Winter Edition *Holiday Greetings*

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

Counterpoint

Vol. XXVII No. 3 | From the Hills of Vermont | Free! | Since 1985 | Winter, 2012

Will Community Money Be There?

One New Residence On Hold; Legislators Question the Budget

by ANNE DONAHUE
Counterpoint

MONTPELIER — The mental health system in development under a new law that stresses expansions in community programs fell short of money to achieve this year's original plans, according to testimony in December to a legislative oversight committee.

If the new system is to continue to roll out, next year's budget would need an addition of $21.6 million just to maintain funding for what was already planned in Act 79, a budget spread sheet showed. That would require $5.5 million in state general funds in order to raise federal matching funds for the rest.

Last year, about $40 million was budgeted to carry out the programs identified in Act 79. If the full cost is $61.5 m next year, it would represent about a 35 percent shortfall compared to the current budget.

Mary Moulton, Interim Commissioner of the Department of Mental Health, prepared the figures on a request made last month by the Joint Mental Health Oversight Committee.

The new numbers came just days after a briefing in which legislators were told that the state was facing an overall $50 to $70 million shortfall that must be addressed for the next budget year, which begins in July.

The committee asked for the Act 79 budget information after a progress report in November from then-Commissioner Patrick Flood. He told the committee that one intensive residential program was on hold and that the current year's budget might still fall short, because of unplanned or higher-than-expected costs.

The Mental Health Oversight Committee monitors the mental health system during the summer and fall when the legislature is not in session.*

Flood said in November that the biggest reason for the current budget shartfall was that operating costs for the 8-bed interim hospital were not included in the numbers approved in the spring. In a written summary, he also said the secure residential program "is now estimated to be about 50 percent more than originally estimated," in part because the planned program size was increased from five to seven beds.

"By the end of the calendar year, 22 new intensive residential recovery beds will be open," the summary noted, and are "turning out to be more expensive than estimated." Flood said that those programs were budgeted at a cost of $250,000 per bed per year, but actual programs are coming in with budgets of $300,000 to

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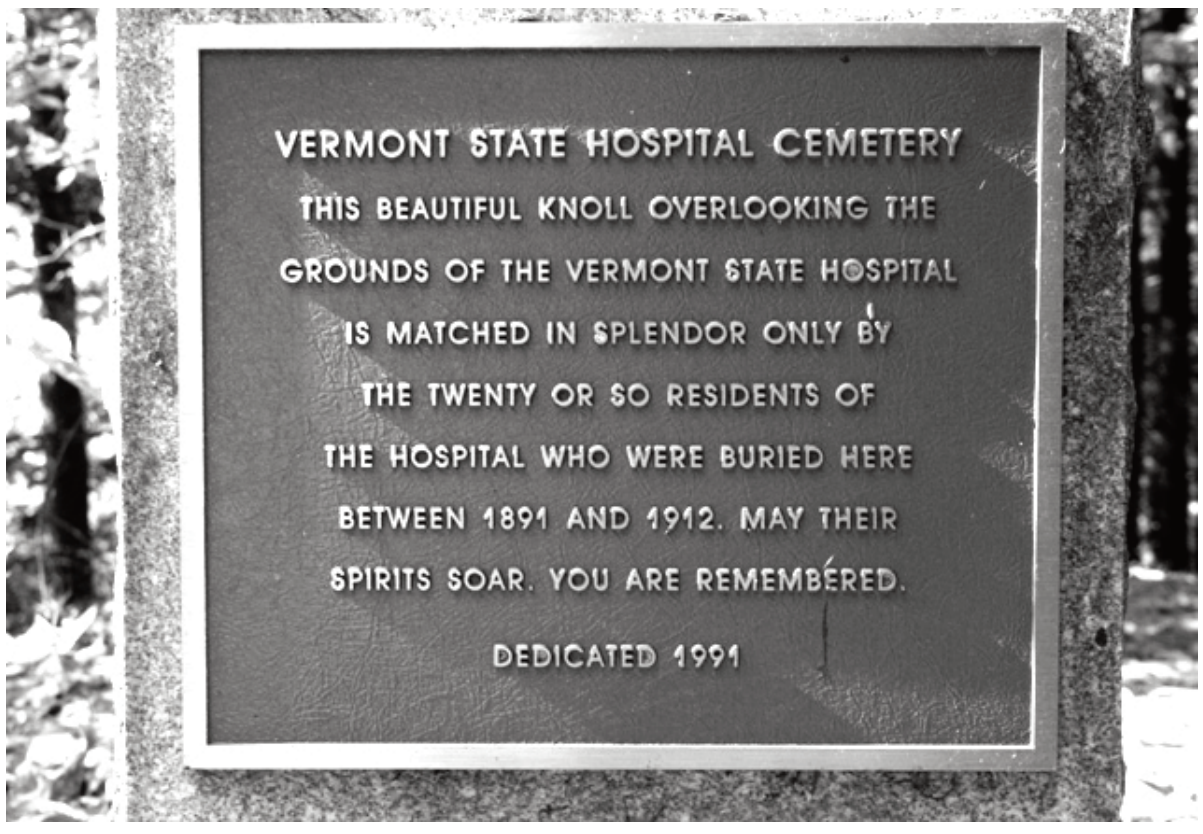

The memorial stone at the unmarked grave sites of some early patients who died at the Vermont State Hospital for the Insane. (Counterpoint Photo: Anne Donahue)

Search for Cemetery Names Puts Faces on Hospital's Past

by ANNE DONAHUE
Counterpoint Special Investigation

WATERBURY — Curtis Urban of Bolton was 15 years old when he died at the Vermont State Hospital for the Insane. He was admitted to the hospital when he was 11, but not because he was "insane." His death certificate says he died in 1933 of epilepsy.

Margaret Cotter was more like the patients generally assumed to be typical in the hospital's first 50 years. The Castleton woman was 34 when she was admitted to the hospital in 1896 and died there 46 years later in 1942 at age 80.

Her immediate cause of death was listed as senility, with the underlying condition of "dementia praecox," an early term for schizophrenia.

A *Counterpoint* investigation that began as a search for the identities of the "20 or so" State Hospital patients buried in a partially forgotten cemetery led to these stories — and countless others — that put a face on the history of those who died in the early years of the institution.

Scores of young adults died there of tuburclulosis. Ernest Patterson, 28, of Montpelier was a laborer when he succumbed to TB in 1903. Was he one of those buried between 1891 and 1912 in the small cemetery on a knoll above the hospital farm? The *Counterpoint* search has yet to find the answer to that mystery.

Hundreds died in the first few decades. Some were brought home to rest by families. Many, unclaimed or unwanted, went to the "Medical College" in Burlington for physician education. Still others are in the "potter's grave" section of the village cemetery. Only a few became the unknown on the knoll. Even their individual grave sites are no longer identified; the wooden crosses once marking them have long since rotted away.

At least two burials took place on the grounds in locations not likely to ever be found again. According to Herbert Hunt, who wrote "The History of the Vermont State Hospital" in the 1960s, a large tree fell on a pa-

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Boards and Committees

Opportunities for Peer Leadership and Advocacy

Peer Organizations

Vermont Psychiatric Survivors:

Special Notice:

Vermont Psychiatric Survivors (VPS) is currently looking for new energetic, open-minded, and forward thinking people to serve on its Board of Directors.

Must be able to attend meetings bi-monthly. Experience with boards preferred but not necessary. For more information call (802) 775-6834 or email vps@sover.net

Counterpoint Editorial Board

The advisory board for the VPS newspaper, assists with editing. Contact counterp@tds.net

Alyssum Peer crisis respite.Contact Gloria at 802-767-6000 Alyssum.ed@gmail.com; www.alyssum.org

Disability Rights PAIMI Council

[Protection and Advocacy for Individuals with Mental Illness] call 1-800-834-7890 x 101

***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, stabler@myfairpoint.net, (802) 852-9283.

State Committees

State Program Standing Committee for Adult Mental Health

Advisory committee of consumers, family members, and providers for the adult mental health system. Second Mon. of each month, 12-3 p.m.; Redstone Bldg, 26 Terrace St., Montpelier. Stipend and mileage available. Contact the Department of Mental Health (Melinda Murtaugh).

Local Program Committees

Advisory groups for every community mental health center; contact your local agency.

Transformation Council

Advisory committee to the Commissioner on transforming the mental health system. New members welcome; stipend and mileage available. Contact the Department of Mental Health (Judy Rosenstreich). Check web for meetings.

Hospitals

Vermont State Hospital/ Successor

Advisory Steering Committee suspended; new format for future advisory group now under review; interim advisory group in formation for Green Mountain Psychiatric Care Center [Morrisville]. Contact the Department of Mental Health (Jeff Rothenberg) for further information.

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.

Announcements

Writers Needed

Counterpoint **offers stipends for writers accepting assigned news articles to research and write. There are always new and interesting topics!**

Contact the editor:
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Counterpoint, VPS, 1 Scale Ave, Suite 52, Rutland, VT 05701,
or counterp@tds.net

Web Sites of Interest

- **National Mental Health Consumer Self-Help Clearinghouse:** www.mhselfhelp.org/
- **National Empowerment Center:** www.power2u.org
- **National Association of Rights, Protection and Advocacy** (NARPA)**:** www.connix.com/~narpa
- **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
- **National Mental Health Services** Knowledge Exchange Network (KEN)**:** www.mentalhealth.org
- **Vermont Legislature:** www.leg.state.vt.us
- **American Psychiatric Association:** www.psych.org/public_info/
- **American Psychological Association:** www.apa.org
- **National Institute of Mental Health:** www.nimh.nih.gov
- **National Mental Health Association:** www.nmha.org
- **NAMI-VT:** www.namivt.org
- **NAMI:** www.nami.org
- **Hearing Voices:** www.hearingvoicesusa.org
- **Peers** (IPS): www.mentalhealthpeers.com/
- **WRAP:** www.mentalhealthrecovery.com/

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)
www.crazymeds.us/CrazyTalk/index.php
http://willhall.net/comingoffmeds/

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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.

Publisher
Vermont Psychiatric Survivors, Inc.
The publisher has supervisory authority over all aspects of Counterpoint editing and publishing.

Editor
Anne B. Donahue
News articles with an AD notation at the end were written by the editor.

Counterpoint is funded by the freedom-loving people of Vermont through their Department of Mental Health. It is published three times a year, distributed free of charge throughout Vermont, and also available by mail subscription.

Counterpoint Deadlines

Fall (September delivery; submission deadline July 7)
Winter (December delivery; submission deadline October 7)
Spring/Summer (June delivery; submission deadline April 7)

How to Reach The Department of Mental Health

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

http://mentalhealth.vermont.gov/

For DMH meetings, go to web site and choose "calendars, meetings and agenda summaries."

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

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Flood, Who Led Reforms, Resigns

MONTPELIER — Patrick Flood, Commissioner of the Department of Mental Health for barely a year, resigned abruptly in November.

He has been credited with leading major changes in the delivery of mental health care in Vermont, including expansions in services provided by peers and community-based services.

Deputy Commissioner Mary Moulton was named Interim Commissioner by Governor Peter Shumlin. He said a search would be under way for a replacement.

The announcement took Department staff by surprise to the same degree as individuals in the mental health community.

"The announcement was made and I think we're all still catching our breath," Moulton said at a Transformation Council meeting. She said she would like broad input on how the search process should be conducted, and criteria for a replacement.

Flood told *Counterpoint* that he had no mental health background, and that in the longer term, a DMH Commissioner needed one.

"I really feel at some point [the] person should be a mental health professional... [A] visionary with a mental health background."

"I don't know where I'm going next," Flood said, but despite the suddenness of the announcement, he said that leaving was his idea, not the administration's. His relationship with state leadership was "outstanding," he said. He said he didn't feel the need to "nail down" a new job in advance because he knew he could always go back to any non-appointed position in state government.

In terms of future planning, Flood acknowledged that the administration did not understand the importance of the peer role in the mental health system in the depth that he did; "in fairness to them, they're not experts."

"We're going to have to emphasize that in the process," he said. "I think they'll want my input."

Flood has been credited as the driving force behind the mental health care reform act that passed the legislature this past spring. It included a major shift in emphasis from inpatient care to community care. He brought in a broad number of peers, providers and family members for ongoing input on the priorities for a new system.

"One thing Patrick did so very well was to reach out to our partners," Moulton said. She noted that she was on a leave of absence from Washington County Mental Health Services, and was committed to returning to her job there no later than next summer. AD

Cemetery

(Continued from page 1)

tient who was out with a wood-cutting team for the hospital furnace. Both his legs were broken, and he bled to death.

It happened just after the hospital cemetery had closed, Hunt said, and so he was buried in a spot "in the middle of the old Johnson meadow, near the old house foundation and a big, old tree."

Another longtime State Hospital staff person recalls hearing that there were several burials "by a big tree" in that same area.

In 1908, a patient who had hanged himself from a tree was buried beneath it because of a stated "inability" to move the remains elsewhere.

Hunt received permission, while researching hospital history, to review early patient files. He said he created a list from those records of the persons who were buried in the old cemetery, but no longer has it.

The granite memorial stone and four corner stones were placed at the site in a ceremony in 1991. Hunt said that Fr. Louis Logue, longtime chaplain at the hospital, led the ceremony and recited the names from Hunt's list. Logue has since died, and the current pastor at St. Andrew's Church found no reference to the names in the files there.

Both the old patient records and death certificates on file in the town clerk's office identify a number of patients whose bodies were transferred to the Medical College in Burlington. They were cremated after use, and if the cremated remains were not returned to family, are at the Greenmount Cemetery in Burlington, according to Carole Whitaker of the University of Vermont.

State law requires the body of a person who dies without the resources to pay for burial be turned over to a medical doctor who requests it for "the advancement of anatomical science." There are exceptions, including family objection made within 48 hours of the death, but the law remains on the books to this day.

Whitaker said that UVM is currently working on a project that will make its old anatomical donation records more searchable. She said she believes it will be possible to access the identities of persons whose bodies were received from the State Hospital.

The death certificates of those sent to the Medical College have no common themes. Frederick Robinson, 43, of Rupert, was a farmhand who died of "chronic diffuse nephritis" in 1903. Royal Pike, 42, of Readsboro, a teamster, also died in 1903, with the cause listed as "dementia general cerebral atrophy." Michael Donahue, 63, of Vershire, was a miner who had spent 22 years at the hospital before dying of "chronic myocardilis" (hardening of the arteries) with a contributing disease of "terminal delirium."

In those three examples, parents were listed as "unknown" and they were single. Among many older patients who died, date of birth was listed as unknown, and even ages were sometimes "unknown" or an estimate.

A frequent listed cause of death at the hospital among older patients was "inanation" (a severe lack of nourishment) resulting from dementia, as well as "exhaustion" as an effect of mania.

Agnes Chapman was a housekeeper from Bristol, born in Scotland, who died at age 53 of "exhaustion following maniacal excitement insanity" in 1911. Michael Collins, a stonecutter from Ryegate, died in 1912 at age 40 of "exhaustion following acute mania."

Other common causes of death included pneumonia and nephritis (kidney inflamation), often with "insanity" listed as the contributing disease. Some were also medical conditions that resulted in death within a few days of admission.

As with young Curtis, epilepsy was identified as a cause of death for some. The next youngest among those for whom death records were found, Belle Lamphere, 16, was also recorded as a death from epilepsy.

Some patient deaths were described as tragic accidents. William Burbank was 17 when he died at the State Hospital in 1909. He was from Burlington, but his parents are listed as "unknown." His cause of death was listed as "shock from extensive scalding of the body caused accidentally."

Counterpoint is continuing its research into the dispositions of those who died at the state hospital, and in particular, in the effort to identify those buried at the State Hospital Cemetery.

Budget in Question

(Continued from page 1)

$320,000 per bed. As a result,"we are delaying the development of the additional eight beds targeted for Chittenden County at this time."

The need to hold back on the residence came despite money in the budget that was saved because programs started larter than expected, and despite an unexpected $4 million in saving to the amount budgeted for inpatient hospital costs.

The original budget was able to shift $18 million from inpatient care costs to community services after the State Hospital closed, because the State Hospital had been operating without federal matching funds, and the community hospitals do receive the match. However, even the remainuing cost to the state's share of Medicaid "have been below early estimates" as a result of a higher level than estimated in the amount of care being paid by Medicare. Medicare is all federally funded, with no state match.

Flood also told the committee in November that not all the enhanced community services are up and running, because low salaries are interfering with the ability to recruit staff in some areas. The projection for the cost to fully implement Act 79 next year did not include any increase in those funds.

