Writing Contest Winners Inside!

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

Counterpoint

Vol. XXIX No. 2 | From the Hills of Vermont | Free! | Since 1985 | Summer, 2014

Sculptors Hope Work Is Healing

by CLARKE HAYWOOD
Counterpoint

BERLIN — If there is a sacred medium that taps into the healing of people, it is art and bringing Vermont's woods and forest animals into it.

"I was interested in the site because the art can be a part of a healing process. I also am interested in how the public art proposal process works and thought this would be a great learning opportunity," said Heather Ritchie, a Plainfield sculptor. The opportunity she described is the new Vermont Psychiatric Care Hospital. Vermont artists are called upon to beautify state public buildings with their art, and the state's new psychiatric hospital is no exception, thanks in part to the Vermont Art in State Buildings Act of 1988.

LABOR OF LOVE — Chris Miller of Calais chisels stone to create the stump of a maple tree for the Vermont Psychiatric Care Hospital.
(Photo Courtesy Chris Miller Studio)

As the hospital construction planning moved forward, a legislative advisory committee chose a design submitted by a team headed by Chris Miller, with Ritchie, Ryan Mays, and Gampo Wickenheiser to make sculptures such as animal-inspired benches and a Habitat Tree, steeped in that rich healing tradition.

The Call

Miller, from Calais, shared his thoughts on the local appeal for this opportunity as public artists. "However, other than some local public projects, we often ship sculpture out to far off locations, so a large multi-piece project in our backyard was particularly appealing," he said.

Ryan Mays, from Montpelier, said that the opportunity resulted in Barre stone carvers teaming up for a first-time local project. "We were thrilled to be chosen, and started the process of back-and-forth with the project's committee to decide specifically what the pieces would be," he said.

The Concept

"We had proposed a series of animal sculptures, which would be, as much as possible, interactive, non-threatening and, hopefully, engaging and comforting. The idea comes from the engagement and comfort that so many people derive from a relationship with animals of various kinds," Mays explained.

"Animals can be a versatile vessel for communicating thoughts, gestures and feelings. There is always a way one can relate to something that eats, sleeps, plays and carries on in life, for we are alive," Gampo Wickenheiser, a sculptor from Montpelier, said.

Ritchie said the idea of the animals tapped into what Miller described as the concept: "to create inviting, safe, soothing places where patients could connect

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Drugs Bill Narrowed, But Passes

by CLARKE HAYWOOD
Counterpoint

MONTPELIER — A new law will create a faster route to a court decision on involuntary medication orders for some hospital patients, but will make little change to the process for others. The final bill, expected to be signed by the governor, made fewer revisions to time lines than what the Senate had passed in February.

Is Medication Overused?
New Reports Give Alternatives
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"We hope that we have struck a proper balance," said Rep. Tom Koch (R-Barre), who chaired the committee to resolve differences between versions of the bill passed by the House and the Senate.

"We recognize that there are patients and their advocates, on one hand, and treatment providers, on the other, who each believe that the balance is off one way or the other. Time and experience will tell if we got it right," Koch said.

Disability Rights Vermont "does not see this legislation as helping individuals with psychiatric disabilities," its Executive Director, Ed Paquin, said. He said that protection of civil rights "has no meaning if it does not include the right to legal assistance" which must include "reasonable time frames to prepare a defense based on independent expert evaluation."

Paquin said that the time it currently takes to get an involuntary medication order — "or forced drugging as it is often called by people who have experienced it" — sometimes exceeds the time lines in existing law due to a lack of resources. "Yet proponents, while claiming a respect for due process, made no effort to ensure adequate legal resources" in the new law.

On the other hand, hospital clinicians have strong beliefs that the "current judicial process for involuntary treatment and medication is not serving all patients well," according to Jill Olson of the Vermont Association of Hospitals and Health Systems, which has pressed for change for years. The legislature has now passed a bill that "better reflects the fact that for some individuals, more time is valuable, and for others, more time is harmful," she said.

The law permits the court process to move more quickly if:

- the person presents a significant risk of causing "serious bodily injury" to self or others despite safety efforts by the hospital;
- the person has been involuntarily medicated within the past two years, and more time is not likely to result in progress in building a therapeutic relationship or in regaining the ability to make decisions; or
- the person has been in the hospital for a month without a

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Opportunities for Peer Leadership and Advocacy

Meeting Dates and Membership Information for Boards, Committees and Conferences

State Committees

Program Standing Committee for Adult Mental Health

Advisory committee of peers, 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. The committee is the official body for review of and recommendations for redesignation of community mental health centers and monitors many aspects of the system.

Adult Standing Committee Needs New Members!

The Adult Program Standing Committee has issued a news release to recruit new peer, family and provider members. It is a "very intelligent, exciting committee," the release from member Marla Simpson said.

"We meet the second Monday of every month, from noon to 3 p.m. at 26 Terrace Street in Montpelier," she said. "The Commissioner of Mental Health and other experts in the field meet with us and we hear the latest and most innovative news regarding mental health matters in Vermont.

"We also review and help re-designate Designated Mental Health Agencies. Duties include attending all meetings, reading relevant materials for the meetings, and/or making site visits to Designated Mental Health Agencies. It is an honor and a pleasure to be a part of this important committee."

The news release said that the Committee is looking for two provider members, one peer member, and one family member. Based upon the desire to have members from different counties across the state of Vermont, the committee is especially interested in adding members from the Northeast Kingdom, Chittenden County, Southeastern Vermont, Bennington County, and Addison County. There is reimbursement for mileage.

Those interested in applying can contact Melinda Murtaugh (Melinda.Murtaugh@state.vt.us) or Clare Munat. Marla Simpson, M.A Member of the VT Standing Committee

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. Third Monday of each month, 12:30-2:30 p.m.; Redstone Bldg, 26 Terrace St., Montpelier, Contact the Department of Mental Health (Judy Rosenstreich).

CONFERENCES

Alternatives 2014

The National Mental Health Consumers' Self-Help Clearinghouse will be hosting a national mental health conference at the Caribe Royale Hotel in Orlando, Florida from October 22 through 26. Individuals can join the Alternatives Conference Announcements Facebook page to get the most up-to-date information. If not on Facebook, contact Susan Rogers at srogers@ mhasp.org for more information.

Wellness Workforce

The Wellness Workforce Coalition website lists upcoming trainings, events and meetings at http://www.vcil.org/services/wellness-workforce-coalition.

NEW FACEBOOK SITE

www.facebook.com/groups/madinvermont

This group describes its purpose as creating a venue for peer support, news, and advocacy/activism organizing in Vermont. "Psychiatric survivors, ex-patients/inmates, consumers, human rights activists and non-pathologizing allies are welcome," it says.

Peer Organizations

Vermont Psychiatric Survivors

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

Counterpoint Editorial Board

The advisory board for the VPS newspaper. Assists with policy and editing. Contact counterp@tds.net

Seeking New Members Now!

Disability Rights Vermont PAIMI Council

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

Alyssum

Peer crisis respite. To serve on board contact Gloria at 802-767-6000 or Alyssum.info@gmail.com

NAMI-VT Board of Directors:

Providing "support, education and advocacy for Vermonters affected by mental illness." Contact Ann Cummins at 802-379-5197 or email at acoopercummins@gmail.com.

For services by peer organizations, see referrals on back pages.

Hospital Advisory

Vermont Psychiatric Care Hospital

Advisory Steering Committee for the new hospital in Berlin. Contact the Department of Mental Health (Jeff Rothenberg) for further information.

Rutland Regional Medical Center

Community Advisory Committee; fourth Monday of each month, noon, conference room A.

Fletcher Allen Health Care

Program Quality Committee; third Tuesdays, 9 -11 a.m., McClure bldg, Rm 601A

Brattleboro Retreat

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

How to Reach The Department of Mental Health: 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

Counterpoint

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

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Have News To Share?

Send It to

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***Your* peer newspaper**

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***Counterpoint* Deadlines**

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New Hospital Nears July Opening Date

BERLIN — With 90 new staff hired and an open house set for July 1, the new Vermont Psychiatric Care Hospital is nearing final preparations for beginning to admit patients this July.

The new hospital will begin on the side of caution in how open programs can be until learning "how the building itself works" and staff get more comfortable with it, according to Jeff Rothenberg, Executive Director.

Participants in one work group on "A Day in the Life of a Patient" urged, however, that the new environment should be used to its fullest.

It can develop that way "if we're able to let go of one perception, to let this happen," said Jane Winterling of Vermont Psychiatrics Survivors.

Michael Sabourin, a Patient Representative, suggested more use of the outdoor courtyard and recreation space than the draft plan showed.

"Are there people who can go to the yard by themselves" without it being part of a group activity? Winterling asked.

Rothenberg agreed that it was important to "look at what we want it to be" in the future, even if more structured planning was needed at the start in order to assure safety. "There need to be enough staff to do that," he added.

He said the leadership team was looking at a model that assigned staff by location, rather than by specific individual, which would increase flexibility. "It is a different way of thinking for staff," he said.

Cathy Rickerby, a parent, reminded the group that the design was intended to allow for walking space around the full corridor that circles the interior office and program space.

Visiting should be "as flexible as possible," said Ruth Grant, another family member.

The draft plan has limited formal visiting hours, but individual needs would be accommodated, as they were in the temporary Morrisville hospital, Rothenberg said.

In mid-May, the new hospital budget received final funding approval from the legislature. The budget is double that of the state hospital that operated in Waterbury, and approval came with a requirement to justify the budget and to establish clear outcomes for patient care by July 1.

The Department defended patient-staff levels as necessary in part due to the large amount of space, multiple rooms and small unit design that will increase supervision needs.

The budget language requires "criteria by which to determine the appropriate staffing level at the Vermont Psychiatric Care Hospital... [including] sufficient direct care and administrative and support staff... to provide effective treatment services in an environment that monitors patient care and the safety needs of patients, and aligns with the guidelines of the federal Centers for Medicare and Medicaid Services."

A written report must "justify and demonstrate the need for each of the administrative and support staff included in the plan, with the goal of limiting positions to those that are essential to meet the needs of operating the hospital."

The Department of Mental Health must also "identify desired outcomes, performance measures, and data requirements to measure whether the hospital is achieving the stated outcomes for patient care and the effectiveness of treatment services, patient monitoring, and safety requirements." AD

Animal Sculptors Hope To Aid Patient Recovery

(Continued from page 1)

with realistic animal carvings. We just knew that patients, especially vulnerable ones, would form connections with this art."

Ritchie explained that the concept developed in group brainstorming and that her sculpture idea "incorporated replicated items on benches and found that it would be appropriate as part of this idea as well.

A Deeper Purpose

The symbolism of the animals is strong. Wickenheiser's piece is a stone fountain with two bronze otters. It will be featured in the hospital's inner courtyard. "I chose a boulder that was excavated from the building site, boulders lend themselves toward fountain design.

"The idea of rehabbing something from the site sits well with me, and working with water as this fluid fixed feature is a wonderful addition to a carving of animals who live in the water," Wickenheiser said. He said he chose otters for their liveliness and companionship, especially holding hands when sleeping together.

Ritchie's benches include one with a small kitten; the other is "a beaver lodge bench," she said.

"It hosts a single beaver working on its lodge. The beaver is life-sized and the lodge has a cut-out seated space able to accommodate two people. This design came about as a result of brainstorming sessions.

"The beaver is native to Vermont, wild yet non-threatening, and possesses qualities that are aligned naturally with the healing process: they are productive, industrious, active, demonstrate strength, and their mission of repair is constant."

Miller is also working on two pieces. "The smaller is a bench with a carved fawn," he said.

Collaboration came through in his other piece, the Habitat Tree. While the other art will be set throughout the hospital, the tree and its creatures will be visible to the public by the hospital's entrance, and is a broader portrait of Vermont fauna.

Miller says that the piece is "…sited among some natural boulders, something that appeared to have occurred there organically. Together we came up with a Sugar Maple.

"The remains of a once-massive tree carries the animal theme of the interior sculptures. There is a squirrel on one side, a rabbit sitting on a fallen branch, an owl hiding in a hole on the tree, several birds and a shoot of new growth."

Wickenheiser is crafting a finch and a sparrow in bronze that will hang in front of the habitat stump. As an artist, he says "Bronze and stone are age-old companions." He chose birds because, "Through song and flight, birds have always captured my affections and imagination."

Mays' assignment was to create two dog sculptures to portray "man's best friend," and how dogs serve as therapy companions because of their temperament and unconditional love.

"I was happy to carve dogs, since I am a veterinarian's son and a life-long dog-lover. One of the pieces is an English bulldog puppy, and the other is a border collie-type mother dog with a puppy.

Artists' Hopes

As artists, they share hopes for the impact of their pieces.

"I hope it simply creates a safe space for patients to spend some of their time. And maybe as they move beyond their care at this facility, that this artwork has made a contribution to well-being," said Miller.

Ritchie added, "We are hoping to communicate a feeling of companionship. Our intent is that the sculptures create a calm, safe and welcoming engagement for patients, staff and visitors."

Mays said, "Hopefully, the pieces will provide some of the benefits of spending time with actual dogs, as well as the appreciation of an art piece. I sincerely hope that the works do bring some comfort to the patients, their families and the staff of the hospital."

Wickenheiser added that "the team expression of this collaboration is to take the outside natural view of animals (with emphasis on local) and bring that indoors in a safe and playful way, to where there might be friendship between art and viewer... Ultimately all I hope to achieve is to bring a little bit of happiness, joy to someone, for them to say 'that's nice, I like that.'"

From Linda Corey, on Her Departure As Executive Director of Vermont Psychiatric Survivors

This note is to all the people who touched my life working at Vermont Psychiatric Survivors:

My only hope is that in my time at Vermont Psychiatric Survivors, I have made a difference.

I am proud to be a survivor in the true form, and not sold out on the survivor principles or history.

It was through mentors and people I saw as heroes that I have received guidance. I especially want to thank Beth Tanzman for giving me the opportunities she did, Patrick Flood for his patience with me as we discussed many issues on many state positions, and Brian Smith for his patience as we discussed the homeless problems and the teaching he provided there. Next would be Linda Chambers, who I learned so much from as we worked together on the Safe Haven Project, and Nick Nichols, who started at the Department of Mental Health the same time I started at VPS. We spent long times together developing consumer grants and at state meetings. Also, my fellow student graduates at Trinity. We have worked long and hard to do systems change. The VPS staff who are dedicated to the work they do. Mary Ellen Copeland and Sheri Mead for all the hard work they have done on training. Dan Fisher for his great work nationally and all the support he supplied to me. Also, I must mention the other survivors and independent advocates like Laura Ziegler, Bill Newhall, Xenia Williams and Morgan Brown. I will always remember the conference in Montpelier and your bravery in picketing. I admire your courage and dedication to the peer movement. Keep up the fight. I am sure I will be seeing you around.

At this time I am told I will be transitioning out of VPS at the end of June. There will be new leadership coming on board. However, I will not be out of the advocacy movement. So you will be seeing me around. If you wish to have my home contact let me know and I will share it.

Again, I am proud to be a survivor and not selling out on the principles. Remember, "Nothing about us without us."

Linda Corey

New Drugs Bill Changes

(Continued from page 1)
hearing, the condition is seriously worsening, and more time is not likely to result in progress on building a therapeutic relationship or in regaining the ability to make decisions.

Paquin said that DRVT agreed that "society has a right to protect itself if an individual is presenting a real danger," but he said that "society has a long history of abusing individuals in the name of treatment and of using their mental illness as an excuse for restricting the right to decide their own fate."

"It is likely true that medical intervention, perhaps even by force, may prove beneficial for some, but in our country the state is not supposed to constrain one's civil rights without the due process of law."

