

Counterpoint

Vol. XXX No. 3

From the Hills of Vermont

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Fall, 2015

Congress Considers ‘Reform’ Bills

Advocates Believe Proposals Over-Rely on Psychiatry, Promote Force

by ANNE DONAHUE
Counterpoint

Bills currently before the United States Congress threaten to set mental health services backwards, according to both national and Vermont activists, who are urging that the bills be stopped.

“It uses the language of ‘reform’ and talks about ‘help.’ But, it actually hurts people with psychiatric diagnoses and our families,” said Sarah Knutson, a Vermonter who is involved with Mad in America in efforts to lobby against two bills, one in the Senate and one in the House.

Knutson said the bills — S. 1945, the “Mental Health Reform Act of 2015” and H.R. 2646, the “Helping Families in Mental Health Crisis Act of 2015” — promote forced treatment over choices in treatment options.

Wilda White, Executive Director of Vermont Psychiatric Survivors, said one of the main problems is that they are “grounded in this blind faith in psychiatry and psychopharmacology” to the “complete exclusion” of alternatives and the research that has challenged psychiatric approaches.

“Some people are helped by psychiatry,” she said, but “this bill [in the House] puts all its money in the psychiatry pot” even though psychiatry is “more and more discredited every day.”

“Psychiatry has a lot to answer for,” including its “silence about harms” of drugs, White said. Psychiatry and drugs “cannot be the whole plan” to address mental health needs.

The underlying premise of the proposals is a return to a belief that mental illness is a lifelong condition and “you cannot recover,” which “goes

See details of the bills and how you can get involved on pages 4 and 5.

against the evidence” of more recent research. Even the definition of peers is narrowed to include only those who are identified as receiving traditional treatment, she said.

She pledged that VPS would use the proposals in Congress “as an opportunity to organize ourselves” as a voice of advocacy “not just statewide, but nationally.”

On the national scale, White fears that the greatest unintended consequence of the legislation would be “massive psychiatric incarceration” in institutions, with the impact falling “heavily on black and brown people” based on the prevalent racism in access to medical services

and psychiatry in particular. Both bills propose to allow greater access to federal funds for psychiatric institutions.

Disability Rights Vermont agrees with the concerns about the directions the bills have taken, and particularly about the ways in which it would limit how the federal Protection and Advocacy programs like DRVT could protect rights, said A.J. Ruben, supervising attorney.

He directed *Counterpoint* to the position of the National Disability Rights Network to identify details about the rights that would be eroded if the changes in law were passed by Congress.

Not all Vermont citizen organizations identify with the strong opposition of some advocates.

Peter Espenshade of the Vermont Association for Mental Health and Addictions Recovery said it was “most worried” about language that would decrease the prominence of SAMHSA, the federal Substance Abuse and Mental Health Services Administration.

VAMHAR primarily sees the bill as “an opportunity lost” for real reforms, with only “small steps” to increase parity and integration of health care. However “we are eternally optimistic,” Espenshade said, and the organization is working with Mental Health America “to improve language in the final bills.”

Laurie Emerson of NAMI-VT, the state branch of the National Alliance on Mental Illness, said its board “has not [yet] taken a position since the [House] bill is just recently introduced.” The national organization is firmly on record in support of the proposals.

Positions of Vermont Delegation

Members of Vermont’s Congressional delegation have not yet taken public positions on the bills. Rep. Peter Welch (D), the sole member of the U.S. House from Vermont, stated strong opposition to the original version of the House bill. That bill was introduced by Rep. Tim Murphy (R-Penn.), a psychologist, in the previous session.

The current Murphy bill in the House [H.R. 2646], reintroduced this June by Rep. Murphy and Rep. Eddie Bernice Johnson (D-Tx.), backed off from some of its most controversial proposals.

It had proposed to eliminate 85 percent of the funding for Protection and Advocacy programs, for example, and that provision was removed.

Welch’s staff did not respond to the question of whether he had changed his views as a result of the revisions to the bill, before *Counterpoint* went to press.

The Senate bill was introduced on August 9,

Increase in Discrimination Feared Under New Child Protection Law

by C.B. Hall
Counterpoint

MONTPELIER — New child protection legislation passed in May has rekindled debate about whether Vermont parents with disabilities face discriminatory obstacles from the Department of Children and Families (DCF).

