email us at connection@ namivt.org

Vermont Veterans and Family Outreach:

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).

VA 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 Centers (Burlington) 802-862-1806 (WRJ): 802-295-2908
Outpatient Clinics (Fort Ethan Allen) 802-655-1356 (Bennington) 802-447-6913

Veterans' Homeless Shelters

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/Wilson 802-864-7402
Free Transportation: Disabled American Veterans: 866-687-8387 X5394

Drop-In Centers

Another Way,
25 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