Paquin said the only positive aspect is that "one part of the new law does try to address the issue of individuals in crisis being held without legal protection in emergency departments for long periods of time."

That part of the bill recognizes that a person is in the temporary custody of the Commissioner of Mental Health, and rights begin, from the time the person is involuntarily held at a hospital.

It also requires a court review of an application for involuntary treatment within three days after a hospital files the paperwork. The court must assess whether there is adequate cause under the legal standards for a person to be held in the hospital.

Sen. Jeanette White, the lead sponsor of the bill, said she felt that addressing problems with the existing law was overdue.

"It is such a personal and emotional issue, the conversation has been avoided… As we saw more and more people with a mental health crisis being admitted to hospitals… and sitting in emergency rooms for days, it seemed we needed to start the conversation, even though it was hard," she said.

"To be clear, it is almost always better to not use [involuntary] medication, but there are times when it is necessary and we need to acknowledge that," White said.

"Our hope is that this will serve Vermonters in crisis in a more humane and just manner... In the end I believe it is a good bill that will serve Vermonters well."

Paul Dupre, Commissioner of Mental Health, said that "DMH's hope is that mental health patients will get timely court hearings and treatment when they lack the capacity to make that decision for themselves."

He said the current wait time from admission to a psychiatric unit, court application for involuntary treatment and then sometimes involuntary medication is about 70 days.

"This bill has found a balance that will shorten this average while protecting each person's civil rights," he said. "This bill clarifies the judicial process for all involved."

Olson said that hospital clinicians "highly value voluntary treatment" but recognize a reality that there may be a few people who may not "regain competence or form a therapeutic relationship with their providers without medication, while at the same time their condition deteriorates as time passes."

She said that the hospital association also supported the changes that start the court process, including legal representation for individuals, as soon as possible.

The new law requires a psychiatric evaluation within 24 hours, and it directs the Department's Commissioner to obtain psychiatric services for patients while they are awaiting inpatient placement, she said.

"That is a tall order but an effort we think is worth pursuing collaboratively," Olson said.

She said she expects that the Department of Mental Health and the Legislature will review the impact of the bill over the course of at least the next two years and that effort may bring additional changes, either in law or implementation.

Koch said as an overview that the bill "will shorten the time it takes for courts to consider whether to order the extremely serious step of involuntarily committing a person to a mental hospital, and the even more serious step of medicating a person over the person's expressed objections."

He explained the process in the new law that begins with arrival at a hospital when a physician determines the person is a danger. The person must then be examined in 24 hours by a psychiatrist, "not 'within one working day'" as stated in the current law. One working day can mean as many as three days over a long weekend.

A person can be held in temporary custody for an additional 72 hours for a choice to be made for release, a voluntarily admission, or a decision to begin an application for involuntary treatment.

The time requirements no longer depend upon whether a hospital admission has occurred. As a result, Koch said the bill will end the practice of "holding people involuntarily in emergency rooms without legal process, by doing repeated exams... thus extending the 72 hour 'hold.'"

If an application for involuntary treatment is filed in court, a judge then has three days to find probable cause in order for a patient to continue to be held involuntarily, Koch explained.

Under current law, a hearing is scheduled to determine whether the person will be committed, and a petition for involuntary medication can be filed with the court only if a commitment order is issued. The first hearing is scheduled to be held within 20 days, but is often continued to a later date.

The new law will allow the commitment hearing and the medication hearing to be consolidated in some cases, Koch said. That will allow the process to move more quickly. In addition, in some situations, the commitment hearing itself will be required to be scheduled within 10 days.

Koch said the process is intended "to create a balance between respect for a person's autonomy and the need for appropriate treatment when a patient is refusing treatment." Due process is honored at each step "so that a court, not the medical establishment, is the final arbiter of when a patient's objections may be overridden."

Koch said that the need for a change in law was clear. "The problem is real: people going untreated or unsuccessfully treated for weeks, even months, because in their illness, they are resisting treatment. That's inhumane," he said.

"While we fully respect the wishes of a person who is competent to decide the treatment he or she will accept, it's wrong to neglect a person who lacks competence."

He also cited taking care of available resources, such as hospital beds, as another crucial aspect.

"We have a shortage of beds for mental health treatment; if a person could be improved with treatment, which may include medication, and then moved to a lower level of care — or even returned home — that will free up a bed for another person who is waiting for a bed.

"Right now, we have people waiting in emergency rooms because appropriate inpatient beds are not available, and that is an intolerable situation."

One family member who followed the legislation asked not to be identified, but shared her hopes that the new law will make a significant difference for those in need of treatment.

"I think the bill will directly improve the plight and decrease the total suffering load of seriously mentally ill people who are involuntarily hospitalized in Vermont," she said.

She termed the delay until a court hearing "protracted mistreatment of people," describing situations requiring repeated emergency restraint and injections of medication when a person became violent while waiting for treatment. "Clearly this has been extremely traumatizing to him and also to staff and other patients who witness the events," she said.

She joined in the perspective that it will free up limited hospital beds, since those who are

Updated Legislative Intent Still Stresses Efforts Against Coercion

The new bill updated the statement of intent in the law. Sections (a) and (c) remain the same; (b) was added.

(a) It is the intention of the General Assembly to recognize the right of a legally competent person to determine whether or not to accept medical treatment, including medication, absent an emergency or a determination that the person is incompetent and lacks the ability to make a decision and appreciate the consequences.

(b) The General Assembly adopts the goal of high-quality, patient-centered health care, which the Institute of Medicine defines as "providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions." A substitute decision-maker is sometimes necessary to make a decision about care when a person is incompetent and lacks the ability to make a decision and appreciate the consequences. Even when a person lacks competence, health care that a person is opposing should be avoided whenever possible because the distress and insult to human dignity that results from compelling a person to participate in medical treatment against his or her will are real, regardless of how poorly the person may understand the decision.

(c) It is the policy of the General Assembly to work towards toward a mental health system that does not require coercion or the use of involuntary medication.

the Law

waiting for court-ordered treatment potentially are "tying up a 'bed' that other patients need."

The bill had review from the Senate Judiciary and Health and Welfare Committees, and the House Judiciary and Human Services Committees.

The Senate passed its version of the bill in February on a vote of 26-4 (see spring *Counterpoint*). That version allowed for the initial filing of a medication application to occur at any time.

When the bill reached the House Judiciary Committee in April, it questioned whether early filing, and the possibility of consolidation, would benefit the process.

Judge Amy Davenport, the administrative judge for the judicial system in Vermont, told them that although there were different issues being decided, there is factual overlap and both hearings require physician testimony. There could be some efficiencies as a result, she said.

A commitment — or "involuntary treatment" — order requires proof that a person has a mental illness and that as a result is a danger to self or others. An involuntary medication order requires a finding that the patient is not competent to make treatment decisions, and that the evidence supports a need for the medication being ordered.

The final bill limited the circumstances under which a medication application could be filed before a commitment. It also made it clear that even if a case is consolidated, the commitment decision must come first, and a finding of lack of competence must come before a decision about approving involuntary medication can be made.

Davenport was among those who provided extensive input during the legislative session. She warned legislators that lack of court resources could cause delay even if a law set out specific deadlines.

Both the Senate and House versions — and the final bill — put limitations on how easily a continuance can be permitted by a judge.

Unlike the Senate, the House did not hold a public hearing. Individual witnesses testified from the perspectives of community providers, hospital providers, advocates, and peers.

Among those to address the House Human Services Committee was Sarah Launderville, the Executive Director of the Vermont Center for Independent Living, who described her experiences with forced psychiatric care.

Launderville told committee members that it is difficult to understand what it is like to be locked up, and that to be forcibly medicated is a form of violence as well as of control.

The expansion of community support and peer services in the past two years means the system is "at a tipping point to create something wonderful in Vermont," which would be contradicted by creating a faster forced-drugging process, she said.

When the revised bill reached the House floor, it passed on a vote of 132-6.

Two House members gave formal comments to explain their votes. Rep. Kristy Spengler (D-Colchester) said, "I want to thank the Judiciary and the Human Services Committees for showing compassion toward our most vulnerable Vermonters by offering this bill."

Rep. Vicki Strong (R-Albany) explained her vote against the bill by saying, "S.287 is a step backward for appropriate mental health care in the state of Vermont. Involuntarily medicating a person is a violation of their freedom and personal autonomy. There are methods of care and treatment that could be available that are more humane and that help people recover in a more timely way. Our Department of Mental Health has failed those in mental health crisis. This bill does nothing to increase the number of resources available to those in need."

The final bill agreed upon by both the House and Senate committees was adopted by voice vote by both bodies of the legislature. The law requires that the first six months of data be reported to the legislature next February.

What the New Law Does

About Court-Ordered Medication: (takes effect July 1)

- If a person presents a "significant risk of causing serious bodily injury" to themselves or other persons in the hospital, despite hospital efforts to address the risks, a commitment hearing can be held in 10 days and combined with a medication hearing (current law is 20 days).
- If a person had court-ordered medication within the past two years and is not making progress on building a therapeutic relationship or regaining the ability to make decisions, a commitment hearing can be held in 10 days, with a medication hearing seven days later if the person is committed. (Current law to schedule a medication hearing is seven days after a commitment.)
- If a person has been in the hospital for a month without a commitment hearing, is not making progress on building a therapeutic relationship or regaining the ability to make decisions, and the condition is seriously worsening, a commitment hearing can be held in 10 days and combined with a medication hearing.

The law re-emphasizes that the Court must decide upon whether the person is competent before going forward with a medication hearing

A long-acting injection cannot be ordered by the court without clear and specific evidence that it is the most appropriate treatment for the individual patient under the circumstances.

An order ends when a person is found competent; the person's lawyer must be informed.

There are fewer ways to have an order put off during an appeal.

A person can agree to let the involuntary medication hearing go forward without being committed first, if the person wants to try to avoid having a record of a commitment.

About Involuntary Hospitalization: (takes effect November 1)

- As soon as a person is being held in a hospital, the Commissioner of Mental Health has "temporary custody" and is responsible for care that is in the least restrictive manner necessary to protect the safety of both the person and the public; respects the privacy of the person and other patients; and prevents physical and psychological trauma.
- A person being held for an emergency exam must be seen by a psychiatrist to confirm the need to be held involuntarily within 24 hours, whether or not they have been admitted to the hospital yet.
- Within three days after an application for hospital commitment is filed, a judge must review it to make sure there is reason to keep holding the person.
- Applications for commitment must give the specific alternatives that the doctor considered and why those alternatives were considered inappropriate, including information on their availability.
- If a hearing has not occurred within 60 days, the Commissioner must determine and report on whether the delay was warranted and if not, make recommendations as to how delays of this type can be avoided in the future.

About Rights of Patients:

- A peer or other person of the patient's choice can visit and attend treatment team meetings or court hearing; the right to reasonable phone access is extended to internet and to electronic mail.
- The Department must provide information on Vermont Legal Aid, Disability Rights Vermont, the mental health patient representative, and on available peer-run support services, for all persons admitted or being held for admission.
- Hospitals must give patients information about advance directives before discharge.

New Department of Mental Health Responsibilities:

The annual Department progress report must give updates on:

- ways in which patient autonomy and self-determination are maximized within the context of involuntary treatment and medication;
- outcome measures and other data on individuals for whom petitions for involuntary medication are filed; and
- progress on alternative treatment options across the system of care for individuals seeking to avoid or reduce reliance on medications, including supported withdrawal from medications.

The Commissioner must provide information to hospitals on the use of advance directives and other written and oral preferences about treatment, for education of hospital staff about the laws on following patient wishes.

The Department must provide a copy of the certificate of need to Disability Rights Vermont for all emergency involuntary procedures performed on a person in custody .

Hospitals must report staff injuries caused by a person in the custody of the Commissioner.

The Commissioner must prioritize the opening of Soteria House (an alternative treatment program) if it is ready to accept residents prior to January 1, and there are funds available in the Department's budget.

The Department and the Court Administrator must give a report next February on outcomes for the first six months under the new law.

Is Medication Overused?

Conference Speakers Raise Issues of Optimal Dosage And Why Playing the Violin or Reading Can Bring Better Results

by ANNE DONAHUE
Counterpoint

FAIRLEE — Two psychiatrists challenged conventional thinking on the need for high levels of antipsychotic medications in presentations at the annual conference of the Vermont chapter of the National Alliance for Mental Illness in May.

For Sandy Steingard, MD, the Medical Director at HowardCenter in Burlington, the issue is dosage. She presented what she has learned from working with patients to seek the lowest effective dose of an antipsychotic medication so that the benefits are not outweighed by the risks.

For Jim Hudziak, MD, the Director of the Vermont Center for Children, Youth, and Families at the University of Vermont College of Medicine, the issue is about how the environment acts to "turn on and off the genes" in the brain that affect behavior in positive ways, as well as negative.

His research suggests the possibility that what happens in the brain through learning to play the violin, for example, may be better than the use of psychopharmacology in addressing mental illness in children.

"Behavior comes from the brain," and so "it's a bit silly to have this [discussion] separated from science," Hudziak told the audience. The science demonstrates that the brain proteins that are needed for wellness can be increased by changes in the environment that "turn on the genome" needed.

Research to date has shown learning to play the violin, reading (or listening to reading), listening to classical music, singing, and participating in sports are all activities that change brain structures, he said. Diet and sleep are also key.

They can counteract the effects of adversity, such as trauma, which are factors in the environment that are toxic to the brain, particularly when it is young and still forming.

Hudziak said his formula for children with serious mental illness is to "taper them off their medications and do skill development" in those beneficial activities.

When one audience member asked whether it mattered that a person read, or was read to, Hudziak beamed and said, "I love it when the question in psychiatry is, 'Is it reading a book or being read to?' instead of 'Is it Abilify or Risperdol?'" Research is now looking at whether an increase in gene proteins that create risks to the brain might actually be a result of some psychiatric medications, he said. There is "emerging evidence it [the protein increase] might be associated with the medication itself."

Although Hudziak's work is with children and families, "this is for everybody," he said. The brain's ability to change — its "plasticity" — continues in adulthood, even though it "loses elasticity" for the amount of potential change.

He bemoaned the fact that modern culture closes out children who do not excel in certain areas, such as music or sports, when those are the children most in need of that particular skill development.

"Find the things you're not good at" and do them to turn on the right genes, he urged.

Steingard's presentation was specific to her clinical experience in working with patients to use antipsychotic medications at the lowest possible dose.

She said that "what people have been taught" is that antipsychotics are critical to treatment, not only in the short term, but over the long term, to prevent future problems. If a medication is not effective, dosing is sometimes increased "faster than it typically actually works," which means that less might have been effective if the increase had been slower.

Steingard presented summaries of research studies that question assumptions about the benefit of long-term treatment with antipsychotics. Treatment may sometimes delay relapse, but over time, relapse rates become similar, the studies show. However, persons on long-term antipsychotics often have poorer functional outcomes — the ability to do well in life.

Steingard said she believes that means the issue is how to balance the risk of relapse against the drawbacks of long term use. "We could do a lot of good" through moderating the doses used, she said.

In her practice at HowardCenter, Steingard now works through "shared decision-making" to raise that question with clients with whom she has worked for long periods of time.

Other professionals express the worry that "if you even raise this topic" people will abruptly stop taking medications and relapse. In fact, "the sky doesn't fall in," she said. Her review shows that about a quarter of patients choose to make no change. More than half have maintained a slow tapering of medication, about 10 percent started a taper but then discontinued it, while fewer than 10 percent made an abrupt stop.