***From the Counterpoint Advisory Board:** Counterpoint did not have an available writer to report on these meetings apart from editor Anne Donahue. Donahue is also a state representative and the co-chair of the Joint Mental Health Oversight Committee, thus representing an inherent conflict of interest for reporting news. This article should be read with understanding of that inherent conflict. The same applies to other articles in this issue that reference the Mental Health Oversight Committee.*

In the interest of protecting unbiases news coverage, Counterpoint continues to recruit for freelance news reporters (see page 2.)

State Curator Seeks Hospital Interviews

MONTPELIER — The state curator's office has stated that it will be conducting a historical study of the old state hospital, and is seeking interested persons to contribute to an oral history as a part of it. Curator David Schutz said that with the help of experts at Vermont's Folk Life Center, it is the hope to interview people who have direct experience with the hospital (former patients, staff, volunteers and members of the neighboring Waterbury community).

"At this point, we are simply trying to get names of people and contact information," Schutz said. There is no start date set yet.

Schutz said that sharing information could take many forms. "If people don't want to record, they don't have to; they can submit their story in writing or be interviewed and the information written by the interviewer." The information can be confidential if an individual wishes. Schutz can be contacted at (802) 828-5657 or curator@leg.state.vt.us.

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, and 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; and **a 7-bed secure residential recovery program**.

Miscellaneous: Requires reporting and review of deaths or serious injuries to any person receiving services; Requires that inpatient psychiatric staff be the primary source for emergency involuntary procedures; 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; Provides funds to continue the police academy mental health training. 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. [Completed.]

Progress Reports in This Issue

What Is the Progress?

Waits for a Bed Worsen Sharply

MONTPELIER — More than a day of waiting in an emergency room or being held in corrections because an inpatient bed is not available has become the rule, rather than the exception, for individuals being held involuntarily, according to Department of Mental Health data complete through October.

There were no hospital placements available for 30 out of 33 individuals held for an emergency exam in October, the highest percentage ever, and they waited an average of 53 hours in the emergency department, the longest in the past seven months. One person waited almost 10 days for a bed.

Numbers are newly being tracked for voluntary admissions as well, and there were no beds available for admission for 14 individuals in September and 16 in October; they waited in emergency departments for an average of two days before a placement was available.

Four individuals each in September and October were found to need a hospital admission after a criminal court referral for a competency evaluation, and were held in corrections instead, for lack of an open bed. Although the average delay went down slightly from September, it was at five days in October, with one person held in prison for a record length of 11 days. Those eight individuals represented all but one of the court referrals in the those two months. AD

Springfield Unit Closes, Despite Some Delay on Secure Residence

SPRINGFIELD — Former state hospital patients being housed in the Springfield Correctional facility were all relocated to community placements this fall, and the prison unit — declared a hospital under the emergency powers of the governor after last year's flood — was closed for that use on October 10. "Kudos to you guys for getting our folks out of there," Kitty Gallagher said to staff of the Department of Mental Health at a Transformation Council meeting. The new placements include a house with a high security, three-to-one staff-to-resident ratio.

A 7-bed secure residential program planned for persons with treatment issues like those being held in Springfield has had obstacles in finding a location, but now appears to be on track. After almost a year of searching, the department identified state-owned property in Middlesex next to the state police barracks. A neighbor's appeal of the Middlesex town permit threatened another delay, but the construction will proceed while the appeal is pending, Interim Commissioner Mary Moulton said. A company that manufactures mobile medical units will be building the residence using modular construction, and DMH hopes to open the program early next year. Although modular units can last for 10 to 15 years, DMH has a three year plan to test the program and determine what the long term needs are, Moulton said. She said there were currently 12 patients waiting in hospitals who would be appropriate for the program. AD

2nd Residence Gets Green Light

WESTFORD — Second Spring North, an intensive community recovery reasidence to be run by the same collaborative as Second Spring in Williamstown, has been approved as an 8-bed program. Director Jim MacDonald said he hopes it will be open by early spring. The program was reviewed by an advisory board at a public hearing in Burlington. At that hearing, and at another one held near the residence, some neighbors expressed concerns and asked questions about who would be served at the program and whether there would be safety issues for the community. Their was also criticism that there were not earlier discussion that might have prevented rumors. "Try doing it (outreach) with the neighbors so they can be at the first meeting," one resident urged. AD

Ombudsman Office Designated

MONTPELIER — An agreement designating Disability Rights Vermont as the state's office of the mental health care ombudsman has been signed by the agency and the Department of Mental Health. The designation was required by Act 79, but does not provide for any funding this year. It appoints DRVT to investigate individual cases of abuse, neglect and serious rights violations; work to reduce the use of seclusion, restraint and coercion; review emergency involuntary procedure reports and make recommendations for improvement; participate on the state's Treatment Review Panel; review any reports of untimely deaths; integrate efforts with the long term care ombudsman and health care ombudsman; and provide the Department with an annual report. Although most of the functions are the same as those DRVT carries out as the protection and advocacy system for Vermont under federal law, the statute establishes the authority in state law. AD

Alternative Soteria Model Principles Focus On 'Being With,' Not 'Doing To' Individuals

Steven Morgan, the former Executive Director of Another Way in Montpelier, recently took on the position of project developer for a Soteria model program in Vermont. Here, Morgan explains what "Soteria" means and his vision for the program in Vermont.

Steven Morgan

Pathways Vermont was recently awarded a contract to develop a residence in the greater Burlington area utilizing principles from Soteria, a successful program from the 1970s that was started in California with a National Institute of Mental Health grant.

The program was described in Act 79, the mental health system reform law, as "... a voluntary five-bed residence for individuals seeking to avoid or reduce reliance on medication or having an initial episode of psychosis. The residence shall be peer supported and noncoercive, and treatment shall be focused on a nontraditional, interpersonal, and psychosocial approach, with minimal use of psychotropic medications to facilitate recovery in individuals seeking an alternative to traditional hospitalization."

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, and its creative and non-professionalized environment.

The most important difference is in 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 original Soteria project lasted for 11 years and was rigorously studied. Compared with controls at a traditional hospital, residents fared as well or better on every measure. In effect, it proved that interpersonal and psychosocial approaches alone can facilitate recovery for many persons on course to being diagnosed with schizophrenia.

Ideally, Soteria-VT will work with people having a first or second psychotic break who have not had substantial exposure to neuroleptic medication. Its primary service will be interpersonal relationship-building in a safe, flexible, empowering, and homelike environment. Additionally, Soteria-VT will offer trauma-informed peer supports, naturopathic consultation, voluntary medication in selective instances, techniques for stress reduction, access to creative tools, skill development, gardening, healthy food, and the ability for folks to continue social roles.

Based on data available, stays at Soteria-VT are expected to average three to four months. The targeted opening date is mid to late 2013. For more information, Morgan can be contacted at (802) 595-2890 or steven@pathwaysvermont.org

Goal To Reduce Shackling Makes Gains

MONTPELIER – It is still "slowly ramping up," but a new project by the Lamoille County Sheriff's Department provided secure transportation for nine involuntary patients as of mid-November with only one person held in restraints.

The project is one of several early efforts by the Department of Mental Health to follow through on state law requiring the least restrictive and least traumatic ways, consistent with safety, to transport individuals to or among hospitals. Although the law was passed several years ago, few changes had resulted until now.

Members of a work group on the new efforts reviewed progress at a recent meeting and praised the difference it has already made, even though a number of steps are still in development.

There has never been "this level of communication" with law enforcement around the state, said Mary Moulton, Interim Commissioner of DMH.

The Lamoille County project is using sheriffs who have taken special training and use a specially designed unmarked van to provide transportation from emergency rooms and courts to inpatient hospital units.

Roger Marcoux, the Lamoille County Sheriff, said five officers are trained and eight more are undergoing the specialized training currently, but "it's going to take me some time" to have the program up to full capacity.

A primary goal is to avoid ever needing to use restraints. The modified van has its middle seat removed to allow for more space for the rear-seat passenger, and a "modified safety barrier" between the back and the driver's seat in the front.

Moulton described one courtroom situation in which an individual was so agitated that the judge ordered the person removed from the court. Deputies who had established a relationship with the patient were able to escort the person with "no hands-on needed," she said.

Moulton said that it was important to get the courts involved in recognizing the stresses the situations put on patients.

On a statewide basis, "we haven't developed a public policy" for addressing least restrictive transport, she said, but that needs to wait while local options are created.

"Other sheriffs need to step in," and some have, Moulton said.

In Windham County, for example, the sheriff has established a protocol that bars the use of restraints unless they are necessary – a very different approach than the traditional sheriff policies that require all individuals to be shackled, regardless of individual circumstances.

Ed Paquin of Disability Rights Vermont said that "the heart" of the current change was that "there's judgment being exercised" instead of automatic rules that are applied regardless of the specific person and circumstances.

DMH is working on state standards for emergency services workers at community mental health centers, Moulton said.

The current efforts are addressing only the transports that are occurring between hospitals or from courts, and not from the community to a hospital.

Those situations involve many more different police agencies and crisis responses, but "we're starting to discuss that," Moulton said.

A major topic at the meeting was an ongoing review of how to record and report data on transportation. Earlier, a broader work group had divided the terms "secure" and "non-secure" based upon whether a person was in restraints.

In reviewing that definition, members agreed that a law enforcement transport was never actually "non-secure." The contrast would be with the mental health alternative program based in Chittenden County created several years ago.

Roger Marcoux, the Lamoille County Sheriff, noted that his program wasn't accurately described as non-secure.

"These folks know… even if they're not restrained" that they are in secure custody.

On the other hand, past data identified transport by ambulance as a non-secure alternative to using law enforcement, without recording whether sheriffs were riding in the ambulance. In addition, committee members noted that for some individuals, transportation by ambulance strapped down on a stretcher was far more traumatic.

The work group agreed that the degree of trauma was more correctly assessed based upon the individual's own perceptions and experiences.

On a related subject, Moulton updated the Transformation Council in November on the progress of training across the state for police and mental health teams to work together in responding to crisis situations.

A day-long trial training was conducted with leadership from both law enforcement and mental health as part of developing "train the trainer" sessions to be provided in January and February, she said.

"A really powerful panel" of individuals shared "how it felt to them" in sample emergency situations. It was "so positive," she said.

The target is for each region to have at least one person that is a trained mental health liaison on each shift, Moulton said. 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.

The Status of Rebuilding Inpatient Care:

25-Bed Hospital on Verge of Breaking Ground

BERLIN — The state is still hoping to break ground for a new acute psychiatric hospital before the ground freezes in December, despite a delay in a local zoning permit and the uncertainty of how much money will be contributed from federal emergency flood funds.

The 25-bed hospital received an expedited state regulatory approval after a public hearing in November, in line for a construction start that was aimed for the end of that month.

A December construction start would maintain a timetable for opening in January of 2014, and "we are on track," Secretary of Administration Jeb Spaulding told state legislators in late November.

It is "going to happen no matter what the final amount of money is that we get from the federal government," Spaulding said, although he noted that it will be up to the legislature to actually find the money.

In contrast to the public concerns and controversy that have arisen in many communities when mental health programs are proposed, no residents attended to object at either the state or local public hearing.

The town permit issues were technical ones aired in late November at a hearing where the chair of the Development Review Board, Bob Wernecke, identified a series of missing pieces of information needed in order for the board to decide whether criteria for a conditional use permit were met.

Among the questions that staff from the state's Department of Building and General Services could not answer were the revised total number of acres to be purchased (one landowner is keeping several acres), the Agency of Transportation's safety rating of a nearby traffic intersection, a conclusion on whether water would be purchased from Montpelier or Berlin, how a planned sidewalk would be maintained, or what the tree and shrub plantings would be.

The hospital is the last but the largest part of a mental health system overhaul that increased resources for community supports. It is part of the replacement plan for the 54-bed Vermont State Hospital that closed on August 29, 2011 after Tropical Storm Irene flooding.

The Commissioner of the Department of Financial Regulation, Steve Kimball, became the newest voice to describe the critical impact from the flooding.

"This has put tremendous pressure on the state's ability to care for Vermonters with serious mental illness," he said in announcing the Department's approval of an emergency certificate of need.

"Our mental health care providers are to be commended for their hard work and dedicated service during this difficult time."

The approval process came with record speed. The application for emergency approval was filed on November 2, a public hearing was held on November 16, and the approval was granted on November 19.

A work team of architects, state staff, community agency and hospital providers, and consumer and family members developed the hospital design in day-long sessions during the summer and fall.

Kimball included several special conditional. He directed that DMH, in its quarterly updates, report on the "integration of mental health care and medical care at the Berlin facility, including discussion of transport and access to emergency medical support."

The DMH application had failed to reference issues regarding medical care and advocates expressed concern at a Transformation Council meeting that occurred just before Kimball's decision was released.

Laura Ziegler reminded the group that years ago, when the replacement options for the state hospital were first being discussed, it was estimated that 24 percent of the patients there had conditions that would qualify for a medical hospital admission.

More than a dozen years ago, when Fletcher Allen Health Care was proposing a new psychiatric facility that would not be on the same campus with the main hospital, one concern was the challenge in getting medical specialties to respond to needs on a psychiatric unit, recalled Ed Paquin of Disability Rights Vermont.

A clinician in the psychiatry department said it was "hard enough just down the hall," and he couldn't imagine what it would be like on a separate campus, Paquin recounted.

The approval by Kimball also requires a report by DMH on the provision of voluntary inpatient care.

The total project cost was estimated at just over $28 million, including the land purchase.

The amount of contribution from the federal government emergency funds as a result of flood is determined in part by whether the state hospital was destroyed or only damaged by the flood. The current federal interpretation is that it was damaged but not destroyed. AD

RIBBON-CUTTING IN BRATTLEBORO — The Brattleboro Retreat has renovation construction underway to create a permanent Level 1 14-bedhospital unit. Ceremonies this fall marked the opening of a secure outdoor garden. Behind the ribbon are (from left) Joe Fortier, GPI Construction; Adam Hubbard, Stevens & Associates Landscape architect; Rob Simpson, Retreat CEO; Gerri Cote, Vice President of Operations; and Anthony Girard, Director of Facilities.

(Photo Coutesy of the Brattleboro Retreat)

Practice Improvement Cooperative Starts Up

MONTPELIER – A new organization will be starting up this winter to consider the mental health practices that have good evidence behind them and should be used across the state. It is intended to be a joint effort among all types of providers who become members.

The "Evidence-Based Practices Co-Operative" is being organized through a grant to the Southern New Hampshire University's Program in Community Mental Health. An opening meeting is set for December 14, 9:30 a.m. to 3:30 p.m. at the Vermont College of Fine Arts on College Street, in Noble Lounge.

The project's leadership team issued an announcement inviting those interested to join in a process to "help design the vision, mission, advisory/steering process and beginning structure for membership contributions and benefits" for "a Vermont Cooperative for workforce development and practice improvement within the state's mental health and substance abuse system."

The announcement explained that "the cooperative is intended to be an independent organization, supported and directed by its members, focused on the implementation of promising, evidence-based, and recovery-oriented practices." It will also focus on "consumer and family-centered workforce competencies." The goal is "to improve the quality of life for individuals receiving services."

"Membership of the Cooperative will include a wide array of stakeholders, including mental health providers of all types, including community mental health, residential and hospital-based providers, peer providers, consumers, family members and organizations, institutions of higher education, and other types of human services organizations. We encourage as much participation and ownership as possible in creating a Cooperative that meets your needs; so please try to stay the whole day." AD

Resignation of Medical Director Further Delays Morrisville, No Relief Visible Soon on Any Front

by ANNE DONAHUE
Counterpoint

RUTLAND — "We're eking our way out of this crisis," Gov. Peter Shumlin said at a press conference this fall marking the beginning of renovations for anew six-bed psychiatric unit at the Rutland Regional Medical Center.

That progress suffered a serious setback in early December, when the Medical Director at the Department of Mental Health, Jay Batra, gave notice of his resignation for later this month.

That will force a further delay in the opening of an emergency, temporary 8-bed hospital in Morrisville, leaving no relief in immediate sight for the state's overburdened psychiatric inpatient system. Renovations to a wing of a former nursing home were recently completed there, but the unit cannot open without a medical director, Interim Commissioner Mary Moulton said.

Moulton said she was urgently looking into what options might be available.

The news came only a few weeks after the abrupt departure of prior Commissioner Patrick Flood, and will leave a second top level management vacancy.

The state lost a third of its inpatient capacity — 54 beds — in August of 2011 after the State Hospital in Waterbury was flooded.

Three hospital units besides Morrisville are under some stage of construction, and each has faced recent new challenges:

- The Rutland unit, originally targeted for a February opening date, is now not expected to be ready until next May.

- A new 25-bed hospital planned for Berlin continues to make rapid progress, but missed its target of breaking ground by the end of November (see article, page 6.)

- Renovations underway for a 14-bed unit at the Brattleboro Retreat remain on course, but the Retreat has struggled with new financial pressures on its other programs and has been forced to lay off staff and reduce program services.