Advocates have long expressed concern that stigma results in discrimination against such parents and harm to their children in both child neglect or custody determinations and in terminations of parental rights, and fear the new law will worsen that situation. (See article, page 6.)

Publicity about the case of a Montpelier mother with a mild cognitive disability, and a new federal ruling under the Americans With Disabilities Act (ADA) generated by concerns in Vermont, have brought a focus to issues of discrimination in the past several months. Both came after the adoption of Act 60.

DCF took criticism for its child-protection

practices after two toddlers who had had contact with the department died in 2014. Those cases both led to homicide charges against family members. The twin tragedies led the state legislature to pass the new child protection law, Act 60.

The Office of Legislative Counsel describes it as an act that “improves the State’s approach to preventing child abuse and neglect, and protecting children from abuse,” and summarizes nine sections:

1. Modifying the definitions of key terms, such as “risk of harm,” and “sexual abuse” in Title 33 to be more inclusive and consistent, and adding the definition of “serious physical injury”;

2. Amending the “mandated reporter” statute, 33 V.S.A. § 4913, to change the reporting threshold from “reasonable cause to believe” to “reasonably suspects,” requiring that mandated reporters personally report abuse and neglect, and clarifying that this must be done within 24 hours

(Continued on page 6)

(Continued on page 4)

Opportunities for Leadership and Advocacy

Meeting Dates and Membership Information for Boards, Committees and Conferences

State Committees

Adult Program Standing Committee

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 programs and monitors many aspects of the system.

Local Program Standing Committees

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

Conferences

Alternatives 2015

The 29th annual national mental health conference organized by and for mental health consumers/survivors and funded in part by SAMHSA, will be held in Memphis, Tennessee, Oct. 14-18. For more information contact <http://altcon2015.jimdo.com/>

Department of Mental Health Conference: Promoting Health, Wellness & Recovery

Oct. 6, 9:15 a.m. to 4:30 p.m. (Registration starts at 8:30 a.m.) Lake Morey Resort, Fairlee, VT

The Department of Mental Health invites peers (individuals with the lived experience of mental health conditions), family members, hospital and community mental health providers, advocates, law enforcement, and interested stakeholders to a one-day conference focused on promoting the health, wellness and recovery of individuals who receive support from Vermont's adult mental health system.

The morning keynote presentation will be How Vermont Taught the World About Rehabilitation and Recovery in People Coping with Severe and Persistent Psychiatric Disabilities by Courtenay Harding, PhD.

The afternoon presentation will be Motivating and Helping Smokers with Psychiatric or Alcohol/Drug Problems to Stop Smoking by Dr. John Hughes. There will be morning and afternoon workshops.

Online registration forms can be accessed and e-mailed to: Jennifer.Rowell@vermont.gov; however, a copy of the registration must also be provided with payment and sent to the following address: Jen Rowell, Department of Mental Health, 26 Terrace Street, Montpelier, VT 05609-1101.

Scholarships for consumers and family members will be available based on need. For questions about registration or scholarships, call 1-802-828-3867.

Events

NAMIWalk VT

Saturday, October 3, 10 a.m., Battery Park, Burlington. For more information contact NAMI-VT at 802-876-7949 x101 or info@namivt.org, or see www.namivt.org

Peer Organizations

Vermont Psychiatric Survivors

Must be able to attend meetings bimonthly. Experience with boards preferred but not necessary. For more information call (802) 775-6834 or email info@vermontpsychiatricsurvivors.org

Counterpoint Editorial Board

The advisory board for the VPS newspaper. Assists with policy and editing. Contact counterpoint@vermontpsychiatricsurvivors.org

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 info@alyssum.org

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

NAMI-Vermont Board of Directors:

Providing "support, education and advocacy for Vermonters affected by mental illness." Contact NAMI-VT at 802-876-7949

Hospital Advisory

Vermont Psychiatric Care Hospital

Advisory Steering Committee at the new hospital in Berlin; last Monday of month, 1:30 - 3:30 p.m.

Rutland Regional Medical Center

Community Advisory Committee; fourth Mondays, noon, conference room A.

Brattleboro Retreat

Consumer Advisory Council; fourth Tuesdays; 12 - 1:30 p.m., contact Gwynn Yandow, Director of Social Work Services at 802-258-6118 for meeting location.