Steingard said her conclusions from use of her tapering protocol have been that the most common problem is a "transient increase in symptoms"; that need for a hospital level of care in response has been very infrequent; and that among clients, those with a diagnosis of schizophrenia are less likely to request a taper and also less likely to discontinue medication abruptly.

Validity of Consent Challenged For Those Who Lack Capacity

MONTPELIER – The March Transformation Council agenda included a brief debate on how to protect persons who agree to take psychiatric medication but do not have the capacity to give informed consent.

Although there is a court process for patients who object to medication, the law does not address how informed consent is given when a person is not objecting.

Wendy Beinner, Executive Director of NAMI-VT, said that it had "always been concerning to me" when there are "people who are taking medication who don't know what they're taking." The law requires that individuals "have to be able to give informed consent" for medical treatment.

Beinner said she felt it was hard to believe that every psychiatric hospital patient who agreed to take medication voluntarily had the capacity for informed consent.

Jack McCullough, who directs Legal Aid's Mental Health Law Project, defends patients in court if there is a petition for involuntary medication. He said that every day that a court petition is pending that claims that the person lacks competence, such patients are being offered medication as if "all of a sudden" they regain the ability to consent if they agree to take the drugs. Giving someone treatment without consent is assault or medical malpractice, he said.

In the hospitals, "the working definition of competent to accept medications is willing to accept medications," McCullough said. In some cases, a person might be "voluntarily taking 20 milligrams [of a drug]," but based on the petition to the court is "not competent because [of] not taking 40 milligrams."

That brought a strong response by Jill Olson, representing the Vermont Association of Hospitals and Health Care Associations, denying the statement. She said physicians at the hospital are very careful about the issue of consent.

Council member Ruth Grant argued that in other types of medical care, treatment is provided based upon a patient's agreement, not based upon whether they are capable of informed consent.

Other Council members disagreed.

Commissioner Paul Dupre offered no comments. He said that he put the issue on the agenda because there were persons who wanted a discussion, but the Department has no plans for any actions or policies on the matter. AD

National Empowerment Center News

Lived Experience Dropbox and BU Site

The Lived Experience Research Network (LERN) team has created a shareable "dropbox" folder of journal articles and measures of potential use to activists, service users, survivors, students and researchers. Go to lernetwork.org and search "Dropbox."

The Boston University Disability Research Right to Know website has information at bu.edu/dark/

Suicide Attempt Survivors Blog

The American Association of Suicidology recently announced the creation of "a new division to represent people with lived experience as suicide attempt survivors and the people who love and care about them." AAS also features a blog, "Life after Suicidal Thinking," at attemptsurvivors.com.

Second Video on Recovery Released

The Café TA Center has announced release of the second video in its ongoing series, Recovery Stories. This series of videos, all of which were assembled from interviews of people with lived experience of mental health challenges at Alternatives 2013, provides a platform for people to share their individual experience of mental health recovery. New and old episodes can be found every week Café TA website, Cafetacenter.net/

IT'S LIGHTS, CAMERAS, ACTION as peers clap with Governor Peter Shumlin and the news media films at the signing ceremony for a new statute that updated Vermont laws to use respectful language when referring to disabilities. Examples of changes include replacing "insane," "mental deficiency," incurable insanity," "unsound mind," and "lunatic" with "mental condition or psychiatric disability," and "mental retardation" with "intellectual disability." The four year process that led to the bill signing included work by a stakeholder group reviewing hundreds of pieces of law to recommend new wording. (Photo Courtesy Office of the Governor)

Housing First Funding Saved

One-Year Special Status Will Maintain Current Clients

MONTPELIER – Pathways Vermont, known in particular for its Housing First model for services, has been temporarily granted a status by the Department of Mental Health that will allow it to receive state Medicaid funds for its budget this year.

At least one of the Pathways programs was at risk of closing down this fall because its federal grant was coming to an end. That program will now be funded to continue services for its existing clients under a direct contract with DMH.

"The model is phenomenal," said Cathy Rickerby during public comment at one stakeholder meeting to provide input. "The more options there are on the table, the better off we are."

Commissioner Paul Dupre announced in May that he was approving a conditional "Special Services Agency" status for Pathways. The agency will have to show it can meet other requirements for the status to continue beyond this year.

Only designated community mental health agencies can receive state Medicaid funds unless the special status is approved, and those agencies expressed concern that their programs might be cut in order to make money available for Pathways.

Pathways Vermont is the first adult mental health program to receive the conditional designation.

The Department heard testimony from around the state supporting the work of Pathways and urging that the Commissioner take the steps to authorize it to become eligible for Medicaid funding.

Prior to the full public hearing, the State Standing Committee on Adult Mental Health had its own discussion and voted 2 to 1 with one abstention in support of the new designation status.

The Housing First model is based upon not requiring someone to accept social services before helping them to access housing, Hilary Melton, the Pathways Executive Director, told the committee.

"For recovery to happen,someone needs stable housing," said Maura Collins, chair of the Pathways board. Regardless of the types of challenges people are facing, "I can always bring it back to housing."

She said that the model is ending chronic homelessness across the country, and she presented statistics from Vermont showing dramatic reductions in psychiatric hospitalization, corrections, and emergency housing in hotels for clients in the program.

The legal requirement for receiving status as a Specialized Services Agency is that the services it provides are unique from those offered by designated community mental health agencies, so that it is not competing with or duplicating the work of the community mental health agencies. They must be services that are not available from, or cannot be developed by, the existing agencies.

Dupre's announcement said that he found that Pathways Vermont "presents a housing and treatment option that is different from what the designated mental health agencies provide."

Malaika Puffer said that there was "value in having something that doesn't have the designated agencies' name on it" on behalf of clients who feel they had a negative experience at an agency.

Collins cautioned that "I don't want to get into an 'us versus them'" in terms of what the existing agencies do. "We're never going to succeed if it's [between] Pathways or the DAs."

"It's not a trade-off," Collins said. It is "an alternative to the great work the DAs are doing."

However, if a client's relationship with an agency is broken, there is "nothing left" for that person, Collins said. "Rightly or wrongly, there are people out there" who feel that "the DAs don't work for them… We allow people choice."

Clare Munat, co-facilitator of the committee, said she didn't think Pathways created a duplication of services, because housing "is such an overwhelming need," but she asked the Commissioner of Mental Health, Paul Dupre, about the financial impact of having a new agency competing for funds. "How much money is this going to take out of the DAs' budget?" she asked.

"This year, none," Dupre answered, because the agencies already have their funding established in this year's state budget. In future years, "Pathways would be part of the mix" of service agencies seeking funding for their work, he said.

Committee member Marla Simpson said her support for the program came from her own experiences. "Homelessness is traumatizing and embarrassing and stigmatizing," she said. As an employee of Pathways, she abstained on the vote.

Committee member Brooke Hadwen voted against support of the project. She once held the position of a police social worker in Burlington, and said that "they're not a team player" with other social service programs and "not very responsive" to complaints about their clients.

Melton, the Director, said that it required client consent to talk with other providers. While she understands that "it's a difficult time [in a community] when people are struggling," Melton said that emergency services are unaware of the majority of clients who are doing well, because they don't hear from them.

The DMH announcement said that it will "undertake a full evaluation of the Pathways' capacity to meet all of the designated special services agency requirements in the upcoming months."

In the meantime, the conditional designation will "ensure that they [Pathways] continue to provide services to eligible individuals who currently receive mental health treatment services from them." AD

New Guidance To Come On Emergency Med Rules

MONTPELIER — The 2012 law directing the Department of Mental Health to create uniform rules for emergency procedures at psychiatric units will be reviewed this year by the legislature's Mental Health Oversight Committee.

The rules were never put into effect after they were rejected last fall as failing to meet legislative intent. Commissioner Paul Dupre later wrote to legislative leaders to say that the Department needed guidance about the requirement that the rules protect patient rights to at least the same level as at the former Vermont State Hospital.

This spring the legislature directed that its summer oversight committee "identify a list of policies that may require clarification of legislative intent in order for the Department of Mental Health to proceed with rulemaking" and to make recommendations as to any legislation needed in 2015. AD

Prisoners Present Growing

by DONNA OLSEN
Counterpoint

Taking care of those with mental illness in Vermont's prison system is a huge challenge for the agencies, staff, medical and mental health providers and correctional officers involved. Mental illness, drugs, and violence have contributed to the incarceration increase in Vermont's seven prisons.

There are issues with funding, staffing, and inadequate capacity to deal with the growing population of those with mental illness who are incarcerated. Some see the changes in access to psychiatric institutions of the past as a key cause of today's challenges.

"People wonder about these horrific mass murders that we have. Well, 30 years ago a doctor could talk to some crazy man like me and say, 'I'm a little concerned about him. I am going to commit him for an evaluation.' They can't do that now. It literally takes an act of God," said P. Mark Potonas, the Superintendent of the Southern State Correctional Facility (SSCF) in Springfield.

The provider perspective is the focus for this first in a series of articles on mental illness in Vermont prisons. (Subsequent articles will provide the perspective of advocates and of those experiencing the system.) Potonas runs the facility that takes prisoners from all over the state for medical and mental health services. What sets the Springfield facility apart from the rest is its mission.

"We have a specific mission to house and deal with mental health as well as deal with medical issues. This is a very unique facility. It was built with a different outlook than other facilities," said Potonas.

"Because of the level of care that we provide here, we have inmates transferred here for medical stabilization, medical long-term care, acute medical care and mental health stabilization and acute mental health care. [As] acute as we can provide in the Department of Corrections (DOC).

"None of the other facilities have a mental health unit," he said.

There are currently approximately 212 inmates carried on the mental health caseload at Springfield. Of the 212, sixty are listed in the category of being "severely functionally impaired," which is a designation about a person's ability to function in Corrections.

Dr. Meredith Larson is the Director of Mental Health for all the prisons across the state of Vermont. "What it means to be on the caseload is that they are receiving some kind of care for some kind of mental illness. But that doesn't necessarily mean that each of them is getting intense mental health services," she explained.

"It may be psychiatric medication or group treatment. Each person has an individualized treatment plan which sets out what their prognosis and goals are and what kind of treatment they will be participating in," said Larson.

She said that one of the problems facing Corrections staff is whether prisoners are willing to participate in a medical treatment plan. Some inmates refuse to take the medications prescribed. Others do not engage in their treatment plans to reach the goals of that treatment plan.

The treatment plans are not a one-size-fits-all program.

"It can't be, by our nature. We work for the Department of Human Services, but we are Department of Corrections. People are here because they violated the law. Because the judge sent them here," said Potonas.

When the judge orders that a defendant have a psychiatric evaluation at a hospital, but there are no beds, they are often sent to Springfield or one of the other correctional facilities in the state.

Larson explained that procedure to *Counterpoint.* "The judge will say you need to have a

Taser Bill Passes; Police Training Required

MONTPELIER — Standards for the use of Tasers will be developed into a statewide policy that all law enforcement agencies must adopt under a bill that passed the legislature this spring.

All officers carrying Tasers will be required to be trained initially and then annually in Taser use. Taser is a brand name for an electronic control device which shoots probes into a person to create uncontrolled muscle contractions.

The law requires special attention to "the potential additional risks" of "situations involving persons who are in an emotional crisis, that may interfere with their ability to understand the consequences of their actions or to follow directions."

The bill was introduced after the death of MacAdam Mason of Thetford in 2012. Mason was shot by a state police officer with a Taser after he had called a medical center for help with a mental health crisis. The officer said at the time that he believed Mason was threatening him.

Mason's mother, Rhonda Taylor, issued a statement thanking the legislature and advocates, saying that she believed that, "Had the standards and training been in place in June of 2012, my son MacAdam Lee Mason would not have been killed by an unwarranted police tasering."

A separate section of the law requires all police to have completed the current one-day training for interacting with individuals having a mental health crisis by July of 2017.

The introductory training is already provided to new officers in the police academy, but many older graduates have not received it, according to the annual Act 80 committee report.

The Criminal Justice Training Council was also directed to coordinate training initiatives with the Department of Mental Health related to law enforcement interventions, training for joint law enforcement and mental health crisis team responses, and enhanced capacity for mental health emergency responses.

Vermont is believed first in the nation to adopt statewide regulations, according to the state branch of the American Civil Liberties Union.

The ACLU summary of additional provisions of the bill included:

•Statewide policy adoption: The state's Training Council will develop a policy on Taser training and use that must be adopted by all Vermont police departments by Jan. 1, 2016. If a department doesn't adopt the policy by that date, the policy will be assumed to have been adopted by the department.

•Revised deployment standard: "Officers may deploy an electronic control device only against subjects who are exhibiting active aggression or who are actively resisting in a manner that, in the officer's judgment, is likely to result in injuries to themselves or others."

•De-escalation stressed: Officers must attempt to de-escalate situations before using a Taser. The weapons can't be used in a punitive or coercive manner and may not be used for passive resistance.

•Annual reporting on Taser use incidents.

•Request for study by Law Enforcement Advisory Board of body camera use by officers authorized to carry Tasers and a policy by the Board on the "calibration and testing of electronic control devices."

Along with recognition for persons in an emotional crisis, the standards will require special attention to "persons with disabilities, whose disability may impact their ability to communicate with an officer, or respond to an officer's directions" and to "higher-risk populations that may be more susceptible to injury as a result of electronic control devices."

It requires compliance with all recommendations by manufacturers for the reduction of risk of injury, including situations where a subject's physical susceptibilities are known.

According to the ACLU report, the road the bill traveled went back to when it joined with mental health advocacy groups and individuals for a press conference in June of 2012 following Mason's death.

Taylor's statement said that it was "difficult to know where to begin" when there were so many to thank for the legislation.

"I am grateful to the legislative committees in Vermont for their hard work and dedication... Many advocates for civil, disability and human rights, legislators, LEAB [the Law Enforcement Advisory Board] and concerned citizens came together, working relentlessly over many months, to create this meaningful bill. Thank you!"

TASER TESTIMONY — Members of the House Government Operations Committee take notes during the testimony of Allen Gilbert of the American Civil Liberties Union of Vermont this spring. (Photo Courtesy Morgan Brown)

Mental Health Care Needs

psychiatric evaluation to determine whether you are sane and competent. And the judge wants that to be done at a psychiatric hospital. But when there is no bed available, then they come here to wait for beds.

"So it is not that the judge is saying you are required to have treatment — we provide treatment because the law says that we will. And it is practical in terms of managing and because it is ethical," said Larson.

Potonas told *Counterpoint* that the prison does not force medications. Staff attempt to convince inmates to take their medication.

"We use verbal skills. We will do just about everything except tap dance to get them to cooperate with medical care and medication," he said.

The Alpha unit houses ten beds and is used to stabilize mental health patients. It has segregation cells. The Bravo Unit is a mental health transitional unit with 10 beds.

The Charlie Unit is a long-term-care unit which houses the growing elderly population of inmates and has 28 beds. The infirmary is a medical unit for acute care and has ten beds.

SSCF is the only facility with a mental health unit. That leads to the question of prisoners at other facilities. Are they not receiving mental health services?

"I wouldn't say they are not receiving services. There is a medical and psychiatric staff at every facility. There isn't a transitional unit like the Bravo Unit," said Larson.

"The fact is that most people who are being treated for a mental illness condition can live successfully in [the] general population without having to be in a special unit," she said.

"People are not here because they have a mental illness, because [saying that] does a huge disservice to all those who do have a mental illness that have not been involved in criminal activity.

"But the people who are here are a complicated combination of criminal issues, personal background issues, mental health issues, economics and education," said Larson.

Vermont's heroin and opiate crisis has been brought to the forefront in recent months after Governor Peter Shumlin made it the topic of his State of the State address.