Last spring, the legislature approved a comprehensive plan to increase investments in community services so that unnecessary hospitalization could be avoided. It also approved development of the new inpatient programs.

The plan for a state-run hospital unit in Morrisville was developed as an emergency response to help with the inpatient bed shortage until the Berlin hospital opens. It was named the Green Mountain Psychiatric Care Center, with an approved construction cost of $2.5 million.

It was first targeted for opening by the end of summer, but a major setback occurred when construction workers found asbestos hidden in the walls.

An open house had then already been scheduled for mid-November for its revised opening date when DMH heard from the Department of Health that it had not yet met all the criteria necessary for an operating license

Then, a day after Moulton said she had received word that a conditional license was being approved, she received notice of Dr. Batra's decision. He has been heading up the programming work group for the hospital.

All of the hospital units under construction will be part of the state's new designation of "Level 1" care. The designation indicates the care and support needed for persons with the very highest acute inpatient needs, who would formerly have been treated at the Vermont State Hospital.

The state will pay a special rate to cover all costs of operating the units at Rutland and the Retreat. The hospitals, in turn, will be under contract to become part of a "no refusal" system for meeting Level 1 care needs.

Currently, that care is being providing on an emergency basis in existing hospital space at Fletcher Allen Health Care, in Rutland, and at the Retreat. According to Moulton, the Retreat is currently providing Level 1 inpatient care for an average of 25 patients in the commissioner's custody. The new unit at the Retreat will not add to the availability of hospital beds, because it will replace onethat has been in use on an ongoing emergency basis since the flood.

Rutland Regional

The budget for the renovations at Rutland Regional Medical Center is $5.4 million. The renovations will create outdoor access for the first time for all psychiatric inpatients there, via a large rooftop patio.

At the ceremony marking the start of construction, Jeff McKee, the unit director, said that admitting such high-need patients to its regular unit since the flood was "exceeding our ability to provide safe care," but was being managed through "the incredible work our staff has done."

State Senator Kevin Mullin noted the importance of having inpatient psychiatry within a general hospital. Mental health "isn't just 'those people'," he said. "Psychiatric patients shouldn't be isolated."

He credited the governor's appointment of the now former Mental Health Commissioner, Patrick Flood, for making the plans for replacing the state hospital move forward.

"He's built up a lot of trust," Mullin said. "It takes a Flood," he joked.

Brattleboro Retreat

The new Retreat unit is projected to be finished by the end of February, at a cost of $5.3 million. The Retreat held a ribbon cutting ceremony in the fall to mark the opening of a new secure yard that will be available to patients.

The Retreat reported that it has needed to make cuts in staffing at its facilities, however, because it "grew too fast" in the past year and has been experiencing budget pressures, Mary Moulton announced at a November Transformation Council meeting.

She said that the Retreat said one of the financial pressures was a recognition of the need for attention to staff salaries and benefits.

Kitty Gallagher, a peer who does advocacy work at the Retreat, said "they've cut therapeutic services," including all art therapy.

The speed of new growth in programs was also what was cited by the Retreat last summer, when it briefly halted new admissions as it addressed deficiencies found by surveyors from the Centers for Medicare and Medicaid Services.

A series of CMS reviews began last winter after the death of a patient who had overdosed on drugs he removed from a medication cart. In July, a notice of possible termination of federal funds was lifted and the Retreat was restored to good standing.

Retreat spokesman Peter Albert offered a response after an email inquiry by *Counterpoint* about the discussion at the Transformation Council meeting. He said the growth at the Retreat "has been positive, it's allowed us to hire nearly 200 people, expand programs, increase inpatient capacity and day treatment programs."

He said it also "made us more aware of the medical needs" that were increasing, which "caused us to evaluate how we use our resources." He said the Retreat had hired an internist with skills in substance abuse treatment to direct its medical clinic.

Albert said the Retreat is "recognizing the changing role of hospitals in the continuum of care and the accompanying financial limits" which lead to the decision regarding staffing changes.

He said the Retreat was looking at the role of therapeutic services and what might be carried forward by nursing staff.

HARD HATS IN RUTLAND — Those on hand for the renovation kick-off at Rutland Regional Medical Center (left photo) included members of its Community Advisory Group, from left, Dirk Nakazawa, NAMI, Merry Postemski, Disability Rights Vermont, Karen Lorentzon, Vermont Psychiatric Survivors, Sarah Neller, a peer, Sam Bethel, Vermont Center for Independent Living, and Claire Munat, NAMI. Right photo, then-Commissioner Patrick Flood (left) addresses guests, standing with Gov. Peter Shumlin (center) and Tom Huebner, hospital CEO.

HEARING ABOUT MENTAL HEALTH — A panel of Vermont health care leaders heard public testimony this fall about health care reform and how mental health should be addressed within it. The forum was co-sponsored by the Vermont Association for Mental Health and Addictions Recovery and Vermont Psychiatric Survivors. Panelists included (from left) Sen. Claire Ayer, Mary Moulton from the Department of Mental Health, David Reynolds from the Deparment of Financial Regulation, Robin Lunge, director of health care reform for the administration, Rep. Alison Clarkson, Beth Tanzman from the Department of Vermont Health Access, and Rep. Sarah Copeland-Hanzas.

(Counterpoint Photo: Anne Donahue)

Care Reform Issues Come to Forefront

By ANNE DONAHUE
Counterpoint

BERLIN – Health care reform: the conversation is bubbling everywhere in Vermont, but the mental health community had its first large scale opportunity this fall for individuals to share ideas with state leaders on what is important to them.

In an afternoon-long forum, issues covered many common themes.

On medical care and access to care:

- "Equal access to treatment that people with physical illnesses receive."
- Where should health care homes be? For mental health clients who don't go to doctors, "it should be where people show up the most": their community mental health agency… but those agencies don't have the ability to bill for regular health care, even basic screenings.
- Needs are under-counted, because "many folks who need services cannot access them"; note that 60% of primary care visits are known to be driven by actual mental health/addictions needs.

On alternative services:

- Broader treatment care options are needed, such as nutritional counseling as preventative health care, not limited to illnesses like diabetes.
- Good self-care (the physical care that impacts mental health) isn't accessible to those on low income.
- Services animal coverage is critical: "I am a healthier person… I don't take any medications" in contrast to 26 pills a day, six years ago.
- Places like the Wellness Co-Op need to be "supported and safe" instead of the money ending up going for hospital care. "It's really hard when you feel alone."
- Recovery coaching "is the most effective program I've seen coming down the line" — it needs to be supported.
- Recovery centers: the value is the peer-to-peer services from "someone who has already been through it"; it "creates a place where you can go" and always access help.
- Aftercare: "there are no support services… there is nothing."

On use of medication:

- Primary care doctors do most of the prescribing, but "they're not getting the information" about risks of overuse of medication.
- There need to be ways to "de-incentivize drugging as the first option" in providing care.
- Medication should be based on "informed choice" that is not "tainted by marketing"; reporting of all off-label prescriptions should be required.
- Services are needed for "supportive withdrawal" for "helping get off drugs."
- "I lost 14 years of my life to psychiatric drugs."

Specific to substance abuse:

- More are turned away than are able to be admitted for substance recovery. "Treatment does work… for it to work, it has to be available," and "payments must reflect the cost of giving care."
- Vermont is the second-highest among the states in alcohol-related health care costs; these costs are preventable.

On supporting the workforce:

- When positions requiring a Master's degree and two licenses have a starting salary of $30,000, "there's no career path."

Responses from the panel

Members of the panel then gave brief feedback on "what we heard."

Rep. Sarah Copeland-Hanzas: "If we don't get the brain right… people aren't going to feel well."

Beth Tanzman, Department of Vermont Health Access: "It makes one think very differently about [the right] health care benefits" that should be included, and about the unintended consequences of putting all health care within the medical, primary care infrastructure.

Karen Hein, member,Green Mountain Care Board: Under a unified health budget, if only clinical services are covered, "we miss supporting wellness"; the typical health benefits that are "covered services" do not cover "assets that contribute to well being… [that are] way outside of traditional medical sources."

Robin Lunge, Director of Health Care Reform: The input fits with goals of health care reform, which are to create access to high quality care; contain costs through new investments; improve health; and create a fairer way of funding.

David Reynolds, Department of Financial Regulation: This is the "public health issue of our age," to achieve "parity in terms of access and cost-sharing."

Mary Moulton, Department of Mental Health: "We need a system that meets people where they need to be met" with available alternatives; "it's what makes people well that counts."

Sen. Claire Ayer: "We want to make you stay healthy."

Some additional topics raised at the follow-up video-conference:

- What has happened to universal release forms for providers to communicate effectively, and universal application forms? "How many applications do I have to fill out?"
- Primary care practices do not always see value from medications, but don't see other options and don't have access to mental health support (the access that the Blueprint for Health model provides).
- There is a need for a central information site to get provider information that includes private providers, not just community mental health centers.
- "It's not OK to be making health care decisions for someone else": there needs to be more use of "less intrusive substitute decision-making" such as advance directives and voluntary guardianships when necessary.

Co-Pay Parity Advances

MONTPELIER — The Green Mountain Care Board has adopted the requirements for new insurance plans that will be available beginning in 2014, and they include equal co-pays for primary health care and mental health services.

The requirement will apply to plans that will be on the health insurance exchange being created under the federal health care reform law. Plans on the exchange will be available to individuals and small employers.

Most current plans count mental health services as a specialty, so that the co-pay for ongoing counseling is charged as though the counselor was a specialist.

The requirement adopted by the board only applies to health insurance exchange plans, but is being reviewed for all plans under a bill that passed the legislature last spring. AD

Witnesses Say Elders' Needs Not Being Met

MONTPELIER — Some mental health needs of elders are not being addressed well in Vermont, according to testimony that the legislature's Joint Mental Health Oversight Committee received at a meeting this fall.

Ensuring that the right services are available for elders who need a nursing home level of care but have disruptive mental health conditions was a gap in the planning for a comprehensive mental health system, said Commissioner Patrick Flood of the Department of Mental Health.

"I don't think we have ever set up the proper analysis" to determine what was needed, he said. Nursing homes are "very reluctant to admit a person with a history of mental illness," Flood said. There is a need to determine ways of "getting [mental health services] to nursing homes."

It is an "incredibly fragmented system," Long Term Care Ombudsman Jackie Majoris testified. A clinical program for providing elder care services has "a huge waiting list."

Majoris described a cycle of residential care homes that use an "emergency involuntary discharge" to address behavioral problems, and then when a resident ends up in a hospital, it becomes very hard to find a new placement willing to admit the person.

Susan Wehry, MD, the Commissioner of the Department of Disabilities, Aging and Independent Living, told the committee that there was a need for a greater public health focus on dementia, and there is a problem with the overuse of antipsychotic medications. Vermont has one of the most rapidly aging populations in the country, and dementia will be a condition will become more frequest, she said.

Wehry told the committee that the problem with the off-label use of antipsychotics was "a huge one." They were promoted for uses other than the treatment of actual psychosis by pharmaceutical companies for years. Among the tools the state is using to attack the problem is to promote training in non-drug treatment, she said.

Mental health services for older adults was identified as an advocacy priority by the Community Mental Health Services Block Grant Planning Council for the new federal fiscal year. The Council makes recommendations regarding the federal blocki grant money to the state. AD

Unresolved Issues Remain In Proposed Restraint Rules

MONTPELIER — The Department of Mental Health has proposed rules for the use of restraint and seclusion at hospitals around the state, but several issues are likely to be contested as the rules go through public hearing and review board stages over the next several months.

DMH sided with hospital representatives on one topic in controversy regarding the rules on restraint, seclusion, or emergency involuntary medication. Rights' advocates said that despite a change in wording, it was not clear whether the department had agreed with their position on a second, related topic. The rules are available for review on the DMH web site.

The members of a work group had disagreed on whether the person writing an order for an emergency procedure was required to be a doctor, and whether that individual had to personally observe the emergency.

The group reached overall general consensus on its other recommendations to DMH for applying former Vermont State Hospital standards on restraint and seclusion to replacement Level 1 hospital units.

Act 79, the new mental health system law, requires that the Department report to the legislature and "recommend whether any statutory changes are needed to preserve the rights afforded to patients in the Vermont State Hospital." It also required DMH to adopt rules meeting the recommendations.

Those rights include standards set in a court settlement *(Doe v. Miller)*, and therefore are different from federal regulations in some parts.

The subject of disagreement had two aspects. The first was whether the VSH standard of "personal observation" of a patient's situation was necessary by the person writing an order, in contrast, for example, to a phone order. The second was whether the VSH standard for a doctor to write an order for an emergency involuntary procedure was still necessary, since other practitioners might be available and have the necessary skills.

Jack McCullough of the Mental Health Law Project said the group's task was to maintain the highest standard of protection, as set by *Doe*. That legal settlement requires a "personal evaluation by the person writing the order," he said. Act 79 says "you don't get to chip away at *Doe*."

The work group identified itself as "stuck" on that issue at its July meeting, and agreement was never reached. The Department's proposed rules now say that "The individual consulted shall personally observe the patient prior to writing an order."

Advocates said they were concerned that such wording was not clear enough to ensure that it was the actual emergency that was observed. A "face-to-face assessment" is separately required within an hour, but not at the time of writing an order.

On the second issue, representatives from hospitals argued that in many situations, a nurse or physician's assistant on the unit might have a better knowledge of the patient.

Meg O'Donnell, representing Fletcher Allen Health Care, said that the important aspect was maintaining the "level of protection" that *Doe* provided, and not necessarily the exact words if they no longer reflected current situations.

She said hospitals had "major recruitment struggles" for physicians, and other authorized staff might have "the right skill set" — or may even be better skilled — even if not a doctor.

Advocate Laura Zeigler said that if there was a "staffing deficiency" because of a doctor shortage, it was "not a basis to reduce rights."

The proposed rules allow a "licensed mental health practitioner" to write such orders.

DMH Commissioner Patrick Flood later told the Mental Health Oversight Committee that while VSH always had a doctor on the premises, the new regional units are much smaller, and the overhead cost of having a psychiatrist on site 24 hours a day and seven days a week would be enormous. Federal rules do not require a doctor on site, he said, but VSH had worked with the higher "on site standard. The only other hospital with 24/7 on site coverage for its psychiatric units is Fletcher Allen.

The new proposed rules will require hospitals to identify strategies with patients, at admission, that might minimize or avoid the later use of emergency involuntary procedures in a crisis on the unit. They also will have to discuss the patient's preferences regarding the use of such procedures if they become necessary. The information is to be provided to the staff on the unit and easily accessible in case of emergency. AD

The rules also detail the training requirements for hospital staff involved in involuntary emergency procedures. AD

The American Civil Liberties Union of Vermont
presents its Thirtieth Annual David W. Curtis Civil Liberties Award
to Laura Ziegler

for protecting the rights of psychiatric survivors and people with disabilities and for her steadfast commitment to government accountability.

Laura Ziegler has been a tireless, self-appointed advocate for citizens who are frequently marginalized and unheard in our society. For them, she simply seeks a measure of justice. In her advocacy work, Laura often clashes with public officials. She files many public records requests to learn the details of government actions. She attends public meetings to understand and follow difficult issues, often reminding participants of past actions they did or did not take. She complains when she feels the open meeting law is being violated. But she also expresses appreciation for a good law passed or a bad one defeated. A society could ask for no better public citizen, and we are proud to honor Laura with our David Curtis Civil Liberties Award.