University of Vermont Medical Center

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

FACEBOOK and WEB SITES

Intentional Peer Support

www.intentionalpeersupport.org
Site for information about Intentional Peer Support.

Wellness Workforce Coalition

www.vcil.org/services/wellness-workforce-coalition
Trainings, events and meetings of the Wellness Workforce Coalition.

Mad in Vermont

www.facebook.com/groups/madinvermont
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."

Counterpoint

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Mission Statement:

Counterpoint is published by Vermont Psychiatric Survivors as 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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The Editorial Board reviews editorial policy and all materials in each issue of Counterpoint. Review does not necessarily imply support or agreement with any positions or opinions.

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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

Federal Agency Seeks Public Input

Administration for Community Living (ACL), U.S. Department of Health and Human Services has released draft voluntary consensus guidelines for effective state Adult Protective Services, and is seeking public input. Adult Protective Services investigate abuse, neglect, self-neglect, and financial exploitation of older adults and people with disabilities.

Feedback on the draft guidelines can be shared by calling into a listening session or submitting a comment by October 30. To read the draft guidelines, view a full schedule of listening sessions and register for a call, or to use the on-line form for submitting written comments, go to the ACL web site at www.aoa.acl.gov/index.aspx

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Back Issues can be accessed at www.vermontpsychiatricsurvivors.org



MADLY JOYOUS — Participants at a recent Mad in Vermont potluck picnic gather for a photo. The group describes itself as a venue for peer support, news, and advocacy/activism organizing in Vermont and says that “psychiatric survivors, ex-patients/inmates, consumers, human rights activists and non-pathologizing allies are welcome.” (Photo Courtesy Mad in Vermont)

State Says Rutland Agency Met Corrective Plan Deadline

RUTLAND — The Department of Mental Health has reported that Rutland Mental Health Services has met its 30-day deadline to submit a plan of correction, after the agency received a notice of “provisional designation with intent to de-designate” from the state earlier this summer.

The Department is drafting a letter accepting Rutland’s plan, according to Emma Harrigan, DMH Quality Management Director. RHM will then have until February, 2016, to complete the improvements.

De-designation means that a community mental health agency is no longer eligible to be the provider of services for its geographic area. It indicates that “most or almost all standards not met” and is the most serious action short of ter-

minating funding. In fiscal year 2013, the agency received \$28.3 million from the state.

“Communication with Rutland has been very good” with interim Chief Executive Officer Dick Courcelle in the process of developing the plan of correction, Harrigan said. She said that DMH will make monthly visits to review progress on implementation.

Agencies are evaluated for designation every four years, and the process includes a review and recommendation by the stakeholder Adult Program Standing Committee. In the Rutland review, the Commissioner accepted the recommendation of that committee to issue the “intent to de-designate” notice.

The notice came after reviews that included criticism of the agency’s leadership and communication with staff, and the quality of many services. Deficits identified included waiting times for children’s services, lack of transportation for clients and poor quality of collaboration regarding hospitalized clients and their aftercare.

Clients indicated that they had token or little participation in decision-making, and were neither aware of their right to file grievances and appeals nor of the process for doing so, the review said.

Three major treatment incidents were reported in 2014 that brought Rutland Mental Health to particular attention of the state in 2014: A patient who overdosed on Benadryl, a 13-year-old girl who died of suicide while on a waiting list for services, and a client who was sexually exploited by a worker at a RMH placement.

The Rutland Mental Health Board of Directors named Courcelle as interim CEO after the resignation of Dan Quinn in June amid the criticisms of his leadership.

The House Human Services committee in the legislature held a special hearing in July to review the agency re-designation process. AD

Vermont Mental Health Commissioner Named

NEW COMMISSIONER — Frank Reed, Deputy Commissioner of the Department of Mental Health since 2012 and recent Interim Commissioner, was appointed Commissioner by Governor Peter Shumlin in late August. He has been with DMH since 1999, and worked previously as a clinical social worker. Reed replaces retired Commissioner Paul Dupre.



(Photo courtesy of DMH)

State Delays Cut to SSI Beneficiaries

MONTPELIER — Elderly or disabled Reach Up recipients who also receive SSI (Supplemental Security Income) were protected from cuts in benefits in August and September after Vermont Legal Aid sued the state.

A federal court will hear arguments in September about whether to impose a longer ban on the cuts, according to Chris Curtis, the attorney handling the case for Legal Aid. The cuts were included in language in the budget bill passed by the legislature in May.