While the heroin crisis is creating havoc and crime in the community it also has become a huge part of Corrections' day-to-day operation. Larson said that the heroin addiction is a far more common condition for people who are coming into prison than two or three years ago.

"In all the facilities, detox is just part of the day. It's something we take very seriously. It's a threat to life and it's also a threat to safety, both the officers and the staff," said Larson.

After Springfield, the next newest prison facility in Vermont is in Newport, which was built 20 years ago. The other facilities were built with incarceration in mind and do not have the space for the kind of medical and mental health units found at SSCF.

Across the country, prison systems have become focal points for mental health treatment. The Los Angeles County Jail is sometimes called the country's largest mental health hospital, with the second largest being the Cook County Jail outside of Chicago.

"These are facts," said Potonas. "Prisons have taken over the place of mental health asylums all around the country because someone decided that it was an infringement on someone's civil liberties in the 70's and they started closing them.

"So it's a historical thing that's taken its toll on society. Now it's starting to come back and bite society in the butt.

"So where are your civil liberties and who is protecting them?" he asked, pointing to his example of mass murders.

Larson says that if there is one thing "Santa" could bring them, it should be a forensic psychiatric unit: "One where we could deliver the highest level of psychiatric care [for those] who are potentially violent who must be incarcerated," she said.

Work With Us, Commissioner Urges

MONTPELIER — Saying that he believed the "window is closing" on keeping legislative support for an expanded community system, the Commissioner of the Department of Mental Health urged stakeholders this spring to work together to make it successful.

"This next year is crucial," Paul Dupre told members of the Transformation Council. "We talk about respect, but do we respect each other? Respect... means all of us."

The Commissioner said that while a change in culture to move further away from a hospital-based system took time and patience, legislators who make budget decisions want to see outcomes. "We're going to have to go [back] and show some results" for "backing and support to continue" for the community programs created in 2012 by Act 79.

Dupre said he was optimistic about achieving change, but that "we've really got to [reach] every place we can to make it work."

When those representing different viewpoints "demonize" others as though there were plots to deliberately cause damage, it hurts the ability to focus on progress, he said. "In our efforts to save the world, we forget the people right next to us," also working for change, he said.

Dupre said that it was crucial to "have enough things in the community so that recovery can take place in the community." Although hospital stays are much shorter than they were years ago, they "still function to some degree" in a model where "people get stuck" at a higher level of care than they need.

"Part of the key" is that "people need to be able to move" so that hospital stays are even shorter. "We judge our success and failure over a very few number of people" by focusing on inpatient care, he said. He pointed to the 24,000 adults and children being served by the department in the state, with only an average of 600 receiving involuntary hospital care, and only about 300 of those in the Level 1, highest-need category.

While no one at the meeting disagreed directly, Ed Paquin, Executive Director of Disability Rights Vermont, said that the effort to change the law and speed the process for involuntary use of medication was giving exactly the wrong message to the legislature.

It tells the public that "the biggest problem with our system is that we're not drugging people fast enough," he said. "I find it to be almost a self-defeating thing" to be putting energy there.

Michael Sabourin, a patient representative, said that the efforts to strengthen recovery in the community should not mean that hospitals should not be accountable.

"We can't let the hospitals off the hook" for appropriate care, he said. He pointed as one example to references to treatment team meetings including patients, when that does not occur at all the hospitals. "We need standards of care" across the state "that are recovery-oriented," he said.

Kitty Gallagher, also a patient representative, said education for doctors needed to be the starting place. If someone is in the hospital emergency room with a broken leg, "they ask your opinion" about your needs. If someone is there for a mental health crisis, they assume you have nothing to offer and "they don't ask." AD

TBI Defense Could Result In Mandatory Treatment

MONTPELIER — A new law both keeps the criminal defense of incompetence for persons with traumatic brain injury (TBI), but also allows for mandatory treatment if needed.

The bill passed the legislature this spring. It was introduced by Rep. Warren Van Wyck of Ferrisburgh, who said he had heard from his local State's Attorney about an individual with a serious TBI who was not being charged with a criminal act, as he could not be prosecuted and there was no law to order treatment.

TBI has been added to intellectual disabilities as a diagnosis which can result in commitment to the custody of the Commissioner of the Department of Disabilities, Aging and Independent Living if a person charged with a crime is found to be incompetent to stand trial, but a danger to others without supervision.

The new law does not take effect until 2017.

In the meantime, the bill directs DAIL and the Vermont Association of Sheriffs and State's Attorneys to gather information on current practices regarding arrest and prosecution.

The Court Administrator must report on the number of defendants examined to determine whether they were insane at the time of the offense or incompetent to stand trial, including a breakdown of how many orders were based on mental illness, developmental disability, and traumatic brain injury, and the number of persons who were found to be in need of custody and care.

DAIL must also develop "best practices for treatment of persons with traumatic brain injuries who are unable to conform their behavior to the requirements of the law, and in identifying appropriate programs and services to provide treatment to enable those persons to be fully reintegrated into the community consistent with public safety." The status report is also required to include the Department's progress on the design of the programs and services needed to treat persons with traumatic brain injuries found incompetent. AD

Point→

A New Exploration of Integrative Mental Health:

By DONNA OLSEN
Counterpoint

WOODSTOCK — A new online resource called Integrative Mental Health for You (IMHU) is promoting healing practices that integrate body, mind and spirit while minimizing the use of psychiatric medications.

The website, imhu.org, describes goals of providing information to enable mental health consumers to "make well-informed choices to optimize mental health and decrease negative side effects of treatments," and to add to the knowledge base of practitioners.

The site stresses the role of spirituality in mental well-being. The organization is funded by the nonprofit Foundation for Energy Therapies, Inc.

Based in Vermont, IMHU offers online courses at low or no cost as well as an audiovisual library, an article archive and a blog, according to Emma Bragdon, PhD, executive director and founder of IMHU.

In an email interview this spring, Bragdon shared perspectives on the philosophy and purposes of the initiative.

1. Why is it important to bring spirituality into mental health care?

We have recently been treating most mental disturbance as if it is a biochemical problem within the brain even though we have no biomarkers, no physical proof of that notion. In the process, we have forgotten the psychosocial and spiritual components of mental disturbances that need attention.

The quest for meaning and purpose is a spiritual quest. It takes us into answering questions such as "Why am I here on Earth? What is best for me to do with my life? Where do "I" go when I die? Is there anything more after this life in a body? How can I put some meaning to the trauma I have had and then move on to create a more positive life?"

Answering these questions and aligning one's actions with one's own sense of purpose is a tremendous source of peace and fulfillment. Not answering the questions and aligning with one's true purpose feeds anxiety, depression, fear and confusion. So, if we want to assist people towards being at peace with themselves we need to support an individual's sense of meaning and purpose in life.

In addition, research shows us that spiritual practices, like mindfulness meditation, lead to less depression, less anxiety, more peace, more healthful lifestyle choices, and longer lifespan. These outcomes are enhanced by membership in a spiritual community that is personally meaningful. Thus, bringing spirituality into mental health care can have a tremendously positive effect.

2. Is IMHU focused primarily on providing information to practitioners or mental health patients? Can mental health patients access online courses and the audiovisual library?

IMHU is for anyone who wants to improve or optimize his/her own mental health, help family members to do the same, or help clients/students/patients to create lives of physical and emotional wellness. Shouldn't we be teaching kids the building blocks of emotional well-being just as we teach them the building blocks of physical education?

The courses IMHU offers are available to anyone who wants to learn. We are currently charging money for the courses. In the future we hope to offer some coursework for free so no one is denied education because of financial stresses. Currently, we have articles and unique video interviews with experts in the field that can be downloaded for free.

I do think it is important to remember that trauma is often an originating catalyst of mental distress and when people heal from trauma they are often relieved of the symptoms of mental distress.

3. The website identifies the causes of mental health issues in trauma and unmet needs for spiritual growth. Could you elaborate on this perspective?

Yes, these are two causes of mental health issues. There are other causes as well; for example, allergies, inadequate nutrition, need for particular naturally-occurring micronutrients, and systemic imbalances (e.g., hormones).

I do think it is important to remember that trauma is often an originating catalyst of mental distress, and when people heal from trauma, they are often relieved of the symptoms of mental distress.

Unmet needs for spiritual growth and spiritual community is rarely acknowledged as a component of mental disturbance — but many people find that when they find a meaningful connection to spiritual community that supports spiritual growth it helps diminish anxiety and depression and creates a doorway to satisfaction.

4. IMHU also advocates for a cautious approach to the use of psychiatric drugs. Could you say more about this stance?

Recent meta-analysis of research concerning the effectiveness of psychiatric drugs indicates the negatives inherent in long-term use. Robert Whitaker, Peter Breggin, MD, Marcia Angell, MD, Peter Goetzche, MD, are a few of the authors who have clarified that psychiatric medications are useful in some situations, but that does not mean they are useful in all situations, or for all people, or in the long term.

A close look at research of pharmaceuticals reveals that long-term use can lead to organic problems and a breakdown in rational thinking. It seems very obvious that we need effective alternatives to psychiatric medications that actually help people heal and do not have such terrible side effects as most of the psych drugs have. Health providers and consumers need to be informed about effective alternatives to meds. This is what IMHU is trying to do.

Counterpoint

A Forum for Exchanging Viewpoints

The Role of Spiritual Growth for Optimum Wellness

5. How does your interest in Spiritism tie into the creation of the IMHU?

I discovered Spiritism when I was invited to teach in Brazil in 2001. Their community centers provide personal development courses, energy work (similar to Reiki), meditation and prayer groups, fellowship, and organized charity to 20-40 percent of Brazilians — without asking for membership or conversion to any religion. Brazilians go to these ecumenical centers when they want to enhance their spiritual lives, build supportive relationships, heal from emotional or physical illnesses, and assist others in need.

Spiritists recognize that a strong spiritual life is a cornerstone of maintaining optimal wellness. Brazil's fifty Spiritist Psychiatric hospitals have developed programs that combine conventional psychiatric care with spiritual treatments to create an extraordinary and very effective way to help those in serious emotional distress. Highly trained sensitives are able to assist with a very refined approach to diagnosis and treatment that complements conventional care and is welcomed by the psychiatrists.

Now that the US mental health care system is in need of an overhaul, it is time we look at effective models from other cultures. So, I bring Spiritism into the conversation as we discuss how to improve what we have in the USA — not to convert, but to provide perspective.

Helping people see what is available in Spiritist community centers and hospitals in Brazil can inspire individuals to build spiritual practices and spiritual community into their own lives. It can also help health care providers understand more about the value of spiritual practices and spiritual community in assisting individuals to create lifestyles that support wellness. It may help improve the ways we diagnose and treat.

6. How did you get interested in the field of mental health?

I looked carefully at the dysfunction in my own family of origin and at a very early age vowed to find and realize a way of life that was more healthy. In the circle of my extended family there's been suicide, alcoholism, bipolar disorder, dissociative disorders and personality disorders.

It seems very obvious that we need effective alternatives to psychiatric medications that actually help people heal and do not have such terrible side-effects as most of the psych drugs have.

7. In your most recent booklet, "The Newest DSM: Deliberately Seeking Mental Health," you reflect on the newest DSM-5 published by the APA. What was your motivation for writing this booklet?

The recent DSM published by the American Psychiatric Association has somehow avoided talking about the causes of mental disturbances and how to help patients fully recover and heal. Instead, the APA's book lists symptoms and categories as if mental disturbance is a medical problem and we need to buffer individuals from feeling the discomforts of the symptoms (e.g., anxiety, depression).

Thomas Insel, MD, director of the National Institute of Mental Health, publicly recognized in 2013 that there are no biomarkers for mental illnesses (like there are for diseases such as cancer, diabetes, etc.). Still, our standard of care is medications that address symptoms, as if mental illness should be addressed with drugs and the tools of medical doctors.

I think we need to move toward articulating the causes and specifically helping people heal from the multiple causes of mental distress. Some causes include traumatic experiences, lack of a good support system, lack of skills in creating supportive relationships, and inadequate nutrition.

When the causes are named and truly addressed, we have a chance to help people toward optimal mental health. This includes what we call "recovery" and potentially goes further to a step into higher functioning. Our highest potential is ever-new bliss.

8. What is your connection to Vermont?

My mother moved to Vermont in the early 1960s. I love the outdoor activities here: skiing, swimming, hiking, biking, snowshoeing. I also appreciate the wholesome lifestyle that includes clean air and organic local food. For me Vermont is family and nature and a perfect place of quiet, conducive for meditation and creative writing.

I live in Windsor. My interests include being with my family, which includes two grandchildren, 6 and 9 years old; enjoying a Vermont lifestyle that includes gardening, outdoor photography, film production and writing. I am a member of the Self-Realization Fellowship and am very involved in the kinds of spiritual practices they teach.

Editorial Page

Opinions and Letters

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

Editorial

Choice Matters

Vermont's laws pledge an effort to eliminate coercion from our mental health system. Sometimes we think about that only in terms of eliminating forced treatment: involuntary hospitalization and drugs.

But coercion occurs whenever choice is restricted. It may be less obvious, but one of the forms of coercion comes as a result of the community mental health system.

Mental health agencies supported by state funding have a monopoly in offering help in each of the parts of the state they control.

For example, a person receiving CRT services (Community Rehabilitation and Treatment) can only access those services through the designated agency for that county. If someone has a bad experience, the person can't just go to another agency down the street. The law gives the designated agencies the sole right to offer those services in that county.

It was therefore a real breakthrough last month when the Commissioner of Mental Health used his authority to approve the first "Specialized Service Agency" for adult mental health in the state.

Pathways Vermont, which runs Housing First, can now have access to state funds to offer its programs throughout the state.

The designated agencies are worried about funding, and this should be a worry for everyone. Having a new agency that is also looking for state money creates the risk that the same amount of money gets cut up into smaller slices for each group. That could mean that designated agencies would have to cut back on some of what they offer.