November 10, 2012
Montpelier, Vermont

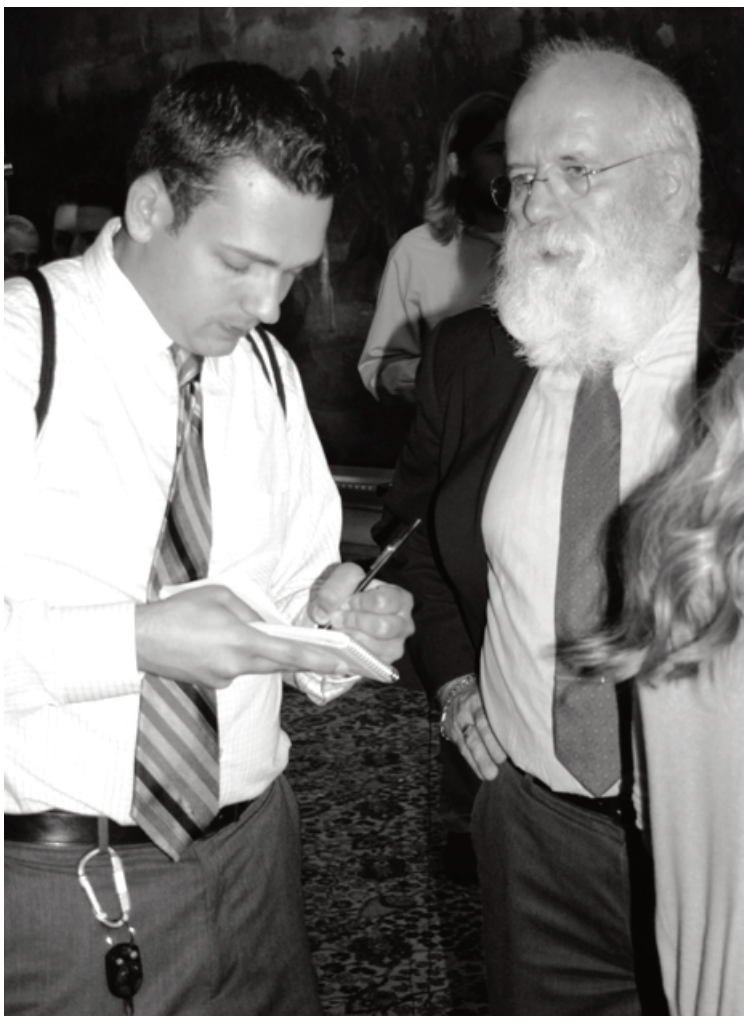
The American Civil Liberties Union of Vermont presented Laura Ziegler of Plainfield with its 30th annual David W. Curtis Civil Liberties Award at its annual meeting in Montpelier in November. It was Ziegler's second recognition this fall. She was also honored for her advocacy work by Vermont Psychiatric Survivors. (See article, photos, on page 11.)

Coroner Rules Taser Caused Death

WATERBURY — More than three months after a Thetford man was hit in the chest by a Taser barb and died, the New Hampshire medical examiner's office ruled that the Taser was the direct cause of death.

Macadam Mason had called a hot line for mental health help. Vermont State Police responded and said that he was lunging towards the officer who shot him in the chest. Mason collapsed and could not be revived. A state police investigation is continuing. The Burlington Free press reported in October that the trooper who fired the Taser had been placed on administrative leave for undisclosed reasons.

Since shortly after Mason's death, the Departments of Mental Health and Public Safety have sped up a collaboration on training, communications, and crisis response teams for dealing with mental health emergencies. A full report on this initiative was in the fall *Counterpoint*. AD



MEET THE PRESS — Attorney John McCullough of the Mental Health Law Project is interviewed after advocates held a press conference last summer to call for a ban on stun gun use until a statewide policy was developed. He and other advocates said the weapons should only be used when deadly force is justified. Governor Peter Shumlin said that a change was not justified before seeing the results of the state police investigation of the death of Macadam Mason.

(Counterpoint Photo:Anne Donahue)

VPR Reports Data on Use In Mental Health Crises

BURLINGTON — A Vermont Public Radio article reported this fall that state police fired electronic stun guns at people threatening suicide or at others experiencing a mental health crisis 10 times in the 18 months prior to October.

The report cited police records and video recordings obtained by VPR under the state's open records law. Tasers were fired 50 times in total during these 18 months, the report said. VPR made the request after Macadam Mason's death in June (see article above).

The VPR report quoted Public Safety Commissioner Keith Flynn as saying the 10 cases of Taser use on mentally distraught people was not that high a number, considering how often police are called to emergencies.

The radio report cited several specific incidents. In one, a state police officer drove to a residential group home in Dorset to respond to a report that a young man was fighting with his caregiver. A state police video shows the man running from the house as the cruiser drives up. The officer gave chase and shot him with a Taser. The officer's report of the incident noted he was developmentally disabled and "mentally impaired."

In another incident, police responded to a house in Pownal where a young man had threatened to kill himself. The police report described the man as mentally impaired. The recording of the incident shows two officers first tried to convince him to get help. After he refused to open the door, he tried to run away, and police drew their stun guns. They ordered him to drop the hammer he was carrying. They scuffled, and a trooper fired his Taser.

Another time, police confronted a woman they described as "out of control and known to have past mental health issues." When she ignored orders to put her hands behind her back, police broke down the door to her bathroom and pulled her — half naked — off a toilet. She resisted, and officers shot her several times with a stun gun.

VPR stated, "that's where the debate over Taser stun guns in Vermont has focused. Are police too quick to reach for these weapons when confronting someone who's suicidal, or experiencing a mental health crisis?"

Disability Rights Vermont forced a change in state police stun gun policy in late 2011 after bringing a complaint about the Tasering of a young Coventry man who had Down syndrome. Police said the shock was justified, since his refusal to cooperate could be seen as a precursor to violence, the VPR report said.

Under the legal settlement reached with Disability Rights Vermont, state police must avoid using a stun gun if a person's disability makes it difficult to follow commands. Many of the 10 incidents took place before the October 2011 settlement between Disability Rights Vermont and state police, according to the VPR report.

AJ Reuben, an attorney with DRVT, examined the reports at VPR's request and said from his review that police apparently did not violate the narrow terms of the settlement agreement.

But VPR said Reuben told them the reports show police apparently breached other policy restrictions, including not shooting people in the neck, face or chest, or in situations where they could fall and hurt themselves.

No Surprises in Gaps Found in Corrections

MONTPELIER — A team led by the Department of Mental Health brought draft conclusions about gaps in care to a work group preparing a report for the legislature, after interviewing 78 of the 110 of Vermont's correctional inmates who are currently designated as "seriously functionally impaired."

Jay Batra, MD, asked those at the meeting to hold back on saying, "I told you so," and to see the preliminary findings as "a call to action to serve Vermonters better" rather than as criticism. Batra is Medical Director at DMH.

The group is being chaired by the Secretary of the Agency of Human Services, Doug Racine, and is required to have a report available for public comment by December 15.

Batra's summary of points the subcommittee agreed on included that the frequency for seeing a therapist, at once per month, "cannot address the needs of individuals who have serious problems (by definition).

"This frequency lends itself to 'putting out the fires' but not proactively working on the core problems. In the community setting this frequency would be more for people who have either minor problems or once had more severe problems but are better." Other points included:

• Lack of clarity by staff on the selection process for designation as seriously functionally impaired;

• A growing trend for persons who were sent to the state hospital in the past to be sent to jail instead;

• Recognition by correctional officers of inmates suffering from mental illness, without knowledge of how to access help for them;

• High trauma and substance abuse levels among women, without treatment targeted to the needs;

• Lack of clinical backgrounds among discharge coordinators seeking community resources;

Ed Paquin of Disability Rights Vermont pointed out that Vermont law requires meeting a "community standard of care" for health services in corrections.

Some levels of care for serious mental illness in the community, such as therapeutic residences, are "nonexistent" in corrections, he said.

Corrections Commissioner Andy Pallito cautioned the group that much of the discussion appeared to press for "turning correctional facilities into treatment facilities," instead of looking for ways to keep offenders with serious treatment needs out of prison.

"Correctional facilities were created for a different purpose" than treatment, he said. Identifying ways to prevent incarceration is also part of the work group task.

The legislation also requires an assessment of the training provided to correctional officers, and Pallito reported that most of the initial recommendations of a subcommittee "are reasonable and can be achieved in a relatively short amount of time." AD

LEADERSHIP HONORED — Karen Lorentzon of Vermont Psychiatric Survivors received recognition for her peer outreach work at the Vermont Association for Mental Health and Addiction Recovery conference this fall. She was awarded the annual Knight Leadership Award for "exemplary leadership in the addictions and mental health field." In the photo at right, Lorentzon beams on stage while flanked by Linda Corey (left), VPS Executive Director, and Patty McCarthy of Friends of Recovery, VAMHAR. The award was named last year for its first recipient, Joan Knight, a consumer who developed the Mental Health Education Initiative in Chittenden County, which later, also under her leadership, became the Voice of Recovery Speaker's Bureau.

Governor Applauds Irene Heroes

KILLINGTON – "What I really see is a room full of heroes."

That was an opening comment by Patrick Flood, Commissioner of the Department of Mental Health, at a statewide conference this fall, and it was the theme of later comments by Governor Peter Shumlin as well.

"I came here to say thank you to you for your extraordinary commitment," Shumlin told those gathered in a packed convention room.

Both acknowledged the incredible unity of efforts to meet the challenges posed after the Vermont State Hospital had to close without notice as a result of the flooding from Tropical Storm Irene.

"No one ever thought things would get so tough," Shumlin said. The governor reminded the audience of hundreds of providers and consumers that the struggle was far from over.

"I can't emphasize enough to Vermonters the crisis that we're in," he said, saying it was fortunate "that we haven't had more tragedy."

"We literally have a series of trains that are hitting us head on at the same time."

The conference, "Beyond Waterbury: A System Without a State Hospital," was held shortly after the anniversary of the disaster, and Flood said that in the wake of "an incredibly difficult year" he saw before him "all the people who are working to rebuild the mental health system," peers and providers alike.

"You have made it possible to get as far as we have."

No part of the system was left untouched, and tremendous pressure continues today, he said, but Vermont has risen to the challenge and "I think we can be proud about the way everyone has pitched in."

Flood said the "amazing thing" was that despite dealing with crisis every day, a new system was being built at the same time, and that he wanted to recognize "the courage and determination that all of you have shown."

"Together this community not only got through this crisis," Flood concluded, but is now building "the best mental health services in the country."

Shumlin, who spoke just before lunch at the conference, echoed the Commissioner.

There is "one thread that gives us hope," he said, and that is that Vermont will "finally deliver the best community mental health system in the country."

In addition, he pledged that construction of a replacement 25-bed hospital will go forward even without knowing whether federal emergency funds will cover some of the cost.

"I made the decision yesterday," Shumlin said, that "we will wait for FEMA no longer."

Flood went through some of the other specifics in his opening remarks. He referenced the ways community hospitals "stepped up" to care for VSH patients, and the expansion of the work of peers.

Peers are broadening the work of Vermont Psychiatric Survivors and Alyssum. An umbrella organization for training and structure is being developed at the Vermont Center for Independent Living. Soteria-Vermont, a medication-alternative residential program, is being created.

In addition, peers are being hired to provide services at community agencies; he mentioned four recovery specialists who have begun working in an outreach program at HowardCenter.

Initiatives in law enforcement and mental health collaboration have been "truly welcomed" by police. Emergencies that bring the police are "simply not criminal situations… they're mental health crises," Flood said.

The Commissioner said that legislators, some of them attending the conference, could be credited with passing "one of the most progressive and comprehensive pieces of legislation in the country" to reform the system.

Community agencies "have been called to do more and more," developing expanded crisis services, broader case management, and more crisis and step-down beds, with "some remarkable success stories."

And the state's own staff – in particular, the state hospital staff – "performed heroically that night and the next morning" after the flood, and have lived with "hardly any stability or certainty" in their work, including the layoffs they have faced. AD

Another Way Names a New Executive Head

MONTPELIER — Will Eberle was named the new Executive Director of the Another Way psychiatric survivor community center in October. He has been doing peer support and advocacy there since early spring.

His prior experience includes work with homeless and runaway youth, youth who experienced trauma and abuse, and youth who are grappling with addiction and mental health issues, at the Youth Services Bureau. He completed his internship there for a degree in psychology at Johnson State College.

Previously, he provided vocational training for the Department of Labor, local high schools, and alternative graduation programs that serve at-risk youth. At the same time, he ran a small construction business which focused on sustainable renovation and new construction projects and historical restoration.

Eberle said that he would "inform my work with my own past experiences with homelessness, poverty, abuse, mental illness diagnoses, and strong input from peers, to ensure that our organization addresses the needs of our community to the highest degree possible." He can be reached at (802) 595-2987 or will@anotherwayvt.org. Eberle replaces Steven Morgan, who took a position with Pathways to Housing under a grant to develop a Soteria crisis residence *(see page 7)*.

Editorial Page — Letters and Opinions

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

Editorial

Some Are More Equal

In the classic book *Animal Farm*, the animals who have taken charge of the farm assure the others that everyone on the farm is equal. The leaders have more privileges, however, because "some animals are more equal than others."

When it comes to the Americans with Disabilities Act and the use of service animals, it appears to be the same. All persons with disabilities are treated equally, but some are more equal than others.

Melanie Jannery, a peer in Burlington, has been learning that the hard way as she fights for rights to have her service dog, Winston, recognized equally. Rules of the Department of Justice make it clear that Winston qualifies under its definition of a "service animal."

She won a fight for recognition of the rules to gain access to college, but the fight itself was so emotionally exhausting, she had to withdraw from school. *(See her article on the experience on pages 12-13.)* She has had other rights taken away; in her words, "like the freedom to fly, [as a result of] having different rules created because of my type of disability."

She can't carry her peer outreach skills to many veterans' facilities, because the Veterans' Administration has chosen not to follow the ADA rules. The VA can do that, because the ADA applies to public entities but not to federal agencies.

The rules are strict in requiring that service animals must be "trained to perform tasks that mitigate the effects of a disability," such as calming a person with PTSD. They don't include "dogs that are used purely for emotional support, comfort, therapeutic benefit, [or] companionship." Thus, the definition is narrow and clear. There should be no excuse for not choosing to follow the ADA, even when it is not mandatory.

Being "less equal" is contradictory. It is yet another example of stigma and the fight for parity of rights when it comes to the category of mental illness in contrast to other illnesses or disabilities. We still have a long way to go to achieve equality.

Cartoon courtesy of the Psychiatric Dog Society.

COMMENTARY

Achieving Health with Good Food and Good Values

by ELEANOR NEWTON

Some of us have been painfully taught that eating certain foods is bad, or bad for you, and that we should feel guilty when we eat foods we like. But try telling someone that healthy foods can taste good and you get a skeptical reply, most often naming broccoli as an unloved "healthy food."

In defense of broccoli, some of us love it in a broccoli-cheese soup at McDonald's (otherwise known for its unhealthy food). You can eat broccoli substitutes instead: cabbage, brussels sprouts, or kale (the "cole" family — think coleslaw). You don't need to eat a lot of it, anyway, only eat it more often.

Cheese also has had a bad rap, for another reason: it contains bad cholesterol (from animal fat). But cheese can be good for you, too, in moderation. Just don't eat too much at one sitting!

People resist healthy eating for several reasons: it requires knowledge, thought, and forming new habits, all of which require time and effort. It means you have to think ahead, select from menus carefully, and decide when, or whether, to eat your favorite, but "limited" foods. It isn't easy. In the short term, it's easier and cheaper to grab a burger and fries or get a pizza.

Now, I love pizza. That tomato sauce and a reasonable amount of cheese is good for you. And a little meat or mushrooms for protein is OK. Plus, you can have onions and peppers or other veggies if you want. And leftovers are good even cold for tomorrow's breakfast. That's healthy eating! (Can't say as much for the burger and fries.)

The real reason I try to eat healthy is that I find that when I do, I feel better. When you're younger, you can get away with eating poorly, although at the risk of developing health problems later that may force you onto a rigid diet. As we age, our digestive systems change and can't take as much abuse. Our dietary needs change. It helps if you have acquired healthy eating habits when you were young, but eating better at any age will help you feel good and keep going.

It's worth the effort. It really is. But as we get older, we need more support and encouragement. I'm still learning, too. But I like to share some of what I have learned and am trying to practice.

I live between two worlds: that of science and that of religion. I am not about to compromise or to trade in one for the other. I'm still an idealist: religion gives and supports the values I believe in and try, albeit imperfectly, to live by. Science illustrates how to explore and understand the material world we live in.

I'm a pragmatist: I need to understand how things work. What is, is. But we need to understand not only what it is, but how it fits in with everything else we know or know about. How does that translate into how we live?

When Moses brought back God's Ten Commandments from Mt. Sinai, he delivered them with a promise — and a warning. Blessings would follow obedience. (Read the human-to-human commandments, which are validated by the human-to-God commandments, and you'll understand how that works to create a good and great society.) Curses follow disobedience. (Think about the consequences of theft, adultery, murder, and even covetousness.) No one should have to explain further.

Does it take courage to do the right thing? You bet it does! Questioning or criticizing the "powers that be" brings consequences, too. Many are too intimidated to "blow the whistle" on evildoers or to "speak truth to power." Those consequences are a serious consideration, too, especially when personal survival is at stake.

Thus are our values tested, and thus are they expressed in the way we live.

Eleanor Newton lives in South Burlington, is a frequent commentator for Counterpoint and a member of its editorial board.

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.

Special Pull-Out Section

120 Years of the Vermont State Hospital Observed

Closing the Doors

Tropical Storm Irene brought an emergency closing to the Vermont State Hospital in August of 2011, but it was only as the demolition of the buildings on the Waterbury campus was about to begin that someone realized that there had been no opportunity to formally observe the passing of this 120-year-old institution.