The new language in the budget counts \$125 of adult SSI income against a household’s temporary cash assistance (or “Reach Up”) benefits. The lawsuit is asking the court for an injunction to stop the cuts from taking effect, and to declare that the reductions are unconstitutional and discriminate against persons with disabilities.

After the lawsuit was filed, the state voluntarily agreed to delay the cuts by 60 days, in order to allow time for legal research and arguments, Curtis said.

“I feel like I’m being punished for having a disability,” Robin Wheeler of Williamstown, one of the named plaintiffs in the suit, was quoted as saying in a Legal Aid press release. Wheeler suffers from post-traumatic stress disorder, agoraphobia, anxiety and depression, the release said. She said she has to meet the needs of herself and her 15-year old daughter and cannot afford any reduction in benefits.

Curtis said that some individuals may have still seen the reduction in their August Reach Up benefit, but that they should have received a payment for the difference shortly afterwards. He recommended that anyone in that situation who did not receive the replacement amount contact the Department of Children and Families. AD

Emergency Waits Continue; Census Capped

MONTPELIER — Inpatient psychiatric hospitals have been running close to capacity, according to DMH data collected through the end of July, and patients continue to have to wait in hospital emergency departments for a bed.

There were 21 times patients had to wait in an emergency room in July. It was a decrease from May and June, but the length of time they had to wait increased to an average of two days each.

The state-run Vermont Psychiatric Care Hospital in Berlin, meanwhile, has had to cap its census at 20 of its 25 beds due to a shortage of nursing staff, according to its Executive Director, Jeff Rothenberg.

The difficulty in recruitment has been attributed in significant part to a salary range that averages \$16,000 less per year than at private hospitals. An Agency of Human Services work group is reviewing all state nursing positions, but the potential for adjustment to market levels “is still months away,” Rothenberg said.

Congress Considers ‘Reform’ Bills

(Continued from page 4)

just as the Senate broke for its summer recess. Those following the legislation say that it has many common themes but does not include all of the components of the House bill.

It was introduced by Sens. Bill Cassidy (R-La.) and Chris Murphy (D-Conn.) Murphy is no relation to Rep. Murphy in the House, but the two “Murphy bill” references have caused confusion.

Vermont Sen. Patrick Leahy’s staff said that, “Since the bill was only introduced just as the House and Senate were about to recess for the month of August, we haven’t had time to evaluate it yet.”

The staff of Vermont’s other Senator, Bernie Sanders (currently running for President), did not respond to *Counterpoint* before deadline.

VPS Criticizes Bill Approaches

White, from VPS, said that a fundamental problem was that the bill was a response to episodes of mass killings such as Sandy Hook and thus is “using a rare but tragic incident to make policy” based on an “unproven connection between mental health and violence.”

She said the House Murphy bill favors involuntary treatment as a way to address violence, contrary to evidence that it is just as likely that expanded choices in treatment, not involuntary treatment, are what make a difference.

It takes away privacy rights, persons’ abilities to make decisions, legal protections, and “leaves it up to the psychiatrist only” to determine appropriate care.

Yet supporters of the bill “don’t want it [psychiatry] to be held up to scrutiny” since oversight and advocacy is significantly reduced. “Psychiatry needs more oversight,” not less, she said.

White said it also starts the process of labelling mental illness with “kids who are just infants.”

“You cannot shake that diagnosis... you are marked,” White said.

VPS will be working on “organizing and educating our members” to oppose the bill, she said. White said that advocacy efforts will include talking with Senators and Representatives, meeting with news media editorial boards, and working with other advocacy partners.

Attack on Rights?

National Disability Rights Network spokesperson David Card said that his association of federal Protection and Advocacy for Individuals with Mental Illness (PAIMI) programs strongly opposes the reduction in protection of rights and the overuse of a medical model that is reflected in the House bill.

Lack of services, use of restraint and seclusion, and civil rights issues “desperately need to be addressed” but the Protection and Advocacy system would be barred from bringing class action lawsuits, blocked from lobbying with its own, non-federal funds, and limited to abuse and neglect cases, he said.

It also sets up a system where advocates “cannot contradict what an MD says” despite the evidence, he said.

The Senate bill does not include changes in the PAIMI system.