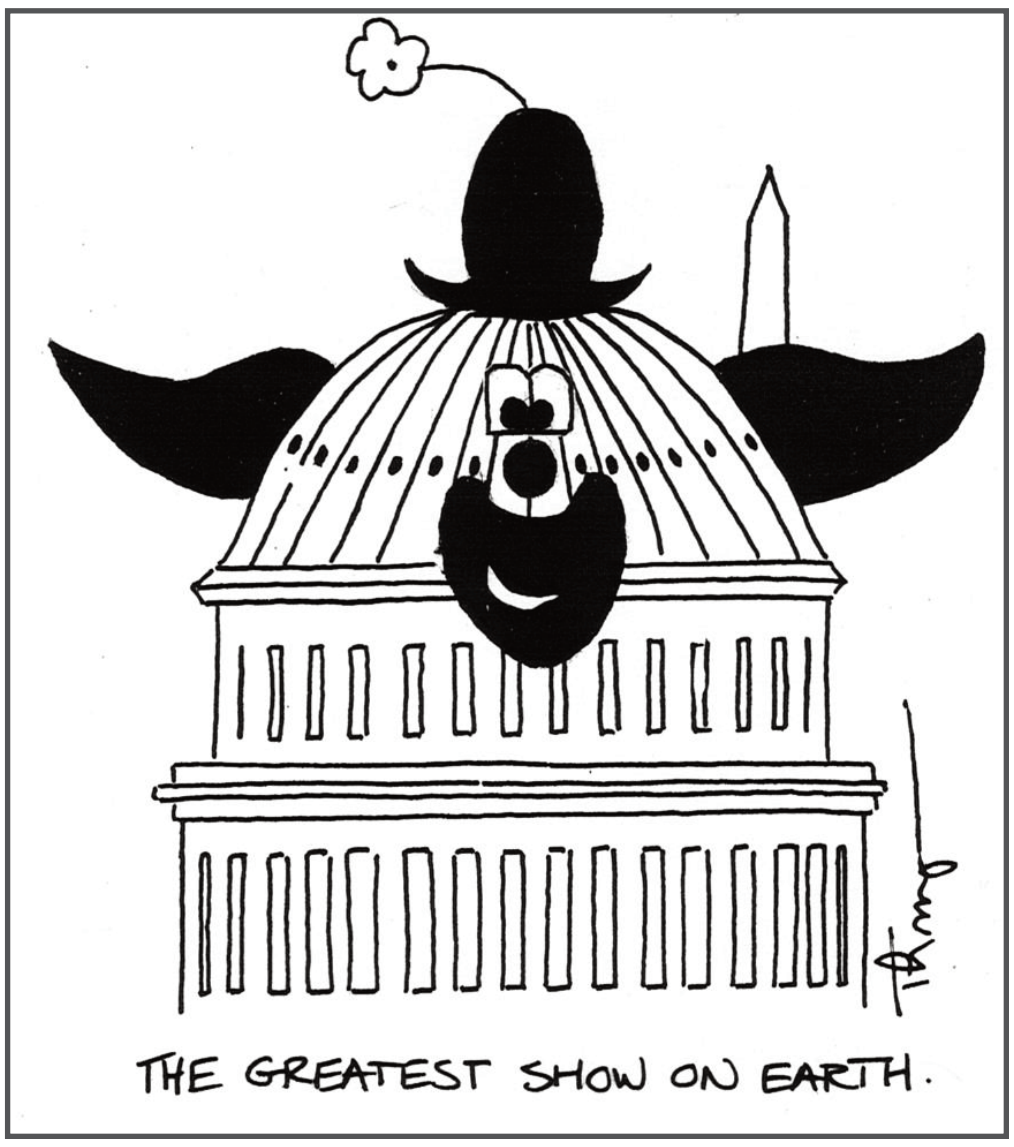
However, having enough money for good services will always be a battle. Worrying about how the money gets divided up is not a reason to limit new agencies that have new options for consumers.

Housing First is an exciting model because it recognizes how important housing is to recovery, and it makes housing the first priority. A person doesn't have to accept services in order to get help with housing. That is a huge step forward away from coercion. It is succeeding in eliminating chronic homelessness around the country.

But beyond that, the fact that there is a new choice for services in Vermont is an important step forward in creating a system that is based upon voluntary choices instead of coercion.

The Commissioner deserves credit for approving Pathways as a Specialized Services Agency.

Vermonters with mental health challenges will be better off as a result.



A Response: Suicide and Secrecy

The following letter was submitted in response to a Counterpoint inquiry about its policy of treating a death by suicide like any other, and not further stigmatizing it by withholding a name as though it was a shameful death. Counterpoint had printed an editorial in response to a request by the Brattleboro Retreat not to use the name of a woman who had died by suicide there. Ed.

To the Editor:

While I admire *Counterpoint's* perspective on normalizing suicide and mental illness (I strive for that, as well), I have to agree with the Retreat's request on this issue.

Unfortunately, although *Counterpoint* and others may want to move society in the direction of reducing, if not eliminating, mental health stigma, there is no denying that it exists. By revealing the identity of someone who commits suicide, the source potentially puts the survivors of the suicide in an uncomfortable situation and exposes them to the existing stigma around the issue.

Most families do not include the cause of death in an obituary when the cause is suicide. Without first-hand knowledge, I can only imagine this is because of the associated stigma and societal response. I do not believe that *Counterpoint* or any other source should have the authority to disclose specific information about someone without the family's consent.

With regards to equating suicide and other incidents in which names of victims are released by the media, I also have a differing perspective. In this regard, I do not believe that the mental health field needs to release personal information in order to demonstrate that suicide is no different than any other incident or illness. Contrarily, I would prefer to see the media step back and withhold personal information from all incidents unless they have permission from the family.

The loss of a loved one is tragic enough. In my opinion, there is no need to subject survivors of any illness or incident to any more grief than they already experience. as a result of their loss.

NAME WITHHELD

Shout It Out!

Have an Opinion AboutThings Going Right or Wrong?

That's What the Letters Pages Are 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.

Op-Ed Page

Letters

Finding More Effective Treatment Solutions

Enclosed is an open letter to Senator Diane Snelling and an endorsement for effective solutions to current mental health treatment problems. Kelley L. Murray

Senator Snelling,

I hope you received the copy of the *Brattleboro Reformer* Letter to the Editor that I submitted a few months ago.

I am part of a very good mental health agency in Vermont.

They are Adult Mental Health and Addiction Services with offices throughout the state. Upon orientation, I was told "your problem is that you are on too much medication." Since then, we have reduced the medication and I have become much more awake, alive, and more like my real self.

But in addition to the medication changes, I have received intelligent and caring support from the treatment milieu. On a regular basis, I see a case manager, a psychiatrist, and a vocational counselor.

The case manager works to acclimate me into the community when I am coming out of inpatient hospitalization and in need of strengthening my relationship with the community. For example, we have performed errands together, such as going to the post office and the grocery. He assisted me in many ways with my move into a more suitable apartment.

In addition, the case manager helps me to manage the mountains of paperwork that go along with receiving the benefits which ultimately contribute to my mental health. Finally, he is there to talk with when that is all that is needed.

I benefit from the psychiatric treatment that the doctor is providing me with. I am beginning to make more sense of the illness and my relationships with others, and to develop a better understanding of myself. I feel like a human being again.

However, I wish that I could see the doctor more often and for a longer period of time. I am literally lucky to see her for a half an hour per week. Ideally, I would be meeting for an hour twice a week. I am a strong proponent of talk therapy. I believe in the power of expression and human interaction.

In addition to the meetings with this team of professionals, I also attend a yoga group, a creative recovery group, and a mindfulness group.

However, I think that it is more difficult to see the benefits associated with structured, non-verbal, and expressive groups.

Let me explain briefly.

There are many occasions when talk therapy is not the first priority or even possible. At these times, the non-verbal expressive arts play a role in recovery. Ultimately, these activities evolve into talk-oriented interaction. *Human* interaction.

These expressive arts, often referred to as therapeutic activities, include but are not limited to music, art, and movement. Sadly, the therapeutic activities are typically the first to be cut from a budget. Furthermore, the attention that this use of activity for therapeutic purposes is given is negligible. At this point, there should be more data and more testimonies available to justify their use in the psychiatric treatment facility.

So, you see, there is a place for both talk-oriented and expressive arts therapies.

To conclude, I have gained a great deal by being on both sides of the fence. There is a new notion that seeks to empower capable mentally-ill individuals like myself. That is the role of the "peer specialist" or "peer-facilitated group." There exists so much to learn from both sides.

KELLEY L. MURRAY
Brattleboro

Kept at the Bottom of the Well By Unforgiven Student Loans

To the Editor:

I am now writing to you, fair pilgrims, of an incident which involves the United States Department of the Treasury. A little-known federal law, and I do mean obscure law: it's just amazing how miniscule this law is. It is truly a needle in a haystack.

Federal law 31 USC s3716 requires the Treasury to reduce the amount of one's Social Security benefits by up to 15 percent to pay a debt. So for those of us at the bottom of the well, writhing and kicking in the symbolic depths of the strain of student loan debt, there is much danger.

With the cost of rent as sky high, cannabis-high if you will, why on God's green earth is the federal government allowed to snag one's sustenance?

It's not as if I have a squad of menials changing my morning dressing gown.

Excuse me, but where do they get off trying to put a barrel around me, letting loose administrative larceny to keep one from actually living? Eh? Food for thought? Are the creatures coming out of the carpet yet?

I should explain that I have schizophrenia, which really does put a cap on how much I can work.

Why, for pity's sake, would they allow social security benefits to be touched, manipulated, scrambled? It is by far, by near, a very unconscionable matter to fuss with.

I genuinely feel badly for those who experienced the same thing, and are there in fact more, other pitfalls that the US Treasury utilizes to scope out people who really can't pay their debts?

There needs to be a new standard, a precedence weaved together for those who, because of a qualified disability, cannot pay their debts. We cannot allow the American dream to become the American nightmare.

GEOFFREY L. MCFAUN
St. Albans

SHARING THOUGHTS

Words and Ideas

by ELEANOR NEWTON

Since I am a language person, and have had, since childhood, bizarre dreams that focused on explaining odd, new or different words, I was not too surprised when it happened again.

One memorable childhood dream was all about the word "moisture." I thought I knew it meant something damp, or dampness, but wasn't sure. In the dream there was a sort of campfire with flames looking like bananas. The bananas writhed like tentacles — and grabbed everything within reach and wrung it dry, absorbing the moisture. I woke up *sure* I knew what "moisture" meant!

In the recent dream, the problem word was "humanities." I was reasoning, "there is just one humanity — all of us humans — so how can there be any other humanities?

So in my dream, I asked my naturopath, thinking she of all people would know. She did! Without missing a beat, she said, "Oh, humanities are things you put in your coffee to flavor it." When I woke up, I was amused. I gathered, since then, that the "humanities" include art, literature, drama, and music. Via television, I learned social studies are also called "humanities."

I don't know why we need such a broad-ranging, non-specific word anyway. But it seems to be much beloved by academia and teaching professionals generally. But I still don't get it. Why?

For me, there is still just one humanity. One.

There are so many different ways a new idea, word or scrap of knowledge can grab our attention, spark our imagination, and open up a whole new area of possibilities. The great teachers know this. They provide these stimuli that make us eager to learn more.

I just ran across a Bible passage on "hope," not in the Bible, but in Guideposts. It can be both a challenge and fun to roam through the Bible finding these nuggets for ourselves, or perhaps reading through the Bible systematically and pausing to reflect and enjoy, when stumbling upon a familiar or especially meaningful quotation in context.

In the "olden days," the Bible was the first reading text available to new readers, so they learned directly from the Bible and shared it with others. Some people rarely read the Bible, but have encountered quotes others found meaningful, perhaps in publications like Guideposts — and that might inspire some to read further: to pick up a Bible and read, as St. Augustine did, and have their lives, too, changed forever!

So many ways to learn!

Eleanor Newton is a member of the Counterpoint Editorial Board and lives in Burlington.

What do we mean by 'Intentional' In Intentional Peer Support?

by Shery Mead

Intentional Peer Support goes beyond the usual idea of healthy relationships. It is about creating relationships with a specific intention.

Being "intentional" about our relationships means we have a specific purpose in mind. We are deliberately deciding to create something. We are trying to create new awareness and understanding for both of us. We are trying to open ourselves to new ways of seeing, hearing and knowing that neither of us could have come up with alone.

We do this by making a commitment. We maintain our attention on the process of this creation. In real dialogue, we consciously learn how to have a new kind of conversation.

Complicated? Not really. It simply means that when we communicate, we try to stay present, aware and open. We pay attention to what we're hearing and saying. We step back from our truth. We become willing to question "how we know what we know." We become deeply open to the truth of the other person while also holding onto our own.

When this type of dialogue occurs, each of us is helping the other to step outside of their current story. We use our relationship as a tool to take a bigger look at how we've learned to operate in the world. We begin to understand how we got stuck and what has kept us here. We challenge old ways of thinking and explore new ideas and approaches. In the process, many of us shift our focus away from problems, limitations, illness and coping. We start asking ourselves what we want out of life. We let ourselves dream and hope again. These are the conversations that can be life-altering!

A Word about Conversation

In Intentional Peer Support, conversation is much more than "just talking." It's more like playing with a great jazz band where you're giving, getting, and creating together. In a jazz band, each musician contributes their voice, their heart and soul while simultaneously listening (and being affected by) the hearts and souls around them. When this works well, the piece of music being created is way more powerful than any of the parts, combined. As this type of creation happens, the process becomes invisible and the players become part of something that invigorates and energizes them. Out of this energy come possibilities that we couldn't have found had we not been part of the creating.

IPS teaches us how to create this kind of powerful, life-changing "music." The tasks, principles and values of IPS guide us in this process. Over time, our conversations develop this energy of mutual transformation. The more we practice Intentional Peer Support, the more our conversations have this natural "artful" flow. Practicing the art of creating new conversations is an important part of what makes IPS "intentional."

About Giving and Receiving

For many of us, service relationships are like a one-way street. Both people's roles are clearly defined. This might not sound like a big deal, but it can have painful real-life consequences. What happens when our relationships have become all about getting? About telling our problem story and then getting help with it? When there is little, if any, emphasis placed on giving back?

Far too often, being in the role of "getter" all the time has shaken our confidence, making us feel like we have nothing worthwhile to contribute. We doubt ourselves. We start to think of others as the "experts" who know and do better. We give up on trying to contribute anything that is uniquely our own. We let ourselves be done to and for. We become passive observers in the drama of our own lives.

In "regular" relationships in the community, people give and take all the time. No one is permanently on the taking side or the giving side. This exchange contributes to people feeling okay about being vulnerable as well as confident about what they're offering. In this dynamic of mutual 'give and take', people keep their sense of authorship. They know the giver and receiver roles change all the time and are just a part of the story. They never stop believing their contributions are needed and that what they have to say is important.

Intentional Peer Support actively seeks to restore this natural, healthy balance. We strive to share power, learn from each other, and take mutual responsibility for the health and well-being of our relationship.

This is Trauma-Informed Peer Support

Trauma-informed peer support starts with the fundamental question: *"What happened to you?",* rather than the traditional question, *"What's wrong with you?"* There is much we can learn from each other when we make this shift.

Trauma is practically a given at some point in everyone's life. Many, many people who receive services in the mental health system have histories of trauma and abuse. People are affected by trauma individually, relationally, and societally (war and other forms of social violence). While a few people may be minimally affected, many others are profoundly impacted (e.g. self concept, relationships, family, meaning). Trauma affects how we think, see, and know, both personally and in our relationships with others. Accordingly, understanding the impact of trauma is critical for our relationships.

In Intentional Peer Support, we seek to make sense of important life experiences, including trauma. We explore how they affect our relationships with ourselves and each other. We find ways to navigate our concerns together. We share the risk and responsibility of growing beyond habits and merely "coping" to a way of life we freely choose.

What About Psychiatry, Therapy, and "Mental Illness"?

Intentional Peer Support really has little to do with traditional mental health. We won't use psychiatric or clinical concepts and terms. We won't train you to solve people's problems, access resources, or help people cope. We won't teach you to diagnose, assess or treat mental health "conditions" or "symptoms."

This article is reprinted with permission from the newsletter of Intentional Peer Support, founded by Shery Mead and found on its website at www.intentionalpeersupport.org *Mead introduced the article with "a warm thank you to Sarah Knutson, who helped to put language around these concepts."*

Webinar and IPS training information can also be found on the website or by writing to info@intentionalpeersupport.org

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Though this traditional way of thinking isn't bad or wrong, it is not our focus in Intentional Peer Support. In fact, we really don't think about illness or symptoms at all!

To be sure, Intentional Peer Support is about creating mental health. But, even more than that, it's about our relationships. On a fundamental level, Intentional Peer Support is about our ability to feel connected with each other and in the world while continuously learning and growing. It's is a creative process rather than a coping process.

IPS is also not an individual phenomenon. Remember the jazz band and making music? The power of IPS depends on all of us bringing our "real" selves to relationship. We open up to really listen and be impacted by relationship. In the process, a dynamic of mutual discovery and synergy emerges.