In October of 2012, Waterbury resident and state representative Tom Stevens recognized that absence, and he took on the leadership to make it happen. The program for the event described his thoughts and intents:

Tropical Storm Irene did what none of us could do: it closed the Vermont State Hospital. Years and years went by with the hope and expectation that this aged facility would be replaced, and in the end, it took the force of nature to do what we could have done at any time.

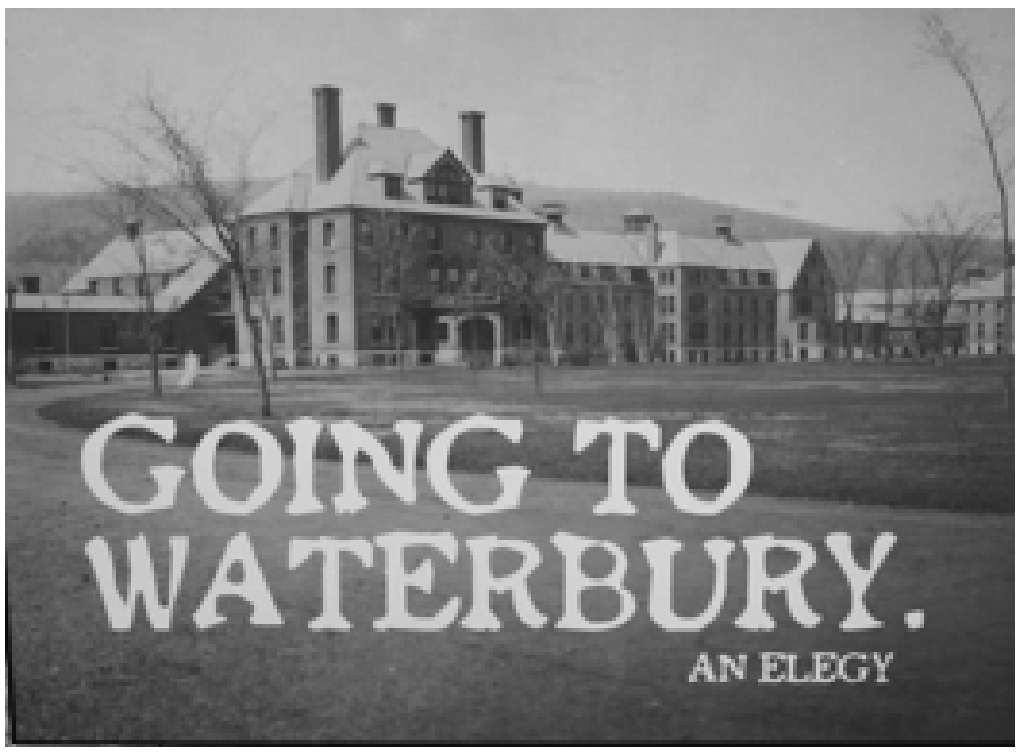
"Going to Waterbury" is an art installation and closure ceremony. Its intent is to allow for a time of reflection and meditation upon the importance of the Vermont State Hospital, and what it meant for the patients, employees, doctors, nurses, psych techs, psychiatrists, administrators, policy makers, local residents, families and elected officials. All of these have had different experiences, from different perspectives, all valid.

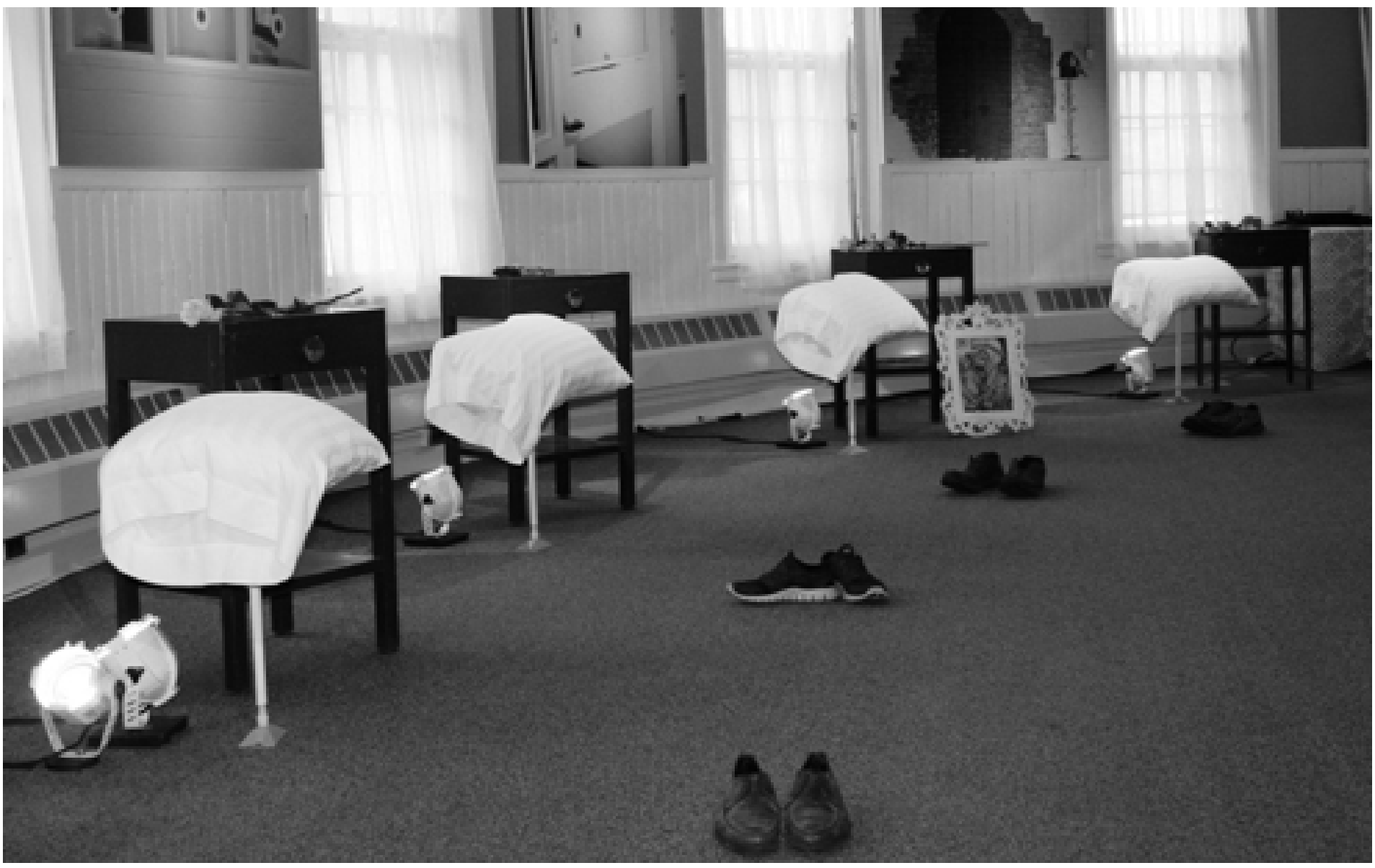
I believe we must acknowledge the breadth of this experience, and contemplate the invisibility of the people and this place in our culture and conversation and our past inability to take a collective responsibility for the anger and stigma inherent in the phrase "Going to Waterbury."

As we move toward the demolition of the Vermont State Hospital and the rebuilding of the Vermont State Office Complex, it's important for us to commemorate this with a closure ceremony — a ritual to honor the many different experiences of the many different individuals who passed through these doors. A closure ceremony will mark the end of a long and complicated history between the institution and the rest of us.

We approached the design of the art installation as near to a theatrical setting as possible — we provide you the clues, and you bring, in your imagination, the characters.

The photos on these pages are from the "Going to Waterbury" event.





The round building that housed the Vermont State Hospital library was the setting for an art installation intended to evoke reflection on the role of the hospital in the lives of those it affected. It (photo above) portrayed stark, larger-than-life photographs, each above a pillow, shoes, and a night table with personal patient items. Top, right, is one of the giant photographs taken in the Brooks building — photos so detailed that this "photo of a photo" looks as though it was taken directly of the door itself. Top, left, is the thematic image for the event.

A representation of coercion was included in the art installation after mental health peers urged the producer to be inclusive in the images used.

No one is entirely guilty. No one is entirely innocent.

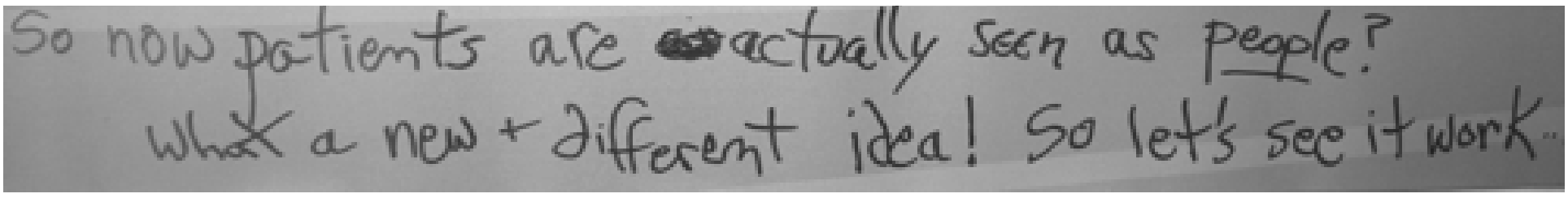
The expressive art in the former Vermont State Hospital library portrayed stark, larger-than-life photographs, each above a pillow, shoes, and a night table with personal patient items. In addition, a video loop shared interviews with former patients. There was also a "speak out" forum for those who wished to verbalize their experiences on Saturday, the first day of the two-day event.

I learned a lot being here. May we never forget what should not have happened.

Memories – feel like part of me has died as well.

The ME/2 orchestra played a series of musical pieces during the closure ceremony, which took place at nearby St. Andrew's Church in Waterbury. The orchestra, directed by Ronald Braunstein, includes a majority of mental health consumers and has as its vision the breaking down of the barriers of stigma through education about mental illness. A testimonial was offered during the ceremony to Fr. Louis Logue, a long time previous pastor at St. Andrew's, who built an enduring relationship with the hospital and its patients.

Thank you for the very important memories… those that helped save many, many lives.



Feel the trees and movement
in Putman State forest near the ice center –
the patients planted those rows of trees –
the jail of our mind is freed with this focus –
the beautiful ones.

This was a decent place
for many over the years –
for them I am grateful that this was here –
for others, it is for them to say.
For me, it was good to work here,
hard to visit.

Representative Tom Stevens discusses an exhibition of background "point in time" notes about the hospital that were mounted in the hallway leading to the art installation. Stevens produced the two-day event.

Nice to be back and not locked up.

Years of pain, years of grace.
May the pain be eased
through what we have learned;
may the years of grace
sustain our resolution for a better future.

Quotations are from the rolled paper that provided visitors at the art installation to share thoughts.
Photos are by Anne Donahue, *Counterpoint.*

And Now... To Become What?

Reflections at the closure ceremony by Rev. Peter Plagge, Pastor, United Community Church, Waterbury

The question before us is to become what? I'm going to spend some time talking about the Greeks tonight. They seemed clearer than most that what we are now, at this moment, is a gift – a gift from the past and from the community of which we are a part – and that what we become is in part because of these things.

. . .

The question implies importance. No point in asking the question if there is no ideal toward which we would aim. I want to wrestle tonight with the idea that "going to Waterbury," while it usually meant the end of the line, it nevertheless presupposes another meaning – the beginning of a new future for Waterbury and all of its inhabitants. It is a future oriented phrase. It implies within it the need for reconciliation and the hope for peace.

There are so many people with so many different experiences of the Vermont State Hospital, good and bad, that I am bound to step on toes. The fact remains that for thousands of people the Vermont State Hospital was a prison; it was a place they could not leave of their own accord. I have a place in my heart for the people Jesus called "the least of these." It cannot be denied that the least of these refer not to the doctors or nurses, not to the administration, nor the security guards. We're talking about the individuals who only a generation ago were deemed inhuman, insane, unworthy, mindless and were subject to medical treatment we would never use on humans.

Even that last sentence is fraught with difficulty, for somehow we knew they were human – the very language we use, insane, inhuman, unworthy, mindless, are negations of a recognized humanity. We understood and yet felt somehow that in the name of humanity we could use dehumanizing procedures to re-humanize. We are in a trap – enthralled by our own ideas.

I do not have a long history in the mental health community. I come to offer what I can out of love for Waterbury. My reflections aim to see the whole, or rather, more accurately, aim not to isolate portions of the community into discrete bits. Our gathering in this church is an expression of this sense that somehow, through all our differences of belief and thought, of experience and work, our common task is the creation of a future through civilized modes of thought, that we are about an appreciation of the values that are not always fully realized in our lives together, but which are implied in the very idea of community.

. . . .

Our honoring of all of the people who lived at the Vermont State Hospital properly takes the form of an elegy. Our words elicit no simple commemoration; our music celebrates a future hope that is not blind to the sins of the past, its melodies moving forward and back, to and fro, care to sin and back again. Tonight we honor, not only a long and mostly silent history, a history which has been important to our town in ways both good and bad, but we honor the silent, Sisyphean inner pain of the residents; we honor the people about whose minds we knew so little and presumed so much.

. . .

In the winter of 1922, Rilke completed a cycle of elegies that he'd been working on for a decade. Those poems, known as the "Duino Elegies," are sublimely beautiful and I almost chose one as the text for today. I did not because the mythic element of transcendent possibility for community is absent. The "Duino Elegies" for Rilke had to do with his inner battle against the demons that seemed to send him into a decade of despair and inability to write.

In the Sonnets, Rilke composes a real elegy; he tells the story not only of the darkness but of the light that can only be seen having been through death. Sonnet One begins:

> O tree ascended there! O pure transcendence!
> Oh Orpheus sings! Oh tall tree in the ear!
> And all things hushed! Yet even in that silence
> A new beginning, beckoning . . .

We will never know the full story of the Vermont State Hospital, for the full story would include the silent experiences of pain and remorse and longing, as well as the verbally expressed hopes and dreams of everyone involved. But even in that silence, a new beginning beckons.

It is for us to become. . . We're still going to Waterbury. May it be the kind of journey Rilke hopes for us – to bloom and re-bloom and sing the songs of the flowers for them in everything we do.

(These remarks have been abbreviated by the author for publication in Counterpoint.)

A Commemoration and a Future Commitment

Seven state senators and 30 representatives were listed in October with their preliminary intent to sign a resolution and to co-sponsor a bill in January that would require the state to maintain the state hospital cemetery in Waterbury. The draft resolution, not yet finalized in its wording, was prepared for purposes of reading at the closing ceremony. It is estimated that upkeep of the cemetery was last completed in 1991.

Joint resolution relating to the history and legacy of the Vermont State Hospital and the preservation of its cemetery
[DRAFT for FURTHER REVISION PRIOR TO INTRODUCTION]
Whereas, in 1888, the trustees of the Vermont Asylum for the Insane in Brattleboro (renamed the Brattleboro Retreat in 1892 to avoid confusion with the Waterbury facility) reported that the facility was beyond its designed capacity, and Dr. Don D. Grout, the member from Stowe and a future superintendent of the Vermont State Asylum for the Insane (renamed the Vermont State Hospital for the Insane in 1898), introduced legislation that became Act 94, "An act providing for the care, custody and treatment of the insane poor and insane criminals of the state," and
Whereas, the state purchased 500 acres of land in Waterbury for the new facility, and after initial construction, the first 25 patients arrived by train from Brattleboro on August 8, 1891, and
Whereas, during its 120 years of service, the Vermont State Hospital played a powerful role in the lives of many Vermonters, including tens of thousands of patients and tens of thousands of staff, and
Whereas, from early on, the Vermont State Hospital confronted a continuing struggle to secure sufficient financing to provide the best quality of care, and in recent decades, it had been recognized that the facilities in Waterbury did not allow for state of the art care, and the existing hospital needed to be closed, and
Whereas, in November 1927, and again at the end of August 2011, the staff and patients at the Vermont State Hospital undertook extraordinary measures to respond to devastating floods, and
Whereas, the severe damage that the Vermont State Hospital sustained in Tropical Storm Irene has required an immediate relocation or replacement of services previously provided at the Vermont State Hospital and abandonment and demolition of many of the original hospital buildings, and
Whereas, as a new chapter in mental health care in Vermont begins, it should be one that integrates mental health care with other health care services, focuses on community supports and treatment close to home, avoids unnecessary hospitalization, and never abandons those with mental health needs, and
Whereas, with the closure of the historic Vermont State Hospital Waterbury campus, it is important to remember those individuals buried at the hospital's cemetery in use from the hospital's inception until 1912 and which includes a memorial stone with an inscription that reads:
This beautiful knoll overlooking the grounds of the Vermont State Hospital is matched in splendor only by the twenty or so residents of the Hospital who were buried here between 1891 and 1912. May their spirits soar, you are remembered, and
Whereas, the preservation of this cemetery and of the memory of those individuals is of lasting importance, and
Whereas, the names of those buried there have been gathered in the past, and can still be located and preserved so that these individuals will not be left as unknowns, and
Whereas, hundreds of other patients had their bodies donated to a Vermont medical school without being memorialized in any way, and their names can also be located and preserved, and
Whereas, there is some evidence that another patient burial ground may have existed, or other patients were buried in unidentified areas on the hospital grounds, but those patients' remains been removed or lost which would be a grievous indication of past indifference to the lives of these individuals, and should never again be permitted to occur in this state, now therefore be it
Resolved by the Senate and House of Representatives:
That the general assembly observes the powerful role that the Vermont State Hospital played in the history of mental health treatment in Vermont and requests the department of buildings and general services to maintain and preserve perpetually the hospital's cemetery and to attempt to locate, safeguard and memorialize the record of those who are buried there or elsewhere on the hospital grounds or whose bodies were donated to a medical school.