However, the focus of both bills is “if we do even more medical treatment, we’ll be fine,” Card said. Although supporting peer programs, the bills say, “this is the subset of peers we support”: only those connected to the medical model.

They also discriminate against a single disability — mental health — in privacy of information by allowing caregivers access to patient information in some situations, he said.

In fact, the language “turns the program on its head” by requiring Protection and Advocacy organizations to ensure caregivers have access to that information, even though they “may have direct opposite interests” from clients.

Both bills allow federal funds for freestanding psychiatric hospitals. Supporting more institutional care “is not the way to solve [the] problem” of access to treatment,

Card said. The new version of the House bill no longer denies funding to states that do not have involuntary outpatient treatment laws, but it uses “a carrot instead of a stick” by offering more funding to states with such laws, he said.

That — and the funding of inpatient and residential care — can result in diverting funds from community services, since the bill will not increase any overall funding for services. “They’ve got to get the money from somewhere,” he said. The Senate bill does not reference involuntary outpatient treatment.

Knutson’s concern focused on the issue of coercion that she said is most apparent in the support for involuntary outpatient laws that is reflected in the House bill, but she said that the Cassidy/ Murphy Senate Bill “is not much better,” because “it embraces many of the assumptions that keep the mental health system broken.”

How To Advocate About the Bills

How can you make your voice heard in Washington if you are concerned about the major mental health bills in the House and Senate? Alyssa Schatz, Director of Advocacy at the Mental Health Association of Southeastern Pennsylvania, has a list of key suggestions. Her agency has been aggressive in its opposition to the bills.

- ▶ Educate, educate, educate. “The biggest thing we’re doing is education about what it [the bill] really means” and how it would change the system, in some cases in very negative ways. This includes talking with community groups, family members, and other mental health providers. For example, she said family groups are where much of the support for the bill is coming from. They “just want their loved ones to be safe” but don’t realize, for example, how it might reduce treatment options, making situations worse. “Having these conversations can be really helpful.”

- ▶ Mobilize other groups. Community-based programs can become major allies when they look at where the money for increased involuntary treatment would come from: those programs may be at risk for their own funds.

- ▶ Advocate with Congress through Vermont’s legislative delegation. One Pennsylvania representative agreed to meet with her association. “Now is the time to get to them,” she said, before minds are made up. There is publicity suggesting that the new version of the House bill, and the newly-introduced Senate bill, are good compromises in contrast to the original House bill introduced last session. Legislators want to be seen as pro-mental health, and many think supporting this bill accomplishes that.

- ▶ Draw public attention to the problems with the bill. Letters to the Editor are helpful if they are timed for when a newspaper has run an article about the bill. News media can also be drawn to cover an event, such as if a group hosts their Congressional representative.

- ▶ Get updates from the Campaign for Real Change in Mental Health: <http://realmhchange.org>, which features a petition, blogs, talking points, and compiled statements. “The Campaign recognizes that we don’t have to sacrifice people’s civil rights to create an effective mental health system. The Campaign also believes that to enact any ‘mental health reform’ that does not take a comprehensive public health approach is a missed opportunity.”

Contact information for Your Members of Congress:

Representative Peter Welch

(identify H.R. 2646, the “Helping Families in Mental Health Crisis Act of 2015”)

Vermont Office: 128 Lakeside Avenue, Suite 235, Burlington, VT 0540

Phone: (802) 652-2450 or (888) 605-7270

D.C. Office: 2303 Rayburn House Office Building, Washington, DC 20515

Phone: (202) 225-4115

Email via the web site <http://welch.house.gov/contact/>

Senator Patrick Leahy

(identify S. 1945, the “Mental Health Reform Act of 2015”)

Burlington Office: 199 Main Street, 4th Floor, Burlington, VT 05401

(802) 863-2525; 1-800-642-3193

Montpelier Office: 87 State Street, Room 338, Montpelier, VT 05602

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Washington D.C. Office: 437 Russell Senate Bldg, Washington, DC 20510

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Email via the web site <https://www.leahy.senate.gov/contact/>

Senator Bernie Sanders

(identify S. 1945, the “Mental Health Reform Act of 2015”)

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Washington D.C. Office: 332 Dirksen Building, Washington, D.C. 20510

(202) 224-514; fax (202) 228-0776

Email via the web site <http://www.sanders.senate.gov/contact>

What the Bills Propose:

A Brief Summary of Controversial Sections

Based on a webinar presented by National Disability Rights Network and the Bazelon Center. The full webinar is available at: http://www.westernmassrlc.org/images/stories/Final_Compiled_Murphy_Bill_Webinar_Slides_081115_1.pdf

House Bill 2646

“Helping Families in Mental Health Crisis Act of 2015”

Involuntary Treatment

- ▶ Would offer a two percent funding increase for states with an assisted outpatient (involuntary) treatment law in effect; requires a report from states with AOT laws comparing outcomes from people in the program to people who were eligible but did not participate.