If we just come to IPS with the expectation that we're here to help people deal with their problems, we miss this. We lose the opportunity to dramatically change the overall conversation between us (and probably the outcome of it). This is especially true when we get frustrated, confused, afraid, or uncomfortable. At these times, it can be easy to fall into psychiatric assumptions and start seeing each other through the lens of illness. The temptation is to take control — especially if we fear that someone is "unsafe" and might hurt themselves or others.

In Intentional Peer Support,-we view these times of potential "crisis" as opportunities. We challenge ourselves and each other to grow beyond habitual reactivity. Instead of automatically doing an "assessment" or calling 911, we turn our attention to relationship. We find ways to stay connected and rekindle hope. We share power and negotiate risk. We move toward what we both want, and emerge together on the other side of discomfort and fear.

The Tasks and Principles Of Intentional Peer Support

In Intentional Peer Support, we share responsibility for the health and growth of our relationships and communities. The following Principles and Tasks can guide our efforts. They are not set rules or formulas. But, they do provide a common language, some general guidance and a compass for when we lose our way:

Three Principles To Help Understand What IPS Is About:

1. *Learning & Growing Together*. We join in a journey of growth and discovery. We learn with and from each other, instead of helping, problem-solving or providing one-way expertise. We honor and explore our diverse experiences. We view differences as opportunities to notice and reconsider fixed assumptions.

2. *Caring for Relationships*. We nurture our capacity to share and connect. We offer respect and dignity. We listen to really hear each other. We look for ways to stay in relationship even when we feel uncomfortable. When faced with conflicting individual needs, we consider together: "What is good for our relationship?"

3. *Hope-Based Relationships*. We hold out hope and explore possibilities. We don't let fear or discomfort confine our choices. Instead, we face them together. We share concerns openly

(Continued on page 15)

GOING MAINSTREAM — More indoor relief areas for service dogs are beginning to show up at airports. One of the newest was opened by Delta Air Lines this spring in Detroit. Most airports still require owners to go outside, according to a list from PetFriendlyTravel.com.

(Photo courtesy of the Detroit Metropolitan Airport)

What Is 'Intentional'?

(Continued from page 14)

and honestly, risk trying new things, and gain trust and experience over time.

Four Tasks To Guide The Practice Of Peer-To-Peer Relationships:

1. *Connection*. We look for areas of shared energy, interest and engagement. We pay attention to "sparkling moments" when we seem to "get" each other. We cultivate this fertile ground. We negotiate the ebbs and flows.

2. *Worldview*. We listen to understand and explore. We're curious how we've made sense of experience. We wonder about "the untold story." Together, we question our assumptions: How did we come to "know" what we are so sure we "know"?

3. *Mutuality*. We meet each other as human beings. We share power and responsibility. We hold space for each other. We welcome all sincere contributions. We create vibrant synergies that work for all of us.

4. *Moving Toward*. We focus on what we can create together. We invite energy and inspiration. We dare to dream and envision. In good company, we prosper toward the relationships, communities and world we want to live in.

LETTERS TO THE EDITOR

A Silent Dilemma: Censorship by the Media

To the Editor:

The discrimination which patients suffer at the hands of the media is of a double-edged kind. Whenever a tragedy such as what happened in Newtown, Connecticut, occurs, the networks and news outlets fall all over each other portraying "mental illness" as the culprit behind the tragedy.

One would think (would we not?) that this alone is a sufficiently grievous affront to the dignity of patients. But, no, there's something else going on, too, which you never hear about: the result when some patient who writes, submits a certain account they've written to any major publication for publishing.

If this patient has written a piece publicizing the existence and history of the mental patients' movement and reveals that they, themselves, are a patient who's participated in this historical event, their manuscript goes nowhere except into the contents of the publisher's File 13. In other words, the piece never sees the light of day.

The answer to this quandary can be found in the makeup of all social and political establishments. Longstanding organizations such as the Mental Health Association and the National Alliance on Mental Illness constitute the mental health Establishment and are known for their lionization of the patients' movement, with its emphasis on rebellion against mainstream psychiatric treatment.

Now let's take a look at the media, more often than not a sucker for any establishment. The press has been only too happy to do the bidding of the mental health establishment, in this establishment's quest to smother the will of so-called, "rebellious" patients.

Undoubtedly, the Mental Health Association and NAMI members are tickled to death with the media's blackout of public awareness of the existence of the psychiatric inmates' movement. For their part, media representatives are probably also not concerned about not publicizing any perceived reason for people who genuinely need help, to not get it.

One thing which I think is certain is that disgruntled patients, aggrieved at the theft of their substantive lives by the circumstance of having mental problems, as well as by the system designated to "treat" this sad predicament, are never going to cease protesting and obstructing, as they should not.

Stigma exists for a convenient reason, and that is that it is the means by which any control freak who fancies themselves a mental health professional, can interfere in a patient's life legally. The media's horrendous treatment of patients is an example of the extent to which stigma permeates every facet of every patient's life. There's never going to be peace at the table until patients are free of this stigma, and of the kneejerk temptation everyone has to control a patient's life.

It has been pointed out to me that the media's prerogative to be exclusionary is Constitutionally protected. Accordingly, neither litigation nor legislation can be used to remedy the censorship I am decrying here. But we all know that the U.S. Constitution also guarantees the right of any citizens who may be aggrieved, to make their grievances known. Therefore, I am proposing that we mount a campaign to pressure the media to cease slandering us and censoring us at the very same time, of its own free will.

Are you a patient who writes? I have put together a 30-page documentation of censorship of patients by the print media. These are patients who attempt to publicize the existence of the psychiatric inmates' movement and are censored each time, regardless of how refreshing, profound, and libertarian this movement is.

Are you interested in seeing a copy of this compilation? I've paired numerous articles I've written over a period of years, with their matching rejection notices, and I will gladly send you a copy if you'd like. I will incur the costs of photocopying and mailing to you. Simply contact me at 1010 St. Paul Street, Apartment 5R, Baltimore, MD 21202; Email: kumininexile@netzero.net.

PHILIP A. KUMIN
Maryland

BOOK REVIEW

Surviving Evil: VSH and the CIA

by ANNE DONAHUE

Karen Wetmore has been a voice for more than 15 years in recounting evidence that the Central Intelligence Agency used doctors from the Vermont State Hospital and the University of Vermont and to experiment on patients. Now she has written a book to present her detailed research and the trail of government documents that demonstrate those links.

Surviving Evil (Manitou Communications, 2014), however, is more than just an assembly of the information Wetmore gathered through her freedom of information requests to the government. It is a compelling story of a girl growing up, losing her grip on reality, and then being subjected to involuntary treatment at both VSH and the university's medical center (now Fletcher Allen Health Care, in Burlington), beginning at age 13.

Wetmore recounts the side effects she experienced during treatment in the 1960s, and the lasting damage, along with the information she learned from pieces of her own medical records. She shares the obstacles she later encountered as she tried to learn what happened to her during the years in and out of hospitals: records that were refused her, bugs on her telephone, and mail intercepted.

It also tells the story of the CIA experimentation done elsewhere during those years and exposed in Congressional hearings. Connections between doctors working with the CIA and Vermont institutions are detailed.

The blend of personal experience and outside research makes for gripping reading and leaves questions unanswered to this day.

The writing is sometimes choppy and sometimes repetitive, and a reader can easily become lost in the details of government documents. Some of the research that is background to her central story remains incomplete: Wetmore often refers to the thousands of deaths at VSH during that time, but she fails to establish whether those rates were comparable to other institutions and did not look into existing public death records.

Ultimately, the book is a plea to be heard and for answers from the past.

Why, she asks, do the state and UVM still refuse to answer questions about those years? What exactly did happen to her?

Karen Wetmore is a survivor in every sense of the word, and her passion to find the truth forms the core of her new book.

(Manitou Communications is a multimedia publishing company that produces books, videos, and CDs on psychological trauma and related topics.)

A Personal Experience

Life in Hell: Suicide Attempt Leads to Time in a Tennessee Jail

Part Two — The Stories of Others, and Madness in the Dark

This story about an experience in a Tennessee jail was shared in the third person to keep the writer's identity confidential. Last issue, the first three sections were published. This section covers the middle episodes in Rex's story. In the fall issue of Counterpoint, the final episode will appear.

Recap: Prelude

Rex Peters had been attempting to cope with his wife filing for divorce the same year that his parents had died and a grandson had drowned. He had been getting inebriated off and on that month, knowing where the drinking would eventually take him: Madness and suicidal thoughts and efforts. He took his Dad's old shotgun and ended up at his brother's apartment with it, planning to shoot himself in front of him. It terrorized his brother, who shut the door and went to call the police.

When the police came, Rex had just tried to shoot himself in the head. The barrel of the shotgun was by his left ear when it went off. Next thing he knew he was running back to his apartment but the police were already there shouting for him to throw down the shotgun and get on the ground. He ran towards the cops, hands in the air, and hollered, "Shoot me!"

The cops finally subdued him and it was on to the jail.

In Part 1, Rex recounts the experience of entering jail, appearing in court, and being ordered to undergo a psychiatric exam. He was then moved from a cell to the medical pod.

Stories from Other Inmates

The medical pod was obviously for those with medical problems but it was also used as a punishment cell for those that had broken rules on one of the other pods. The irony to this was that most of those being punished came to like the medical pod and preferred to just stay there. And it was even a cell for protection of someone that had sex charges of being with a minor.

The pod had three cells in it. Though each cell was to contain only two men there were usually two more and sometimes three sleeping on the floor. Upon first arriving with no "seniority," Rex had a mat on the floor with very little matting in it. Good blankets were also a high commodity as it got so cold in there at night. Rex's initial blanket had two large holes and he would wake up trembling from the cold.

Eventually a younger "hard con," Snowy, who was going back to prison told the guard to get Rex another blanket. Snowy always called him "Pops," and everyone started calling him Pops because they were mostly so much younger.

Snowy was being transported between a maximum security facility in Nashville and the county jail in this country town, as he was considered such a danger. He had been accused of attempted murder of a couple of policemen.

He found it very humorous that he was put into a cell with three more of us when he was actually supposed to be in a maximum security cell alone. Snowy had mischievous blue eyes that took in everything and he particularly enjoyed tormenting Rex — pretending he was going to strike him to see how much Rex would jump. Rex began to do the same thing to Snowy and it did actually help to pass the time and created a few smiles not only between Rex and Snowy, but the other inmates also.

Rex did request to see the doctor and most of the guys told him he was wasting his time to see him for anxiety. The doctor looked at his record and sneered, "New experience, huh? Bet you never imagined it would be like this. Hmmm... they really stuck the charges to you."

"I need something for anxiety." Rex uttered and the doctor looked at him as if he were crazy.

"Not here, buddy. I'd have to have your medical records and even then I wouldn't know what to give you as I'm not a psychiatrist. You won't get medicines like Klonopin in here, I assure you."

There were two fellows that were waiting to go to prison. Both were exercising vigorously in preparation for whatever prison they would be sent to. Snowy made a third person who was exercising and getting ready for a long sentence. He would do at least 100 push-ups a day and would walk the length of the cell and the hallway if we weren't locked down.

There was a huge skinhead, Big Boy, who claimed to be part of the Aryan brotherhood. He had the tattoos for it and he would also regularly exercise though he only had a couple more months to do in the county jail. He and Rex had panic attacks and talked about that.

Every day that Big Boy saw Rex he would smile and say, "Goddam, I need a Xanax. I'm going fucking nuts in here. You know what I mean, Pops?"

"I could use one too, Big Boy." Rex would say, and they would smile at the suffering of panic though at the worst of times they weren't smiling at all. It gave them a connection.

James and Fred were both quite friendly. Rex already had a sort of fame in this place as the local newspaper was passed around with its stories written about those that were arrested.

"Oh, so you are that guy!" they would laugh. "Tased twice even!" Everyone that knew about Rex got a laugh out of that and it forced him to see the humor in it. He wouldn't laugh, but it did at least bring a smile to his face.

James was desperate because he had been in jail so many times and he was pretty certain unless some miracle happened he'd be going to prison this time for breaking into cars and stealing stereos and what not. He would get upset and start weeping and sometimes beat on the walls.

"Do you think God can get me out of this mess? I have a girlfriend and baby to get back to. They need me!" he spoke with tears streaming down his face.

Fred was a converted Jew from Chicago originally and planned to go back up there as soon as his four-month jail sentence was up. He'd been in jail so many times that it had become a way of life for him.

"Jail up in Chicago isn't as bad as this," he said. "They will give you medicine that you were already on even if it was Xanax or Klonopin. Klonapin… you can take a whole bottle of that shit and really get wasted. Thing is, when I do it and I don't remember anything that I do. You know what I mean? I'm sure I did whatever they say I did."

Once they got a really psycho guy in the pod. He was really crazed and would not shut up. Buck, who was going to prison again, promised Fred four of his snacks if he could get rid of the guy. An anonymous note was sent to one of the guards and psycho boy was out of there. Good to his word, Buck gave Fred the snacks.

Thoughts of Madness in the Dark

Here in the medical pod they did turn off the lights at 10 p.m. This was a relief — sweet darkness. There was only the tiny window in the jail cell door and another tiny painted window on the wall. But the darkness could turn on an inmate. At least it could for Rex. Sleeplessness and strange thoughts assailed him often. Abstract fears and a sort of madness would assail Rex when he would awake during the night. He would take deep breaths in order to calm down.

Time — that was a shocking perception and it wasn't "flowing like a river" like in the old Alan Parson's Project song. Rex felt as if he were in an eternity that never ended. It gave way to odd thoughts such as being in a hell that he didn't believe in and an alternate universe. It was that strange. Days and nights were blurred — didn't exist in a jail without windows.

Thoughts of opposites — good and evil, beauty and ugliness, yin and yang, anima and animus, male and female, pain and bliss, love and hatred... many times thinking of opposites and listing them in his mind and wondering why he was doing that. Madness encroached in timelessness. How could it be such an illusion where there was a very strange opposite in which it was not? How could one explain, understand such opposites that bombarded one?

Rex wished that he could reach out and grasp all this while lying there on his thin padding at night... He could die here and no one would really care. He meant very little and knew that his mark in history would be about as much as a serf in another time. And yet there was again the opposite that he did matter and his actions would have a ripple effect like everyone else's — big or small in the eyes of people in whatever day and age, present or past. Be careful what you think and always see the opposites and that no concrete statement can survive in the face of opposites.

Rex thought he could die there. He reached a place where he really didn't care if he died in jail. He had no idea how long he was going to be there so it was easy to imagine dying there.

Fred was taking Seroquel and would palm those and pretend to take them in front of the nurse. He would trade for one snack and would sometimes give a little away. He gave Rex half of one, and it knocked him out from evening until the next morning. That was probably the only night he slept the whole night, but Rex didn't like it and never took another.

One adapts to places in jail. Amazingly so. The will to survive is a hell of a lot bigger than Rex ever thought it would be.

In the third and final episode in the next issue of Counterpoint, Rex finally sees the court psychiatrist and the judge, to learn his fate.

Personal Reflections

An Ineffective Method of Utilizing Psychiatric Medication

by C.P.

Up until this point in my life, my decisions about whether or not to use psychiatric medications have been guided by the following conceptual model, which I developed all by myself. I could call it "An Ineffective Method of Utilizing Psychiatric Medication":

1. Have a crisis and decide that you will try absolutely anything to alleviate your suffering, and start taking a new pill.
2. Experience side effects.
3. Obsess over the question of whether the meds are making things a little better, or whether they're not helping at all.
4. Stop taking the meds abruptly not because they aren't working, but for one of the following three reasons:
   - Someone mentions Robert Whittaker.
   - You hate yourself and decide it would be a good punishment.
   - It might be interesting "just to see what will happen."
5. Whatever you do, don't taper: that might result in less dramatic effects.
6. Experience withdrawal, and blame yourself for it, repeating the affirmation "I have permanently destroyed my brain." Vow that you will never take medication again.
7. After a period of time, have another crisis and return to Step 1 to start the whole cycle over again.