'May Their Spirits Soar'

A single memorial stone sits atop a knoll in state forestland in Waterbury to commemorate the "20 or so" patients from the Vermont State Hospital who are reported to have been buried there between 1891 and 1912. The granite marker was installed in 1991, and four cornerstone were placed. Underbrush is regrowing at the site, and one of the cornerstones is missing.

Celebration: Psych Survivors Turns 20!

First Director Shares Stories

I was fortunate to serve as the first Executive Director of Vermont Psychiatric Survivors from 1995 to 1999. It seemed as though the entire peer movement was changing during my first two years with VPS. There were some very assertive peer advocates at that time and issues such as involuntary treatment protocols and peer and family member representation on community mental health center boards took up a lot of time in Montpelier and at the CMHC's.

Boyd Tracy

It seemed like when people listened to Patricia Deegan, for example, and read her articles, they began to realize that there is hope for recovery, reconciliation with self and others, and moving beyond a label into a life that includes work, education, a bank account with more than $5 in it, a nice place to live, and something left over to share with others.

My thing has always been employment for people with disabilities. Peers who are regarded as having a mental illness have a most difficult time getting and keeping jobs, and finding the job that really leads to joy is a dream that many of us have abandoned.

When I joined VPS in 1995, it was clear to me that the board and members were excited about the recovery message that was being woven into a tapestry by Mary Ellen Copeland. I think that we were hoping to touch more lives with this message, but there was a huge canyon of pain and distrust between our organization and the provider network in Vermont.

You never know when your wildest dreams are going to materialize. Mine started to materialize after one Systems Improvement meeting in Waterbury when Linda Chambers, Executive Director of the Clara Martin Center, asked me if VPS would be interested in collaborating with her agency to open a shelter under the Safe Haven initiative offered by HUD.

I replied that it sounded good, but I also realized that it would be a scary thing for some of our members to jump off the cliff in faith and partner with a community mental health center in a project as big as a Safe Haven. As we began to discuss the partnership with the Clara Martin Center, I realized that it was destined to happen.

CMC already had a suitable building that was zoned residential, so there could be no NIMBY barrier put up by the Town of Randolph. Orange County had never received a dollar in funding for such a shelter. We also learned that Senator Leahy was interested in promoting the project. VPS was slated to staff the shelter as a contractor of the Clara Martin Center.

The vision was that shelter positions would be filled by peers, because peers experience recovery up close and personal. VPS was also to be an equal member of the Safe Haven operating team. I will never forget one Friday afternoon at VPS when we got a fax from Senator Leahy's office saying that our collaboration had been awarded a $400,000 grant to open Safe Haven!

There was one hurdle left, however. The tensest moment came in one of our Board meetings when the deal was spread out on the table and put up for a vote. It was approved by one vote — the narrowest of margins.

I would like to congratulate VPS on its 20th anniversary year for never looking back from that day forward. Almost overnight our staff increased from 4 to 17. Our annual budget more than quadrupled. In addition to maintaining its partnership in Safe Haven, VPS has continued to spread the recovery message through a peer relationship with other components of the mental health service provision network in Vermont.

I am proud and thankful to have been a part of this, and I wish Linda Corey, her staff, and the members of VPS continued blessings in the years ahead.

Boyd Tracy was asked to write about his memories as the first Executive Director of VPS by Judy Rosenstreich of the Department of Mental Health for a Commissioner's update. This reflection is reprinted from that update.

Warm Words Mark Anniversary Event

RANDOLPH — Speakers shared memories from the past and warm praise for the work of Vermont Psychiatric Survivors during the past 20 years at an anniversary event this fall.

"After 20 years, the fun has just begun," said Commissioner Patrick Flood, referring to emerging changes in the philosophy of psychiatric care. "You've been slogging it out for 20 years and still fighting the good fight."

He said it was critical that peers "are embedded in everything that goes on. There is a need that you can fill better than anyone else can."

Former Commissioner Paul Blake commended "all of the people who built up to this moment in time."

Isaac Turnbaugh said that the survivor community provides "the spirit that helps us endure," and that being a guest of Safe Haven who became staff "makes me feel humbled and blessed."

Laura Ziegler, reviewing a history of advocacy in the country, said that the lure of accepting money from the government was the cause of major splits in the movement. But solidarity still exists, she said. "Before there was money there was us, and there still is."

Nick Nichols, who has been the Department of Mental Health liaison to VPS for many years, said that "much of where we've gotten today" in peer involvement "is in big part due to VPS."

He recalled working with VPS leadership the first time he was developing a grant proposal, under the gun with a deadline, and "we were losing it."

A VPS staff member suddenly said, "Oh, crap, I forgot to take my meds." Then she looked at him and commented, "I think you need them more than I do."

He is honored to be "the token bureaucrat" in the peer movement, he said. AD

HONORING COMMITMENT — Three special awards were given out at the Vermont Psychiatric Survivors 20th anniversary celebration. Kitty Gallagher (above) was recognized for dedication to peer services, Laura Ziegler, (center), for her dedication to advocacy, and Melody Jannery (right) for dedication to education. Kelli Gould of VPS (far left) presented the awards. (Counterpoint Photos: Anne Donahue)

An Advocacy Victory, But at a Personal Loss

According to the Law...

by MELANIE JANNERY

Last year my life turned in a direction that led me to feel that I wanted to return to college. I would be taking my first class after more than 10 years of not having taken a college class in person.

For reassurance, I checked with the school what I needed to do, if anything, in order to attend with my service dog. I was informed that, in order to attend a college class in person with my service dog, documentation was required. This didn't feel quite right.

I did not want to disclose what my specific struggles were to the college, both due to a recent personal experience and to knowing that the Department of Transportation (DOT) created separate rules for individuals who use psychiatric service animals.

For my personal presence in this difficult world, I like to focus on my strengths and what I am doing that is working. Utilizing a service dog helped me reclaim my independence. I don't want to need to disclose a diagnosis, except when referring to a diagnosis is something I choose to reveal.

Although it did not feel right, I chose to provide a letter from my primary care physician. I chose to have a letter written that was not revealing of what is "wrong" with me, as I feel that is between my doctor and me.

The letter stated:

"Melanie has been a patient of mine for many years. She is disabled and requires the assistance of a service animal."

The school's response was that I was required to provide a letter from my doctor revealing my diagnosis and how my dog helped me. In order to follow what was being required of me, I had a second letter written, this time a slightly more revealing letter from my psychiatrist. I felt very uncomfortable about being required to do this in order to take a college class.

When I am in a not-so-good space, I sometimes feel that when I share I live with Post Traumatic Stress Disorder (PTSD), it creates a silent reaction — are you a veteran? No. So, then, you are a victim. It is an uncomfortable thought for me, but it is a thought related to the insecurity in the nature of what happened to me and how I 'let' it affect me as it has.

Despite the discomfort I felt from these distortions that were surfacing, which were creating extreme discomfort for me, I really wanted to be welcomed at this college to take a class. However, my desire to attend was fading quickly as a result of being unfairly required to justify utilizing my dog Winston at the college.

The letter the college received from my psychiatrist read:

"I am writing this letter in regard to Melanie Jannery, who is a patient in my care. Because of her medical condition, she qualifies as having a medical disability due to diagnosis of PTSD and a mood disorder. At times, this impacts her ability to concentrate and work in environments with the public. I recommend that she receive all necessary accommodations and receive all available services to aid her in her studies, including having her service dog with her when on campus. Thank you for your time and consideration. Please do not hesitate to contact me with any questions."

I felt comfortable having him reveal this much of what is "wrong" with me in order to receive "accommodation." I was asked to come into the college to explain further what my dog did for me and what I experienced that led me to need a service animal.

I was in a very good state of mind at that time, to have felt ready to return to college. I was dating a woman who worked when I did not, and in an attempt to engage more in life, I helped out some by helping her paint the interior of her house.

At the same time I was being ripped apart inside in finding such resistance in trying to take back some of what I lost along the way. Wanting to take a class was a huge step for me, but the inquiries by the college were breaking me down fast!

After two doctors' letters, the college's request that I go in for a meeting for further discussion on the matter really felt quite invasive. I contacted the Office of Civil Rights, US Department of Education in Boston, and I was advised that the college should not be requiring documentation requiring me to disclose private medical information to them.

In my heart and soul, I really thought that all a college should ask me were the questions stated in the Revised ADA Requirements: Service Animals, "(1) is the dog a service animal required because of a disability? and (2) what work or task has the dog been trained to perform?" It goes on to say that "staff cannot ask about the person's disability, require medical documentation, require special identification card or training documentation for the dog, or ask that the dog demonstrate its ability to perform the work or task."

During my meeting at the college, even with not one, but two doctors' letters regarding the fact that I use a service dog for medical reasons, I was told that the school still needed to determine if I was using the dog to help with my disability. It was stated to me that if I was blind and I used a guide dog, then it would be obvious. I was asked if I knew the difference between a therapy dog and a service animal. I couldn't believe I was being asked this!

I was then told that the college needed to filter out people who would bring their dog if it was not required for disability reasons. In the letter from my psychiatrist, he specifically stated, "Please do not hesitate to contact me with any questions," yet my psychiatrist was never contacted.

At this point I was numb and did everything I could do to remain sitting there. Welcome back to campus after 10 years, Melanie! I was extremely confused as to why, after providing two letters by two separate doctors, that I was still being asked these ridiculous questions, while sitting next to me was a very well-behaved Border Collie service dog that was clean and visibly identified with a service dog vest.

I presented a copy of the Revised ADA Requirements to the col-

Melanie Jannery's advocacy resulted in a new policy complying with the law.

Community College of Vermont intends to provide the broadest possible access to service animals in all of its public and employment areas. CCV is committed to insuring that individuals with disabilities requiring the use of service animals can participate in classes, services, employment and activities at all CCV centers.

GENERAL GUIDELINES

The Department of Justice/ ADA rule defines "service animal" as a dog that has been individually trained to do work or perform tasks for the benefit of an individual with a disability. Service animals are working animals, not pets. The work or task a dog has been trained to provide must be directly related to the person's disability. Examples of such work or tasks include:

- Guiding people who are blind
- Alerting people who are deaf
- Pulling a wheelchair
- Alerting and protecting a person who is having a seizure
- Reminding a person with a mental illness to take prescribed medications
- Calming a person with Post Traumatic Stress Disorder (PTSD) during an anxiety attack

Individuals with mental disabilities may use service animals that are individually trained to perform specific task. Dogs that are not trained to perform tasks that mitigate the effects of a disability, including dogs that are used purely for emotional support, comfort, therapeutic benefit, companionship, are not service animals under the ADA.

Inquiries Regarding Service Animals:

When it is not obvious what service an animal provides, only limited inquiries are allowed. Staff may ask two questions:

(1) Is the dog a service animal required because of disability?

(2) What work or task has the dog been trained to perform?

Staff cannot ask about the person's disability, require medical documentation, require a special identification card or training documentation for the dog, or ask that the dog demonstrate its ability to perform the work or task.

Veterans' Affairs Definition Rejects Comments on ADA

WASHINGTON — The federal Department of Veterans' Affairs adopted rules on service dogs in 2012 that limited the definition to dogs trained to aid people who are blind, hearing impaired or have "substantially limited mobility." The explanation of the final rule stated that the department had received multiple comments that argued that the omission of mental health impairments violated the Americans with Disabilities Act of 1990 (ADA) regulations, which specifically recognize service dogs trained to assist individuals with mental impairments and defining "service animal" to mean "any dog that is individually trained to do work or perform tasks for the benefit of an individual with a disability, including a physical, sensory, psychiatric, intellectual, or other mental disability".)

The Department said that the ADA and its regulations apply only to public entities, and "federal government agencies such as the VA are not included in the ADA definition of a public entity."

Service Dogs in College

lege representative on Service Animals, with a few of the specifics mentioned above highlighted and including "...for example, in a school classroom."

I was told that this information would be passed on, but I was still asked to give an example as to how my service dog helped me. I surrendered and gave an example of how he helps me during a panic attack.

I then described how horrible it felt to have to come in and talk about what is "wrong" with me and to feel under examination regarding what my dog does for me. I was told that most students with disabilities are grateful for the services the college provides.

I was not asking for any accommodation, I only needed to have my service animal present with me as he is in the rest of my life — to me, something that feels very "normal." The inquiries every step of the way felt wrong to me, inside and out.

This entire ordeal hurt deeply because as a person with a disability I am committed to understanding the laws that help me access the world that I had avoided for a little too long.

By the time it came time to attend class, even though the "accommodation" was granted since I satisfied the college's requirements by providing letter(s), a diagnosis, and an explanation as to how my service dog helps, I was emotionally exhausted.

I could not leave my house that day to attend class. I withdrew and then went through another whole process with the school about being charged despite a disability-related withdrawal that took another couple of months.

To clear this negative energy from me, I put on my advocacy hat and I filed an official complaint against the college. I wanted clarification on the law because what happened to me felt so wrong, and to me the law seemed so clear. Yet many service dog handlers face similar situations all across the United States.

I didn't want others to have to experience difficulty accessing life if it could be avoided. I contemplate today that if had I been taken at my word and treated with respect about having a service dog, like just about anywhere else in Vermont, whether I would have succeeded in taking that sign language class I was so excited about.

So I am eager to share that the college's inquiries to me were found not to be in accordance with current law. The questions that service animal handlers are allowed to be asked are the same ones that may be asked in any other area of an individual's life (doctor's office, grocery store, hospital, bus).

The ease of the process for the complaint pleased me. It was followed by the college becoming willing to revise its service animal policy as a result.

I am hopeful that by sharing this policy, which is in accord with current law, that individuals who use service animals nationwide will be able to refer to this policy if they are questioned unnecessarily in the way that I was. [The new policy, dated March 29, 2012, can be found online at *http://www.vsc.edu/CCV_Public/Service%20Animal%20CCV%20Policy.pdf*]

Melanie Jannery is from Burlington, and works with peers at the Wellness Co-Op. She hosts a service dog circle there every Tuesday at 3:30 p.m. for current and prospective handlers.

How Becoming an Advocate Gave Me a Voice as a Peer

To me, advocacy work holds a value that no dollar amount can hold. If I never knew what it was like to go into a store and not feel welcomed, I may not have gotten to where I am today. Through being an active member of an online ListServ over many years, I learned how to find my voice.

Six years ago, I made every attempt to show up in life and I attended a psychosocial clubhouse on mornings I was able to leave the house, each morning showing up with a bag full of pills that took me until 12.30 p.m. to create enough energy within to take them. I was not able to answer the telephone there like others or hold much of a conversation.

Melanie Jannery

Winston

Somehow, I found the inner strength to fight. I fought to take care of my dog, and eventually I learned to fight to advocate for many people who might come behind me who also use service animals.

I didn't have much will to live, so really, why would I fight for my rights? It was always easier to go back into an establishment that did not quite welcome me with the thought that I did not want another person to have that experience.

Over time, I found my voice and started to advocate for my rights, for my place in this world. With so much encouragement and support from others, people just like me, I was really able to engage in life and fight.

Fighting seems like such a horrible word to use, but it's the reality of what we have to do when we feel discriminated against. The fight I refer to is often the fight within oneself where life already brings pain and one just wants to be able to get food, do laundry and on a good day, go out to eat with friends. Laws are created to support our independence, yet they are not always followed. Mostly, laws that are not followed are often not followed because people simply need to be educated.

After being someone who could not answer a telephone in a small friendly atmosphere, I really found my voice through advocating for rights of people like me, that ultimately ended up in me advocating for my rights, once the realization came that ***yes***, these laws are for me too, I deserve this, having felt like I lost so much for so many years living with the suicidal feelings that would continually resurface.

After facing a very uncomfortable situation in trying to go back to school, I realized that going back to school was not really part of my journey. Advocacy work, having a voice, and having a voice that is heard are important to me. Finding my voice within myself led to me finding a life within and a desire to reach beyond what I ever thought was imaginable.