If you aren't currently using this method, I don't recommend it. That is, unless you're getting bored with the lack of suffering in your life, and are seeking the jolt of a new drama. If that's the case, though, there are ways of using psychiatric drugs that are probably even less likely to contribute to long-term well-being, such as taking pills when you have no idea what they're even supposed to do, or choosing a medication because the commercial that implored you to "Ask YOUR doctor about __!" was especially well done.

I'm currently in Step 3 of this process, experimenting with a new medication that appears to do nothing except for making me sick to my stomach. Every psychiatric drug I've taken, except one, has had this effect. People sometimes say that when life doesn't bring you what you want you should adjust your expectations, and maybe that's what I need to do. If I just adopted the concrete, measurable life goal "Experience nausea or stomach pain at least once every 24 hours," I could meet this goal almost one hundred percent of the time by just taking one little pill per day!

But since I'm inflexible and refuse to seek out gastrointestinal problems, I finally tried researching medications using the Internet. I should have known this would be a bad idea, since no one on the Internet ever agrees about anything. For example, a couple of years ago I grew valerian in my garden, and when I Googled the apparently straightforward question "how do I harvest valerian root" I discovered a shocking level of controversy about how to do it "the right way" that left me feeling like no matter how I did it I would be making a drastic mistake.

First I looked at sites where consumers could rate how much a particular medication helped them and leave "comments" about it. For every medication I examined, people expressed the following general themes in their comments:

- I've taken tons of medications before and this is the only one that has ever worked for me! I feel so much better!
- It didn't do anything.
- It gave me insomnia.
- It made me sleep all the time.
- It made me sleep all the time, but that was exactly what I needed!
- I gained 30 pounds.
- I had no appetite.
- I have no idea what it will do since I only started it 2 days ago.

These themes were so predictable I began to guess what people would say about a drug before I looked it up. In fact, I predict that even drugs that haven't been invented yet will have these same wide-ranging helpful and completely unhelpful effects. What I can't predict is the one thing I actually want to know, which is which drug (if any) will help me. All I can be sure of is that many people will have strong opinions. (This has already been demonstrated in my personal life. When I'm not taking medication, people I know try to convince me to take it, and when I am, [different] people I know try to talk me out of it.)

Since these anecdotal reports didn't provide clear guidance, I turned to reading research studies. I don't necessarily believe studies produce accurate results, and suspect that what gets funded and what makes it into publication is highly influenced by who pays for the research (pharmaceutical companies). However, taking their findings into account might be better than trying drugs completely at random.

I found several studies claiming that people with PTSD (my primary and favorite diagnosis) may be helped by taking neuroleptics, specifically risperidone; others found them to be completely unhelpful. I certainly hope neuroleptics work, since everyone wants to take them. They have no potential problems other than causing diabetes, sexual dysfunction, tardive dyskinesia, sedation, a lot of weight gain, and all the other side effects.

I also happened upon a study that found that people with synesthesia are more likely to develop PTSD (Hoffman, 2012). No one really knows why this is, but the authors speculate that "synesthesia results from disinhibited feedback or abnormal cross-wiring between brain regions," and that this increased connectedness could make one more likely to experience PTSD symptoms.

Anyway, I have PTSD and synesthesia, and I found this article oddly comforting. I may be screwing up my mind and body with useless drugs that do nothing to relieve my suffering; but as a consolation prize, it's nice to think that the fact that I live in terror all the time could be due to the same brain quality that allows me to experience letters and numbers as having vivid colors, a cool phenomenon with no practical value whatsoever.

References: Hoffman, S. N., Zhang, X., Erlich, P. M., & Boscarino, J. A. (2012). Grapheme-color Synesthesia and PTSD: Preliminary Results from the Veterans Health Study. *Psychosomatic Medicine*, 74(9), 912-915.

Louise Wahl Creative Writing Contest

SECOND PLACE — POETRY

Four Walls and Me

They locked me
in a room,
They took with them,
the key.
All I saw
in this darkness,
was just
four walls and me.

Not a sound entered
from outside.
Not a familiar
face to see
I just sat
in total silence
these four walls
and me.

Again, I no longer
existed.
My soul inside
had died.
I could not feel
the hurt within
just the tears
that stung
my eyes.

I could not understand
why was it me
locked away?
I hated the world!
I hated myself!
I became silent,
with nothing to say.

And with my
hidden razor,
nothing had I felt.
As each red drop
emerged,
surrounding me
where I knelt.

The words came forward
drop by drop
landing in red
on the floor.
But no one
stopped to read them
as they carried me
out the door.

And it was only
a matter of hours
when I was placed
back in that room
to face the challenge
of death again
that would rid me
of this gloom.

For death
was oh, so near.
It was all
that I could see
as I sat
in total darkness
Just these
four walls
and me…

by Lynn Brunelle Cushing
Milton

SECOND PLACE — PROSE

A Letter to My Many Selves

Dearest Mirror Book,

Is there progress in merging my many selves? How does one measure, without knowing the reference points of beginning to end? Mirror Book you are but a reflection of my many selves, so perhaps within you the answers rest.

I feel my tortured soul has been given a reprieve, my mind a chance to breathe, my spirit hope for rest but is this just another test? How many times, Mirror Book have we sat out on this ledge, gathering strength, courage, renewed hope and then, just when we believe we are free, find ourselves tossed back into the pit of ourselves to fight our demons within? Forty five years of rising and falling. Still lost is my identity and true self.

This inward struggle has me questioning my own reality. Is all but an illusion, a delusion within my confusion? Is there a point of wakefulness and awareness in discovering my identity? How do I know who I should be when I've never had a chance to have been? Within our fractured selves is there a whole or are we all lost in the end, having never truly been.

by Bonnie L Barrows
Burlington

2014 Winners

The Louise Wahl Creative Writing Contest

Prose

First Place: I Hear the Music, by Laura Lee Saorsa Smith ($100)
Tied for Second: Dreams, by Linda Carbino ($25)
A Letter to My Many Selves, by Bonnie L. Barrows ($25)
Third Place: Untitled, by Ocean Chance ($10)

Poetry

First Place: You Came Walking In, by John Caswell ($50)
Second Place: Four Walls, by Lynn Brunelle Cushing ($25)
Third Place: Past Is Present, by Todd Johnson ($15)

Louise Wahl Creative Writing Contest

FIRST PLACE — PROSE

I Hear the Music

To this day "Damaged Goods" is what I hear echoing throughout my mind. Deep down in the darkest parts of my psyche I feel that I do not deserve to live, that I have no right to exist. My behavior tried to change that feeling, having a very "look at me I exist" agenda. Pathetic as it was it really didn't work, there was nothing that I could do well enough that would fill that void in my heart or shed light in my soul.

What does work, though I still harbor those negative core beliefs, is accepting those negative thoughts, they are there and accepting that they are incorrect beliefs. I am worth existing, I bring joy to others and I can be joy-full without feeling guilty or like I am merely refuse to be gotten rid of. "Be the Butterfly" is my mantra. I was most certainly the lowly caterpillar nearly getting stepped on. As luck would have it I stayed alive long enough to see that there is more to life. More to life than these dark thoughts, they exist for whatever reason and I can listen to them or change the music.

I am more than what my past is, I am more than my diagnosis, I am, I am here right now and I deserve to be here as much as anyone else. My wings are beginning to dry as I step out from my cocoon. The transformation from caterpillar to butterfly has been arduous and sometimes felt futile but here I am, still here. My legs standing strong, my heart still pumping, my lungs still fill with breath. I am!

Now that I have wings and they spread beautifully full and light as air I flutter them to first flight. It is scary and it is wondrous. A few near falls, but all in all ever worth the effort. We never truly know what we are capable of unless we step off and try our wings. It is an act of faith a faith in who we really are and what we really can do.

I will never be one to say that it is easy, no, it is the harder path to take but it is the struggle that makes us stronger, it doesn't have to break us... I have successfully muted those voices in my head degrading me and I have turned up the volume on my own inner voice. I am allowing myself to be me. I hear the music, my music that-allows me to dance on air. Be the butterfly.

by Laura Lee Saorsa Smith
Cabot

FIRST PLACE — POETRY

You Came Walking In

I'd like to thank you for your support,
for being a true friend.
In times of challenge as others walked out,
you came walking in.

You shared with me how you've overcome,
how you have been set free,
how by meeting challenges one by one
you now live with sobriety.

You didn't preach, but said within my reach
I too could be set free.
To many friends, I've made amends
since you shared those words with me.

No longer caught in shadow cast
it's a better life I share.
Your lessons taught as years have passed,
truly prove how much you care.

I'd like to thank you for your support,
for being a true friend.
For in times of challenge as others walked out,
you came walking in.

by John Caswell

March Forth

Vermont State Hospital — by Katherine Gluck

acrylic on canvas — by Nia Rachel Grossman

untitled — by Tom Savard

Man, Myth and Magic — by Adrienne Goulet

"When we create art, another part of our brain takes over and the mental illness takes a break."

— Arts Collective coordinator Bryant Pugh

HowardCenter's Arts Collective presented "March Forth," their third exhibit of client and staff artwork in March at the Flynn Dog Gallery in Burlington. The mixed media show included the works of more than 20 artists.

Photos of exhibit by Donna Iverson

untitled — by Ricky Bove

untitled — by Thomas Dunn

Louise Wahl Creative Writing Contest

SECOND PLACE — PROSE

Dreams

Dreams Really can come true!

I was stuck lost in a world of believing what others
said about me were true.
They told me I was sick, crazy, ugly, lazy and worthless.
I felt lonely sad and unwanted.

I still had my dreams of having many friends, someone to love and that would love me just the way I was. A life I loved, working at my dream job. I loved myself enough so that no one could make me sad again.

I asked myself if I could make some of these dreams come true?
So I challenged myself to make some of them come true.
I needed to change my beliefs.

I took loneliness first, I saw that I hardly spoke to anyone,
I stayed home most of the time. I knew what I needed to do.
I had to challenge myself by going out fearlessly and talking to people, not worry of their judgments,
Not assume they are thinking the worst of me.

What I found is yes, there were a few that didn't talk to me.
But there were many that did. I made many new friends that day.
my dreams of not being lonely came true!

I wanted to be loved by someone.

I found first I had to find what I loved about myself.
Here are just a few things I found: I loved to draw myself
doing things I loved to do like going fishing, sitting by small streams
catching salamanders, enjoying the feeling of the water between my toes.
Dancing in the moonlight, making a great meal. Enjoying time by myself.
Now that I know what makes me happy, I can look for others that
love all these things, too!
Soon I found him and married him.
My dream of finding love came true.

The last thing I wanted was to not feel worthless.
I am disabled so I knew that this one would be hard. I thought
back to many years ago when I dreamed of having a good paying job,
what was it I always wanted to do?

I wanted to be a doctor to help people that had mental illness just like me.
I also knew that without years of school this could never come true.
but I also knew that for many years others helped me find healing in my life.
I saw so many in need of healing, too!
What I did find was I had found ways of coping with a life of mental illness.
So I put on my thinking cap when an ad came on the TV saying,
be a star, create your own TV show. My mind knew just what to do!
I would have people talk about their stories of recovery, too!
Surely this is the way to help! I soon came to know that once again
my dreams came true!

by Linda Carbino
White River Junction

THIRD PLACE — POETRY

Past Is Present

Touched and abused from one to five
Broken and dead but still alive.
Family found him Grandma, Granddad
Treated as a slave the life was so sad.
Mother died of cancer at the age of 23
Never knew his father, his looks he never seen
Grandparents took him in but tormented his soul
Beating him daily, still young but felt old.
Abused sexually to physically, mentally he's in hell
At the age of 11 he took his first line to feel well.
Years went by and the abuse continued
He turned 14, ran away, so go figure.
In and out of trouble with the law and DCF
All he wanted was some love and a family
Either that or sudden death.
Twenties he hit and life threw him out
Full of questions and hate about God, and self doubt
Til this day he's surprised that he made it this far
Walking straight up, but the mind is still scarred.
Late twenties with his own family, happiness he truly knows
Now all I can do is give my children a good home!

by Todd Johnson
Berlin

THIRD PLACE — PROSE

Untitled

It's summertime. We went to the beach. I was eight, and learned to swim in a shallow tidal pool. Being underwater I thought it was the best thing in the world. I held my breath and swam back and forth again and again. After an hour I was exhausted and dried myself on the sand. The sun was hot and the excitement burst within me as I ran across the beach thinking, "Won't Mother be proud. Just two months ago I nearly drowned in her friend's swimming pool."

I could see my mother now holding my sister and dragging my brother by the arm across the sand.

"Mother," I shouted, "I can…"

"Shut up!" she screamed. "Your father's taken the car again! I should never have married that worthless nigger! Get you ass in gear and go tell your grandmother we are going back with her."

I began running down the beach as fast as I could toward Grandma. The sadness surged through me until I could no longer run, no longer move. I fell to the ground and stared upward toward the sky and I cried.

by Ocean Chance
Morrisville

Arts Creative Writing and Poetry

Cat Sabotage

by C.P.

So recently I had a crucial insight about life, which is: the less well I am, the happier my **cat** is.

This is because when I am unwell, I end up spending a lot more time with her. I sit on the futon, and my **cat** stretches out in my lap and I pet her FOR HOURS ON END, which is her second favorite activity ever (her absolute favorite is, of course, getting fed).

When I'm working, I spend hours away from the apartment paying no attention to my **cat**, and so the less able I am to work, the better off she is.

This made me realize that in addition to the million and one things that I already worry about, I need to be alert for yet another danger, which is that my **cat** will move beyond passively enjoying my suffering into actively sabotaging my recovery.

For instance, I might come home one day to find my Wellness Recovery Action Plan shredded into teeny little pieces, or the walls papered with Post-It Notes containing anti-affirmations like ***You Will Always Feel Miserable*** or ***Believe Your Negative Voices!***

Then it occurred to me that not only do I need to be worried about **cat** sabotage, but it could be a systemic issue facing Vermont. How can we protect ourselves from this threat?

I propose that peers and mental health providers begin hearing people via a new model, which I'll call "a **cat**-sabotage informed 'lens.'"

This means listening between the lines of what people are actually saying for the possibility that they may be facing hidden problems of **cat** sabotage.

For example, if someone says, "My alarm clock didn't go off this morning," consider the likelihood that what s/he ***really*** means is, "While I was sleeping, my **cat** turned off my alarm, hid my bus schedule, wallet, and keys, then consciously decided not to call out sick for me in order to make me look bad."

Alternatively, we could approach this problem by creating a new series of self-help books, which would have titles like ***The Cat Sabotage Workbook*** or ***The Courage to Heal from Acts of Cat Sabotage***.

When I adopted my **cat** from the Humane Society, she came with a piece of paper that says, among other things, "We do our best to tell you what we know about an animal. However, your animal may do things that are unexpected." (This is actually true; I am not making this part up.)

I think we should advocate for **cats** to come with a more explicit black box warning, such as, "However, your animal may send you into a psychiatric, spiritual, or existential crisis from which you will never recover." If the Department of Mental Health began collecting statistics on this, I bet it would discover that well over 50 percent of hospital emergency room visits are precipitated by acts of **cat** sabotage.

Well, I'd better stop writing now and get back to my research for my next article, which will tell you how to protect yourself from acts of sabotage by your **dog**, your **cows**, and (most insidiously of all) your **service animal**.

Chickens In The House

Here we do not share the prejudices of others
We share our home with cats and a dog and lots of chicken mothers
The chickens don't seem to mind inviting themselves to dine
So prim and proper eating cat food and drinking milk as if it were wine
Sometimes they join us to watch T.V. they like sci-fi like myself
Planting themselves quite naturally on a chair or a shelf
Once in a while an accident will occur but we scoop it up and put it in the trash
These birds they are silly, brazen, and brash
They have come to demand their milk in a fine china bowl
And some of you may find this situation ever so droll
But living with chickens in the house or even grouse
Is far better than a mouse-filled house

by LAURA LEE SAORA SMITH
Cabot

Alternate, Unrealistic State of Mind

Some create a delusional world in their mind
Who knows what they will think of and find
Everything that comes out of their mouth and is said
Gets misconstrued from the false world inside their head
Nobody is able to help them see the truth and get through
And help them craft a life that's new
They get so stuck on their idea
Everything revolves around the inner world that they hear
It's in the form of a bizarre fantasy
That only they are able to hear and see
They are prisoners in Plato's cave
As people enter to tell the truth and save
This problem is not small
It's life threatening to them all-in-all
It is definitely foretold
This way of thinking is uncontrolled
Consider their actions and words sometimes a default
That hopefully one day will come to a halt
These individuals should not be overthrown
No one is made of brick or stone
Leave them be and don't judge or criticize
Even though they are holding onto untold lies

by NIKITA LAFERIERE
Lyndonville

Close To The Surface

River frozen on the right
hand side, but running
along the left side
nicely. Probably something
to do with the shade
and sunshine. Sometimes logic
is deep down below
the surface, well-prepared
to remain unseen.
A fish understands.
Other times, it's so close to
the surface—in clear sight—
that it's catchable
with just your two bare hands.

by DENNIS RIVARD
White River Junction

Haiku for the Love of Chocolate

Delicious Sweetness
Chocolate Enlightenment
Merry and Wise Followers

by LAURA LEE SAORSA SMITH, Cabot

Arts News and Poetry

by Pamela Gile, Barre

PTSD — Not Just a Name, Not Just an Excuse

Speak louder, they say, as if I am whispering.
They don't know that quiet was a child's survival.

Let your past go, they don't know that it visits me in my sleep,
That medication is the only way I can sleep, to keep the nightmares away.

Chill out, they say, they don't know that I'm trying to be calm.
That I have to practice every day to breathe through the anxiety.
That the medications I take every morning bring me to this calmness.
That without it, I can't be, the world is too unpredictable.

Forgive and Forget, that's my favorite.
What should I forget?
The isolation?
The head punches?
The starvation?
The terror of sexual abuse?
The names?
How exactly do you think I should forgive?
Thirty years later and my life is still dictated by my past.
Maybe the answer lies in asking these questions to the abusers not the survivors.
At least they had a choice.

ANONYMOUS

Share Your Art!

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

Exhibit Connects Domestic Violence, Brain Injury

MONTPELIER — A traveling art exhibit is highlighting the connection between domestic violence and brain injury, as well as shedding light on what people with traumatic brain injury can accomplish, according to a news release from the Vermont Center for Independent Living.

The exhibit was on display during the week of April 7 at VCIL in recognition of National Crime Victims Week. People with disabilities are impacted by violent crime at much higher rates than the rest of the population, experience higher rates of victimization by persons known to them and report crimes less frequently, the news release said.

The report said the art exhibit is the brainchild of Mary Lou Webb, program coordinator for the St. Johnsbury Brain Injury Support Group, which is sponsored by the Vermont Center for Independent Living and the Brain Injury Association of Vermont. The group meets monthly to offer resources, information and a safe place to share about brain injury for survivors, family members, caregivers, friends and the community.

The seed for the idea of the exhibit was planted several months earlier when a member of the support group pointed out that people often don't make the connection between domestic violence and brain injury, VCIL said.

"This whole thing is a voice for the voiceless," Webb said in the report. "The pictures are really a cry from the soul of these people."

All but one work of art in the exhibit was created by someone with a TBI. The artwork depicts everything from shaken baby syndrome and elder abuse to a pregnant woman and a person in the military. Different types of paint, crayon, magic marker and even fabric from a baby bumper were used to make the art.

Kenny Smith of Hyde Park, a VCIL employee, described his creation this way in the news release: "I used water-based acrylics to paint a depiction of a faceless veteran in combat fatigues who has experienced traumatic brain injury and is living with an 'invisible disability.'"

He added, "I was motivated by a passion for caring for our brothers and sisters who serve and then return home from combat—especially those with disabilities."

Marie-Anne put a lot of energy in her piece about baby-shaking, the VCIL release stated.

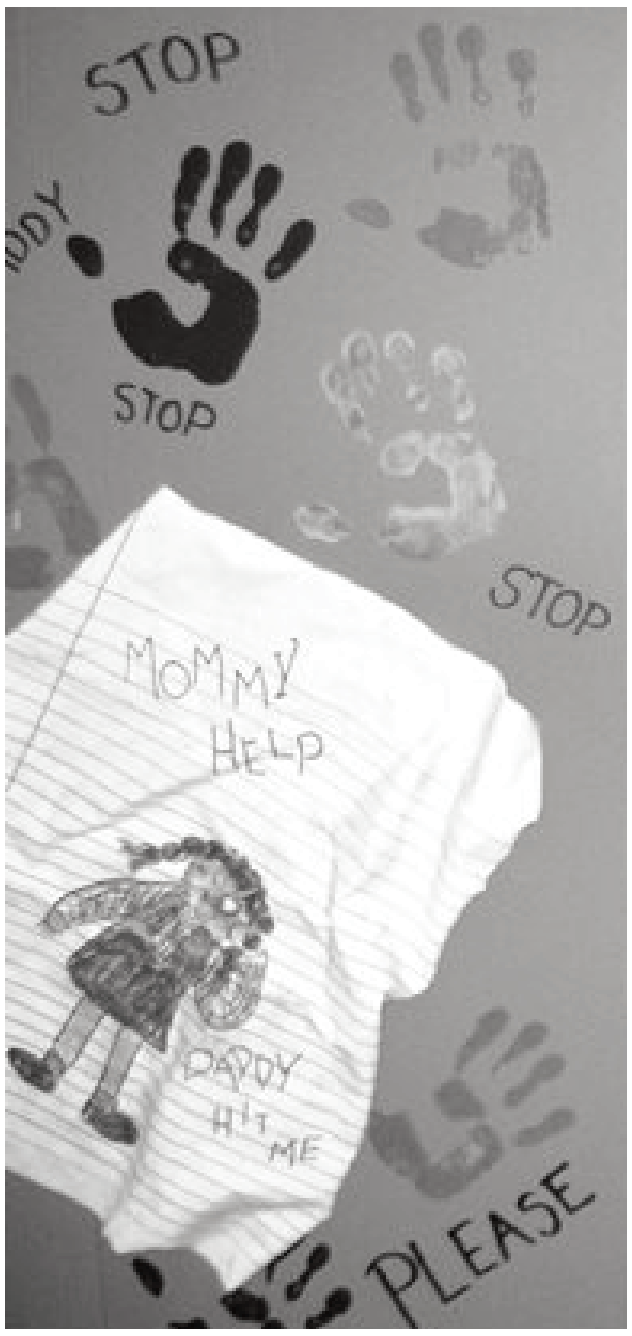
"It means a lot to talk to people, to relate to someone," said Marie-Anne, who has been abused by three different partners, VCIL said. She was quoted as saying she would like victims to know that they do not have to live with a batterer, that there is always someplace they can go and talk to someone they trust.

"Eventually, you hear a little voice that tells you, 'There's something wrong here.' Batterers are way more dependent on you than you are on them. They need you, and not just for financial reasons."

Signage that accompanies the exhibit shares messages such as "Domestic Violence Can Cause Brain Injury," "From Hopeless to Hopeful" and "From Hurting to Healed." The backs of the artwork contain information about where people can get help.

Webb said in the report that she thinks the art exhibit is going to open the eyes of a lot of people and clear up some commonly held misconceptions about people with brain injury, and it may also help people in domestic violence situations understand that they may be getting brain injuries.

Those interested in displaying the exhibit or in joining the St. Johnsbury Traumatic Brain Injury Support Group, can contact VCIL Ability Specialist Tom Younkman at 802-888-2180.



VIOLENCE EXPOSED — This art work is part of an exhibit showing the connection between domestic abuse and brain injury.
(Courtesy Photo: Tom Younkman)

Resources Directory!

Check Out the VPS website: www.vermontpsychiatricsurvivors.org

Vermont Psychiatric Survivors Peer Support Groups

Brattleboro:
- Changing Tides, Brattleboro Mem. Hosp, 17 Belmont Ave., Brattleboro; every Wednesday, 7-8:30 p.m. **Call Sandra at 802-579-5937**

Bennington/UCS
- United Counseling Service, 316 Dewey St., Bennington; Mondays and Wednesday, noon-1 p.m. **Call UCS at 802-442-5491**

Central Vermont
- Another Way,125 Barre St., Montpelier; every Monday; 5:30-7 p.m.; **Call (802) 229-0920**

East Arlington
- Federalist Church, Ice Pond Road, East Arlington; every Monday, 6 - 7:30 p.m. **Call Bryan at 802-375-6127**

Northwestern
St. Paul's United Methodist Church, 11 Church Street, St. Albans; 1rst and 3rd Tuesday, 4:30-6:30 p.m. **Call Keith at 802-370-2033**

Rutland
- Wellness Group, Grace Cong. Church, 8 Court St., every Wednesday, 5-7 p.m. **Call Beth at 802-353-4365**

Windsor
- Windsor Resource Center, 1 Rairoad Ave.; every Thursday, 5-6:30 p.m. **Call Rebekah at 802-674-9309**

Burlington
Learning Community (practicing Intentional Peer Support), Nuyan's Bakery & Café, North St. and Champlain, every Saturday, 1-3 p.m . **Call Sarah at 802-279-3876**

***Coming soon* - Springfield -** For information **call Diana at 802-289-1982**

VPS is a membership organization providing peer support, outreach, advocacy and education; 1 Scale Ave., Suite 52, Rutland, VT 05701. (802) 775-6834 or (800) 564-2106.

If interested in helping develop a support group in your area contact George at VPS, 802-282-2267; vpsgeorg@sover.net

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 County Mental Health Services
72 Harrel Street, Morrisville, 05661
888-5026; emergency screener line: 888-8888
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

Peer Support Lines

Vermont Support Line (Statewide): 1-888-604-6412; every day, 3-11 p.m.
Peer Access Line of Chittenden County: 802-321-2190, Thurs-Sun, 6-9 p.m.; for residents of Chittenden County.
Rutland County Peer Run Warm Line: Fri, Sat, Sun, 6-9 p.m.; 802-770-4248 or email at warm_line2012@yahoo.com.
Washington County Mental Health Peer Line Service: 802-229-8015; 7 days/wk, 6-11 p.m.

Peer Crisis Respite

Alyssum, 802-767-6000,
alyssum.info@gmail.com;
www.alyssum.org

DBT Peer Group: peer-run skills group; Share materials, advice, information and activities. Sundays, 4 p.m.; 1 Mineral St, Springfield (The Whitcomb Building). More info at http://tinyurl.com/PeerDBTVT

Brain Injury Association

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

Advocacy Organizations

Disability Rights Vermont
Advocacy in 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.

Mental Health Law Project
Representation for rights when facing commitment to a psychiatric hospital. 121 South Main Street, PO Box 540, Waterbury VT; 05676-0540;
(802) 241-3222.

Vermont Family Network
Support for families and children where the child or youth is experiencing emotional, behavioral or mental health challenges. 800-8800-4005;
(802) 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 or nursing homes.

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.

Health Care Ombudsman
(problems with any health insurance or Medicaid/Medicare issues in Vermont)
(800) 917-7787 or (802) 241-1102

Peer Centers

Another Way, 125 Barre St, Montpelier, 229-0920; info@anotherwayvt.org
The Wellness Co-op, 279 North Winooski Avenue, Burlington, Mon and Wed-Fri, 10 a.m.-7p.m.; Tues, 10 a.m.-9 p.m.; 888-492-8218 ext 300; thewellnesscoop@pathwaysvermont.org/ More information at www.thewellnesscoop.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); Every Wednesday, 7-8:30 p.m., Turning Point Center, 191 Bank St., 2nd floor
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 -12:30 pm; HCRS, CRT Room, 390 River St.

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

National Alliance on Mental Illness - VT (NAMI-VT)
provides upport, 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

LGBTQ Individuals With Disabilities

Burlington, Tuesdays, 4:30 p.m. at RU? Community Center, 255 S. Champlain St., - The Wellness Co-op, 43 King St, Thursdays, 3 p.m.
St. Albans, Northwestern Medical Center, conf room 4, Wednesdays, 5:30 p.m.
St. Johnsbury, Unitarian Universalist Church, 47 Cherry St, Fridays,11 a.m.
Online group through Pal Talk Monday nights 7-9 p.m. in the Vermont Chat GLBTQ And Disability chat room. Questions? Brenda@ru12.org / 802-860-7812 www.ru12.org

Vermont Recovery Centers

www.vtrecoverynetwork.org

Barre, Turning Point Center of Central Vermont, 489 N. Main St.; 479-7373; tpccvbarre@gmail.com
Bennington, Turning Point Center, 465 Main St; 442-9700; turningpointbennington@comcast.net
Brattleboro,Turning Point Center of Windham County, 112 Hardwood Way; 257-5600 or 866-464-8792; tpwc.1@hotmail.com
Burlington, Turning Point Center of Chittenden County,191 Bank St, 2nd floor; 861-3150; GaryD@turningpointcentervt.org or http://www.turningpointcentervt.org
Middlebury, Turning Point Center of Addison County, 228 Maple St, Space 31B; 388-4249; tcacvt@yahoo.com
Morrisville, North Central Vermont Recovery Center, 275 Brooklyn St., 851-8120; recovery@ncvrc.com
Rutland, Turning Point Center, 141 State St; 773-6010 turningpointcenterrutland@yahoo.com
Springfield, Turning Point Recovery Center of Springfield, 7 Morgan St., 885-4668; spfldturningpoint@gmail.com
St. Albans, Turning Point of Franklin County, 182 Lake St; 782-8454; tpfcdirecton@gmail.com
St. Johnsbury, Kingdom Recovery Center, 297 Summer St; 751-8520; n.bassett@stjkrc.org; www.kingdomrecoverycenter.com spfturningpt@vermontel.net
White River Junction, Upper Valley Turning Point, 200 Olcott Dr; 295-5206; mhelijas@secondwindfound.net; http://secondwindfound.org

Please let us know if your group's schedule changes: counterp@tds.net

VA Mental Health Services

VA Hospital: Toll Free 1-866-687-8387; Primary Mental Health Clinic: Ext. 6132
Outpatient Clinics Bennington: 802-447-6913, Brattleboro: 802-251-2200, Burlington Lakeside Clinic: 802-657-7000, Newport: 802-334-9777, Rutland: 802-772-2300
Vet Centers (Burlington) 802-862-1806 (WRJ): 802-295-2908

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 groups: contact www.vtvettovet.org

Helping Veterans Connect

The Department of Veterans Affairs has launched a new campaign, Make the Connection, to help veterans and their family members connect with the experiences of other veterans, and with information and resources to help them confront the challenges of transitioning from service, help them face health issues, or help them navigate the complexities of daily life as a civilian. The campaign's central focus is a website, www.MakeTheConnection.net, where veterans and their families can view the candid testimonials of other veterans "who have dealt with and are working through a variety of common life experiences, day-to-day symptoms, and mental health conditions."