A short time after filing this complaint, I became quite involved with the peer initiatives in Vermont, took on a position as a warmline peer and was quickly elected team leader. I have been employed for six months as a credentialed peer support specialist ("Peer Staff") and involved in opening a peer community center.

Getting a dog that became my service dog is part of my journey. Once on 26 pills a day, 13 years on disability. I have found myself once again, much to the credit of finding my voice through advocacy work, one feeling at a time. When I've expressed my voice and it is heard, an inner belief is created and life continues forward.

I would have not been able to find my voice without peer support. I have had a lot of inquiries around having service dogs in Vermont. I have decided to pursue hosting a Service Dog Support Circle where I work for current/prospective service dog handlers. Life is Good.

Melanie Jannery and Winston, Burlington

Thoughts on the New World

Both Sides of the Scissors

What does it mean to have entered the stigmatized space of being a person experiencing 'mental health problems'?

"So," my new boss says, after I've accepted the job offer. "Why did you leave the last job? Did you, like, flip out or something?" She laughs.

I don't laugh.

I haven't lied to my employer. Everything I've said about why I left the last job and am applying to this one is true. It was "not a good fit" for me (a generic phrase that could mean anything). I say that I found that I couldn't do that job and also take care of myself well. I say that although I was making good money, I was miserable, and this job is more in accord with my values. I say, "Yes, I know it's part-time, and that works well for me based on other things that are going on in my life." All of this is true.

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On the intake form, it asked something like, "How would you describe the problems you are seeking treatment for?" I wrote, "My soul is tired… I am tired of violence."

"You're speaking very rapidly," said the woman. Her eyes looked kind behind her rectangular glasses. "I know," I responded, watching her out of the corner of my eye. "It's just because I'm anxious. I'm not manic."

What I didn't say was that I needed to make sure I talked fast enough in order to jam every piece of information that could possibly be relevant into the intake interview. If I didn't include everything, in full detail with the proper caveats and disclaimers, they might get the wrong impression. They might think I was lying, or malingering. They might think I was exaggerating in pursuit of "secondary gains." I was certain I seemed fine to everyone.

"I need a bathroom break," I said partway through the intake. "Actually," she replied, "We need to do a urinalysis. I believe you when you say you're not using drugs, but we have to test every client because you can't be actively using substances and be in this program."

I handed a cup of my pee to this stranger. She checked the little thermometer strip on the side to make sure it was the right temperature.

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At the old job, I slipped my old boss the "Certification of Health Care Provider - Employee" justifying why I was too mentally ill to work and required unpaid leave under the Family Medical Leave Act. I couldn't look at her, either, out of shame that she would think what the form said wasn't true, or maybe shame that she would think it was:

"_____ has severe Post-Traumatic Stress Disorder (PTSD) as well as Major Depression. Her PTSD symptoms have become exacerbated… to the point of extreme suffering and impairment in basic functioning, and necessitating a higher level of care than outpatient psychotherapy. The current diagnostic picture and situation is not sustainable for _____. At this time, the Intensive Outpatient Program and/or Partial Hospitalization Program is a crucial intervention to prevent a more serious breakdown in basic, daily functioning (likely… creating the need for a longer-term inpatient hospitalization)."

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"Did you, like, flip out or something?" Did I? How would I respond to that question if I dared to tell the full story? What does "flip out" even mean? I imagine someone creating chaos and violence, being restrained by police officers. I wasn't "a danger to others." I didn't hurt anyone but myself…

...although I did lead my friends to worry. They still worry sometimes, I think. A friend leaves a message on my answering machine, saying she hasn't heard from me in a little while and could I please call her to let her know that I'm okay. I feel sad when I hear the fear in her voice. I wonder how long it will take for my friends to trust that I didn't answer the phone because I'm not home, or busy, rather than possibly dead. I didn't realize I would cause so much concern. I tried not to tell them too much about what I was thinking precisely because I didn't want them to worry. Yet they worried anyway. Maybe I didn't seem as "fine" as I thought.

No one at my old job seemed to notice that I wore long sleeves throughout the ninety-degree week in July. Perhaps they attributed it to the air-conditioning.

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In the partial hospitalization program, we were making "coping cards" and I was covering my cards with words and pictures cut out of magazines and photocopies of pages from *Skills Training Manual for Treating Borderline Personality Disorder*. The group therapist had gotten the scissors from the office for me to borrow.

(From "Patient Responsibilities and Guidelines": "Please do not bring any sharp or dangerous items with you to the program… Should a program participant self-harm while in the building, this will result in being discharged from the program… My initials…indicate that I am aware of this policy and am committed to extinguishing self-harm behaviors.")

At the end of the group, I handed the scissors back to her, handles first. For a split second frozen in time we were both holding them at once, hands connected by plastic and metal. It hit me full force that now I was the one returning the scissors. Once upon a time, I had been working. I had been the one who kept track of the scissors around people like me.

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Now, I am working again. I'm the one with access to the "sharps" container. Who am I now that I've been on both sides of the scissors?

I'm making half as much money now then I was at my old job. My plans to save enough money to buy a car have been put on hold. I've been forced to let go of concerns about status and climbing some career ladder. I ride my bicycle across town in the yellow autumn sunlight, boots on the pedals, cool wind blowing across my face. I'm spending time with other people again. I'm still scared a lot of the time, but I don't hate my life anymore. One minute life feels great and the next minute it feels unbearable. I look forward to work, when I have to be on a more even keel and can't think about myself too much. I often think terrible things are about to happen. Sometimes I'm able to remind myself that this might not be true.

I feel raw, like a bird hatched out of the egg. I've just landed in the world again and am looking around wide-eyed at something fresh and new. It's hard to keep track of anything that's happening more than a week in advance; I'm in a narrow band of reality surrounding the present.

I'm not sure how to make sense of myself anymore. I'm not sure how to hold my capabilities and my struggles and accept having entered deeper into the stigmatized space of being a person experiencing "mental health problems." I feel less human and more human at the same time. I feel more humble and also less confident.

Who am I now that I've lived on both sides of the scissors?

Anonymous, at the writer's request.

Always Waiting:

by SUE HOHMAN

Having bipolar disorder requires a lot of waiting… waiting for the moods to change, waiting for the meds to work, waiting for doctors to get back to us, waiting to receive benefits when we apply, and waiting for the "other shoe to drop." There is almost a constant aura hanging over us as to whether we will be healthy as a commitment approaches, a vacation gets near, or other things approach that we want to do. It's a huge waiting game.

Sometimes the waiting pans out and all is fine. At other times, we wait and are sorely disappointed when an event comes up which we are unable to attend because our symptoms get in the way. Or a person in our life becomes disillusioned with us because of our frequent bouts of illness and a relationship dissolves. Or we wait for an improvement that never comes from a medication, therapy or other treatments.

Waiting and being disappointed is hard to take. However, so often that is the nature of our illness. The one thing we can count on, having bipolar disorder, is that we can't count on anything. Wherever we are, we know that, in time, that will change. Our depressions don't last for ever, and that is hopeful. Our manias don't last forever, and again that is hopeful. What is difficult is that our periods of wellness don't last forever either. "How unfair!" we cry. We wonder what we did to deserve this. Why so much change, so much upheaval?

After a Label of Mental Illness

I'd Rather Wipe My Own Mouth, Thank You

Don’t make me helpless by treating me as incapable.

by ANN MADELONI

While I was raising my children, I had a job. In social services, no less. In both roles my responsibilities included, but were not limited to, teaching, mentoring, and reminding all concerned that they needed to have the overall social awareness and self-respect sufficient to motivate them to wipe the crumbs off their own mouth when necessary.

I was always loving, non-judgmental and yes, strict; very no-nonsense, as life tends to be. Some have even termed me harsh. I have responded that life is harsh. Many have accused me of being unfair. I retort life isn’t fair. My philosophy has always been if you don’t take care of and respect yourself, no one else will. I practiced and preached all the buzz words and phrases that today are worn so thin they don't have any real substance anymore. Empowerment was a big one.

My rules were simple. Don’t hit/pick a fight first, for I will not defend you. If it was two kids or “Big Brother” against one (depending on whether the victim was my child or a client) I would march with child or client in tow and confront the other kids down the block or the welfare office personnel. I’d get the story from their perspective, and then knock on the parent’s or supervisor’s door for a pow-wow.

By bringing the child or client with me I was demonstrating first hand that it’s okay to stand up for yourself and confrontation doesn't have to be scary. Self-respect is essential if you want the respect of others, so your strongest, most important advocate is ***you.*** If you want something done, do it yourself.

Having also worked in a hospital as a dialysis technician, I saw the emotional and psychological effects of long term, debilitating illness on the patient as well as care-takers.

Many patients, in great pain, obviously dying, desperately trying to hold on to a last vestige of control over their environment and circumstances, decompensated to become bully and tyrant. Many caregivers, feeling helpless themselves, tried to smooth things over by doing too much of everything. Unwittingly, they contributed to the very thing that was making the patient so difficult to work with.

You see, loss of autonomy is infuriating to the soul. It's that simple.

Then the awful, fork-in-the-road day of ***my*** life came. I was told I had a “mental illness”... a “disease”... life long... “like diabetes.” As a result of this “condition,” I was now expected or required to take medication... for the rest of my life.

In the blink of an eye I found myself in the system, necessary papers and numbers and labels all neatly stacked in a row, my identity redefined. I was told in a myriad of words and actions that I was now... different; better yet... special. As such, many services would be provided for me: Therapist for sanity. Housing for safety. Income for security. Medical coverage for health. Transportation for freedom. And, most importantly, a psychiatrist for the now-understood necessity of medication.

However, all these offered services deprived me of my right to pursue happiness on my own terms. Things were done to ensure that I lost my children. In all the years that I was “medication compliant,” my mental and physical faculties were slipping away. I was told/believed that this was the expected progression/culmination of my “disability.”

I couldn’t keep awake long enough, think clearly enough, to maintain a job. My favorite pastimes of reading and writing were no longer an option for my now sluggish, forgetful brain. My hobby of crochet became impossible as my increasingly arthritic fingers fumbled to control the hook and yarn. For the first time in my life I was overweight, underactive, and unplugged from society.

Grandma always said: You don’t get something for nothing.

All of which leads us to today. I have been medication-free for almost three years. Obviously I am back to writing. The pleasure of going to far-off lands through the printed word or creating something beautiful with my crochet hook are part of my daily routine.

My increased mental acuity has enabled me to read and understand recent socio-political influences on the law. And I'm not happy. The trend seems to be a substitution of governmental collective control for personal responsibility, resulting in an over-reaching infantilizing web of bureaucracy, at great cost financially, socially and morally.

I am disgusted by the “need” for an anti-bullying law. Parental authority and responsibility have been so demeaned, so undermined, that it apparently is no longer an option to knock on a parent’s door, little Jimmy in tow, with a reasonable expectation of the righting of a wrong, and the learning of a lesson in common decency.

I am disgusted by laws focusing on “special” segments of the population to afford them “special” services, “special” rights and privileges. Am I the only one who sees these actions as counterproductive to the much touted ideals of empowerment, self-sufficiency and self-realization?

From personal experience I can tell you that the more “special” I was treated, the less I was treated as an equal. The less I was treated as an equal, the more incapable I felt and behaved.

I was nearly (prematurely) put into the grave, i.e., killed with kindness.

As a former social service worker, I am fully aware that there are those of us in need of guidance and common sense. As a former hospital worker, I am fully aware that there are those of us truly physically incapable of putting spoon to mouth to get nourishment. As a mother, I am fully aware that there are parents in over their heads in need of support.

But:

When did these circumstances become justifications for the governmental, faceless bureaucracy to sweep in, and in the name of “rights” and “protection” usurp from those they purport to serve their right to pursue happiness on their own terms?

When did all these agencies become an expected/mandated substitution for individual common sense and community morality, interaction and cohesion?

When did it become acceptable to dictate to others their mode of speech, in direct contradiction to our God-given right to free speech?

Do people say mean, callous things? People, like life, can be harsh and unfair. We can no more protect the weaker of our society from these realities than we can protect anyone from the reality of death. But, as I did with my children and my clients, we can teach them skills to cope. We can give them tools to build self-esteem and autonomy, even in the worst of circumstances.

What we can’t do is continue to section off a segment of society in the name of kindness or diversity.

The cost of your obsequious doting to my self-esteem is much too damaging.

As helpless as you seem to like to make me out to be, I’d rather wipe my own mouth, thank you.

Bipolar Swings

Bipolar is not for the faintheartedl We are put together in a glorious way, but it comes at a cost. Many of us are creative, hard workers, able to accomplish more than a majority of people, and even, dare I say, smarter than average. It is a wondrous thing to have this spectrum of moods and talents. It can be exciting to get close to the top of our capabilities. Many people are not able to tap into that ability, and they never experience the joys that we take for granted.

The downside is also a blessing in disguise. Depression also taps into depths of parts of us that are rich and inspiring, should we choose to hold on dearly for the ride. No one wants to be depressed, but again, most of us come out of depression wiser and deeper and eager to really live again.

Mood swings come and go, and we wait them out. We hate to play that waiting game, but there is no choice. We cannot see over the hill to where and when our next mood will be. All we can do is hang on tightly, and live our life as deliberately as we possibly can.

Life is good when we radically accept that our life involves a lot of waiting. We must simply make sure that the waiting is as much a positive part of our life as those things that we wait for. Life is every minute: the ups, the downs, the wellness, the waiting. Let us make sure we experience the total ride. We only get one life, so enjoy.

Sue Hohman writes from Bennington.

DISABILITY RIGHTS VERMONT ANNOUNCES FY 2013 PRIORITIES

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

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

DRVT has engaged in the efforts to create a more robust community-based system to provide support and services to people experiencing mental health crises or needs in order to avoid involuntary treatment, incarceration or other major life disruptions. DRVT staff continues to monitor the situation and provide advocacy services to people placed in the designated psychiatric units around Vermont. Within all this work, DRVT continues to advocate for the reduction and eventual elimination of the use of restraint and seclusion against individuals with mental health issues.

DRVT staff has also assisted in providing emergency preparedness planning and disaster services to people with disabilities. DRVT works with the Vermont Red Cross and FEMA to provide functional accessibility surveys for all major shelters in Vermont and to provide disability rights training to shelter staff throughout Vermont.

DRVT is working with Vermont Legal Aid, concerned folks from the Community of Vermont Elders (COVE) and the Vermont Center for Independent Living to foster reform of Vermont's Adult Protective Services. DRVT and VLA have currently have resorted to litigation to insure that timely and thorough investigations lead to safe and just resolutions for vulnerable adults who have faced abuse or neglect in our communities and institutions. We are hoping that a mediated resolution can soon be reached.

We have continued our work with DLP monitoring Special Education services for youth detained at Woodside Juvenile facility. In addition, DRVT staff is involved in monitoring and providing quality assurance regarding uses of force against youth detained at Woodside. DRVT continues to work with Woodside staff and DCF in the transition from the former status of Woodside as a detention facility to its current position as a treatment program.

DRVT has also been a vital participant in the ongoing work of the AHS State Interagency Team organized to assure that people with serious functional impairments (SFI) at risk of incarceration or delayed release from incarceration have access to the most effective and appropriate services to avoid their disabilities from causing them to loose their liberty. We currently participating on the committee formed by the Agency of Human Services that is studying the needs of prisoners with SFI.

We continue to monitor the designated psychiatric hospitals in Vermont, as well as perform outreach to residential and community care homes. We continue to expand our focus on community placements to include outreach to homeless shelters and contact with refugee communities.

In this election year, DRVT has registered voters and given information on rights in all of our outreach settings around the state. We produced and distributed another edition of our popular "Voters' Guide for People with Disabilities". And DRVT staff continues to survey polling places for accessibility, providing the results and recommendations to provide access to local officials.

We have continued our work with beneficiaries of Social Security facing barriers to employment, resolving cases of employment discrimination based on disability.

DRVT has also worked to provide victims of crime who have disabilities with accommodated assistance as they deal with the criminal justice system. This work has resulted in DRVT participating in statewide ethics and civil rights training for victims' advocates, including issues of assisting victims with disabilities.

DLP and DRVT staff has made real and positive differences in the lives of the many individuals who have contacted us and for whom we have provided information, referrals, short-term assistance, investigations, and litigation.

DRVT is publishing our formal Fiscal Year 2013 (10/1/12 - 9/30/13) priorities for the Protection & Advocacy for Individuals with Mental Illness (PAIMI) program on the opposite page. These priorities serve to focus the work of the agency and are developed by our Board and our advisory council, who get input from the community and staff. **Your input is appreciated!** We strive to do as much as we can with the resources we have and we can do that best when folks in the community let us know their greatest advocacy needs!

We need volunteers, too!

Disability Rights Vermont (DRVT) is looking for volunteers to serve on our PAIMI (Protection & Advocacy for Individuals with a Mental Illness) Advisory Council (PAC). We are looking for members with connections to the broader community who will assist DRVT in developing annual priorities and assess our performance.

Each applicant must identify with one of the following categories:

- **You are a psychiatric survivor**
- **You are or have been a recipient of mental health services**
- **You are a mental health professional**
- **You are a mental health service provider**
- **You are the parent of a minor child who has received or is receiving mental health services.**
- **You are a family member of an individual who is or has been a recipient of mental health services**
- **You are a lawyer**

If any of the above categories apply to you and you are interested in having an impact on our community we want to hear from you!

Please call 1-800-834-7890 x 101 for an application to join our PAIMI council.

Send us your comments to help us stay connected to the community we serve!

DISABILITY RIGHTS VERMONT FY'13 PAIMI PRIORITIES

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

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

Measure of Success:

A. Work on a minimum of 100 cases of abuse, neglect, or serious rights violations of people with mental health issues. Among closed cases, at least 75% of those not withdrawn by client or found to be without merit by DRVT staff should be resolved favorably.
B. In at least 2 opened cases, DRVT will advocate for adequate discharge of involuntary patients in the spirit of the community integration mandate of the Americans with Disabilities Act.
C. DRVT will assist at least 5 clients with medication-related issues including coercion, informed consent, and inappropriate medication and ensure that clients have been informed of the risks, benefits and alternatives to psychiatric medications.
D. Note whether the individual describes the issue as having occurred during a first contact with the mental health system because of the potential for coercion and trauma.

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

Measures of Success:

A. Work with at least two institutions to create respectful, trauma-informed, violence free and coercion free mental health treatment environments, particularly during an individual's first contact with the psychiatric system.
B. Advocate in the legislature, and with the administration, to preserve or enhance the right of Vermonters to be free from coercion in their mental health treatment.
C. DRVT will implement recommendations of our current cultural sensitivity self-assessment to insure that our services are delivered in a culturally responsive way.
D. Work in at least one community to improve the system-wide response to mental health-related emergencies to prevent unnecessary use of force, involuntary treatment and incarceration.
E. Work towards a constructive settlement in our litigation regarding Adult Protective Services.

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

Measure of Success:

Outreach and monitoring is conducted at a minimum of 20 community care settings, including but not limited to residential care homes, therapeutic community residences or licensed residential childcare facilities.
Outreach is conducted at all eight state prisons.
Outreach is conducted at all designated facilities, including intensive rehabilitation residences and any state run facility.
DRVT literature is distributed to all of the community mental health agencies, prisons, and designated hospitals, including their emergency departments, intensive rehabilitation residences, and to homeless shelters, "club houses" and peer-run services.
Outreach to individuals labeled with a disability who are victims of crime or domestic abuse.
Monitor all treatment environments (e.g. designated hospitals & their emergency departments, residential care homes, correctional facilities) to assure that unnecessary or inappropriate use of seclusion, restraint, coercion or involuntary procedures are not used and that treatment is only administered with proper informed consent.
Expand outreach to diverse communities and non dominant cultures, monitoring that they receive services in a culturally competent way. Examples would include refugee resettlement programs, and organizations like the Association of Africans Living in Vermont, etc.

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

Measure of Success:

Four self-advocacy and/or advance directive trainings for 40 individuals.
Assist at least 5 individuals across the State of Vermont with their preparation of Advanced Directives.
Work with the administration, other advocacy groups and individuals on the implementation of Act 79, including a wide array of treatment options in the least restrictive and most community based settings possible.
Encourage the development of peer run services in Vermont's mental health system reform and educate peers on access to these services.
DRVT will participate in systemic efforts to improve state services for individuals in or at risk of incarceration to speed successful reintegration.
Participate in efforts to insure that state and local emergency planning efforts include the needs of people with mental health issues.
Participate in coalition efforts to address transportation infrastructure needs of low-income people with mental health issues.
Support the Vermont Communications Support Project in order to ensure that people with communications disorders related to their mental health can participate in the judicial and administrative systems.

In addition to priorities DRVT does not ignore evolving situations and other cases, or treatment facilities, which require attention.

Case acceptance is based on these priorities and whether a client meets the federal definition of an individual with a mental illness; whether the case has merit and is within the PAIMI priorities; whether the client does not have other representation; and whether there are sufficient staff resources to take on the case.

How can you make your voice heard?

Contact DRVT at: 141 Main Street, Suite 7, Montpelier, VT 05602 Or by phone: 1-800-834-7890 or, locally, at (802) 229-1355
By email at: info@disabilityrightsvt.org Please visit our website at www.disabilityrightsvt.org

Arts

Poetry and Prose

Fred Senser-Lee with young admirers alongside his flowers on the bikeway in Lake George.

Bikeway Beauty

Fred Senser-Lee, a peer from South Glens Falls, New York, is attracting attention along a bike trail and in the news for his project planting colorful wild flowers along the Warren County Bikeway in Lake George. An article in the Lake George Mirror has featured his effort to expand the plantings all the way to New York City. In addition to spreading beauty, the project makes people think about their own growth and development, Senser-Lee told the Mirror. "Describe the growth of a seed into a plant and a blossom, or something that takes longer to grow, such as a bush or a tree," the Mirror quoted him as saying. "Now think of the way you've grown over time. What 'seeds' did you plant to grow over time?" Blossoms of many varieties, from petunias to sunflowers, line wooden railings on bikeway shoulders leading up to a bridge in Queensbury, the news article said. Senser-Lee also told the paper that the project was a unique community opportunity. "At some sites, it's a neighborhood thing. People who may have never talked to one another before are getting involved. They can plant something, watch it grow and work with their hands in the soil. It's great for kids."

Starting Over Strong

Vermont provided crisis counseling to Vermonters related to the stress and loss caused by Tropical Storm Irene. These services will end this month. The Department of Mental Health applied for this program grant through FEMA in September 2011 following the flooding of so many of our towns. The grant recipient was Washington County Mental Health Services. Twenty SOS staff were hired to work statewide; they supported and educated our citizens regarding normal reactions to disaster and coping strategies. This resulted in approximately 12,000 contacts throughout the state. One of the basic tenets of disaster response is to assist the survivor in regaining some sense of control when there has been such evident loss. To that end, Vermonters have exhibited great strength and resiliency, sharing their stories, re-creating family photos, seeking group and individual support, and participating in re-building activities. For the children, a premier program was "Storming Super Heroes" allowing kids to create their own super hero to help them talk about their storm experience and recovery. David Flight, one of the SOS crisis counselors, shared his thoughts about this valuable work at a closing exercise with his team:

We came together as a team
To help survivors of storm Irene
To look beyond the flood's great mess
And see the hidden mental stress
We offered those who still need more
Then mucking out the basement floor
To find new ways to serve our neighbors
With our compassion and counseling labors
Helping those with unmet needs
Our own capacity grows and feeds
The inner voice that speaks our tongue
And drives us forward until we're done
We're doing the kind of work we want
We're Starting Over Strong Vermont
We, ***are***, Starting Over Strong Vermonters

#48

talkin 'bout shadows
dancing in my dreams
floating all around my head
in systematic schemes

playing games outside my soul
turning in on me
shouting darkly in the night
my spirit must be free

wandering through the liquid fire
bursting out inside
I question what I'm hearing now
the peace that seems to hide

circling 'round my monolith
I wonder who I am
am I lost in inner space
will I be found again

talkin 'bout shadows
dancing in my dreams
floating all around my head
in systematic schemes

by m. a. wakeman
north bennington

Arts

Poetry and Prose

...who am i?

Who am i
Where am i
What defines me
What does it matter
Life is short
It is not good
It is not fulfilling
It is miserable I am miserable
It is what it is
Clouded by the medicine
High on life
POOF
Back to the olden days
Reality strikes
Depression flows
Up
Down
Left
Right
Inside
Out
All around

Energy
Appetite
Desire
All sucks

Feel trapped in this body that will not move
This mind of mine circles around and around
For who am I – what am I
I am gay
I am alone
I am me
Where nowhere to go

Desires come and leave
They dissipate into the thick air that clouds my mind
Hope dreams everything vanished
Scars of yesterday existing today yet to face just another day

Medication or me
I do not know
Sadness desire hope all fades with all I do
No matter
School is hard
Eating is hard
Thinking feeling wanting
But not having
I try and try but I want to hide
Hide from what I do not exist
But that is the problem existence I do
Matter I don't
Existence without presence failure I be

Open and SLAM!
Out of my life into my life
Open and SHUT
Angry I become
Hurt I am

Alone

Scared
But of what
Myself
My thoughts

Want the blood hate the tears
Want to die afraid of fear

Hope I get
Let down I am

What am I – I do not know
Define me
Tell me
Show me
Somebody HELP ME
Anybody, but me
Lead me the way
Show me the truth
The good
I am clouded I am blurred

Tomorrow will come I know it will
The strength I fear
To take a pill
It's in my head
They are bad
I do not know if it's me or the lack of meds

When will I know what do I do
Until then I exist hope pray-but I don't
I mend
I heal
I listen
I learn
I try
I find
I need
I want
I have to
Got to
Need to
Figure this out
Why can't I leave
Why am I here
Why
Why so hard
Why now?

God help me whoever you are
Somebody show me find me
givemestrength
DAMNIT!
I hate this
3 o six am
I am what I am
And well, that's ok

by Melanie Jannery,
Burlington

by Pamela Gile

Announcing

the 2013
Louise Wahl
Memorial
Writing Contest

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. Only one entry per category of poetry or prose; 3,000 word maximum. Limit of two lifetime First Place awards. Winners announced in Summer, 2013 issue. Send submissions to:

Counterpoint,
Louise Wahl Writing Contest,
1 Scale Ave, Suite 52,
Rutland, VT 05701
or to counterp@tds.net
Please include name
and return address.

Annual deadline:
March 15

$250 in total prize awards!

Arts

Poetry and Prose

Winter Wonderland

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

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

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

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

You could hear a soul drop here
On a cold February day.
All seems so wrong to see not a bit of life
Except perhaps a dog or man
Bent against their strife.
A glassy road mirroring your contorted face
Reads somehow thirty below in some dark brain-space.
The unending waves of snow race madly to a point
So far, so endless, it turns the eye out of joint
To follow it; and the days are years.
And the wind -
The wind that flogs your mast-like flesh,
Shivering listing wails to pipe the dead man's tune
Right into your living room!
Seal doors and windows all you will,
Ghostly lips fife through every sill,
And the song is chilling.
And yet there is a silence.

There is no throb of life,
No chirping thing, no crush of grass,
No color except the white shroud,
The world seemed shocked still,
Suspended in its animation,
A frame, long as a reel
On the film of life.
Silence deeper than sound, more profound,
Crystal, brittle, stinging -
And not a fly to drum upon it.

With a blast
The village groaned when the storm hit,
Wires went down or snapped underground,
Pipes burst like glass,
Asphalt buckled and highways zippered open,
And the houses howled behind storm windows,
Heaven and earth are lost!
Blind! Blind as a white cataract
Or the madman's inward-rolled sight,
White humor out-rolled from heaven downside-up!
A rabid animal, a dragon with a trillion eyes,
Flashes white fire in your face,
And streets, houses, stores all
Are salted to his taste.
Icicles form on your lashes,
Eyes stick and burn and the face turns red.
Your nose drools and you swear.
You bend and slip and somebody says you're drunk
Even if the wind is fifty.
It carries you along like a wind man flailing,
Making a sail of your coat,
A flying Dutchman on a lifeless sea.
And yet you're only in your yard.
Still yard, still garden, still house,
Dead and silent in the raging storm.

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

by Patrick W. Bradley, Jr.
St. Albans

Knowing People

by Nikita Laferriere
St. Johnsbury

It's not nice to use, and you definitely don't want to abuse
People will come and go, those are the ones you never truly know
The ones in your life who stay must be in your book as okay
You have those who are shy, that may pass you right by
The ones who are outgoing are the ones you usually end up knowing
Everyone is different; some aren't in this life to really live it
People tend to vary, because everyone has different baggage to carry
Those who stay on your mind are the ones who are most defined
Stick with those you truly know and you will never experience a low blow
With new people be cautious — especially if they leave you feeling nauseous
The people you feel comfortable around are never going to bring you down
You only truly know you, so be cautious if approached out of the blue
These are some of the things I have learned, because numerous times, I have been burned.

Arts

Poetry and Prose

TRIBUTE — Peers from Bennington pay tribute to their friend, Catherine Shepard, by reading some of her poetry at the Vermont Psychiatric Survivors 20th anniversary celebration. She was a long time contributor to the Counterpoint Arts section. Reading, left, is Barbara Baker, as Andrea Kolbe listens. Caroline Gauthier and Brenda Patten were also with the Bennington group.
(Counterpoint Photo: Anne Donahue)

A Tribute To Catherine Shepard

Catherine Shepard was a long time CRT client in Bennington who was a published poet and a contributor to the **Counterpoint** *Arts pages. She died this past fall. These reprints of poems from past issues are offered as a memorial to her.*

A Prayer

Dear God,
I cannot tell you all the grief I have known.
I cannot believe the beauty I have seen.

At one time in space at church
I heard a black friend sing
"Nobody Knows..."
It was a work of art we all shared.

But in the valley and the shadows,
It is more than dust —
It is beyond awe;
And beneath are the
Busy ants and bees,
Carrying out their place
In the constellation.

You have a place for us
And it echoes from the hills and mountains
To the depths of the ocean floor
Forever — and ever more.

Catherine Shepard

We

I looked out and there he stood,
He came to me as he said he would.
We both took a chair and started to chat,
Each of us knowing he's not come for that.
Then both on the couch lie quiet and still;
Simply our nearness gives us a thrill.
No words are exchanged, just touches and sighs,
We, sharing each other, know silence is wise.
Such is the course of our mutual love,
Just a simple union, blessed from above.

Catherine Shepard

Counterpoint

♥ Would Love To Have Your Art **Right Here!** ♥

Share Your Sketches, Photos, Poetry, Paintings, Stories and more

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

Me

In times of change
some are strange
Strangers everywhere
But nowhere
to connect
Empty heart
and I still
move on
With a very new song
With help from friends
I'll move
forward, but
Class is where
it's at from
now on
and some just
don't belong
in my life
I've learned
from strife.

by Lisa Carrara
Weatherfield

Resources Directory!

Phone Lines — Support Groups — Agency Contact Information

Vermont Psychiatric Survivors Support Groups

Northwestern
Call Jim at 524-6555 ext 4333;
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 Sandra at 579-5937
Brattleboro Mem. Hosp, Wednesdays, 7-8:30 p.m.
Central Vermont
Call 225-6526, Another Way
125 Barre St., Montpelier
Women's Support Group, Tuesdays, 3:30 - 5:30
Another Way, Tuesdays, 6-7 p.m.
Bennington:
new group now forming: Call Caroline at 733-7883.
Vermont Psychiatric Survivors is looking for people to help in starting peer support groups. Funding is available to assist groups. For information, contact George at VPS at 802-282-2267; vpsgeorg@sover.net

Drop-In Centers

Another Way, 25 Barre St, Montpelier, 225-6525 anotherwayvt@gmail.com
Brattleboro Area Drop-in Center, 57 S. Main St.
Our Place, 6 Island Street, Bellows Falls
COTS Daystation,179 S. Winooski Ave, Burlington
The Wellness Co-op, 43 King St., Burlington
[call or check web site for hours and for support and discussion circles: 888-492-8218 ext 300 thewellnesscoop@pathwaysvermont.org]

Warmlines

Peer Access Line (P.A.L.) of Chittenden County: 802-321-2190, Thurs through Sun, 6-9 p.m.; for residents of Chittenden County.
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.

Brain Injury Association

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

LGBTQ Individuals With Disabilities

Talk, connect, and find support
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. www.RU12.org

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

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; 488-6200
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 Screener Lines

(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 (adults) (802) 488-6400;
First Call – Baird Center:
(children and adolescents) (802) 488-7777
(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 and Support Groups

www.vtrecoverynetwork.org
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 RiverJunction: Call 295-5206; Turning Point Club, Olcott Ave., 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

Getting Help In Finding Help

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.

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

Support, education and advocacy for families and individuals coping with the problems presented by mental illness. 1-800-639-6480, 162 S. Main St., Waterbury, VT 05671; www.namivt.org; info@namivt.org

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

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 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 a psychiatric hospital, or, if committed, for unwanted treatment. 121 South Main Street, PO Box 540, Waterbury VT; 05676-0540; (802) 241-3222.

Vermont Client Assistance Program (Disability Law Project)

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

Vermont 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]

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