Extending Medicaid Funding for Institutions

- ▶ Would establish a state Medicaid option to fund psychiatric hospitals that are not a part of a larger hospital and residential treatment services; hospital services would cover hospitals or units if average stays are 30 days or less. New cost cannot result in overall increase in federal spending in mental health services. [Note: Vermont already uses federal funds for freestanding psychiatric hospitals, without a length of stay limit, through a federal waiver; thus allowing Medicaid funding for the Brattleboro Retreat and the Vermont Psychiatric Care Hospital.]

Defining Peer Specialist

- ▶ Would create a definition of a peer support specialist: must be in mental health/substance use disorder treatment for at least the preceding two years; individual must be supervised by a licensed mental health/substance use disorder professional.

Rights Protection and Oversight Changes in H.R. 2646

- ▶ Would limit federal Protection and Advocacy for Individuals with Mental Illness (PAIMI) programs (such as Disability Rights Vermont) to advocacy on neglect or abuse (eliminating, e.g., civil and human rights protection including employment discrimination, denial of educational services, or housing discrimination cases); the new version no longer contains the 85 percent cut to PAIMI funding.
 - ▶ Would bar PAIMI from raising concerns with decisions made by doctors, families or guardians.
 - ▶ Would require the PAIMI program to ensure that caregivers have access to the protected health information disclosed under the Act.
 - ▶ Would bar PAIMI programs from using even separately raised money for lobbying on public policy.

Privacy of Health Records

- ▶ Would allow access to protected health information by caregivers without consent when “the individual by nature of the severe mental illness has or has had a diminished capacity to fully understand or follow a treatment plan for their medical condition or may become gravely disabled in absence of treatment” when “necessary to protect the health, safety, or welfare of the individual or general public.”
 - ▶▶ Would permit disclosure of: “diagnoses, treatment plans, appointments, scheduling, medications, and medication-related instructions, but not including any personal psychotherapy notes.”
 - ▶▶ “Caregiver” is defined as an immediate family member, personal representative, or someone “who assumes primary responsibility for providing a basic need of such individual” and “can establish a longstanding involvement and is responsible with the individual with a serious mental illness and the health care of the individual; and excludes an individual with a documented history of abuse.”
 - ▶ It adds some qualifiers that were not in the original bill:
 - ▶▶ Information must be “beneficial to the treatment of the individual if that individual has a co-occurring acute or chronic medical illness”
 - ▶▶ Must be “necessary for the continuity of treatment of the medical condition or mental illness of the individual”
 - ▶▶ “The absence of such information or treatment will contribute to a worsening prognosis or an acute medical condition”

Administrative Changes

- ▶ Would create an Assistant Secretary for mental health and substance use disorders to take over responsibilities of the current Substance Abuse and Mental Health Services Administration; the Assistant Secretary is required to have a degree in medicine or doctorate in psychology with pharmacological training.
 - ▶ Would establish Interagency Serious Mental Illness Committee to make recommendations to the Assistant Secretary and National Institutes for Health. Duties include developing a plan to enhance treatment compliance.
 - ▶▶ Committee includes only one member in recovery; individual must currently be in treatment with a MH professional
 - ▶▶ Committee includes only one family member; their family member must have had a suicide attempt or be incarcerated for violence
 - ▶▶ Committee now includes one member that is a certified peer specialist.
 - ▶ Establishes a National Mental Health Policy Laboratory; 80 percent of members must have professional degrees (MD, psychology, SA, research), 20 percent appointed by Congress.
 - ▶ Requires 50% of grant peer-review groups to have a medical degree, doctoral degree in psychology, or be a licensed mental health professional and 50% of advisory councils to be mental health providers with experience in mental health treatment or research.

Differences in Senate Bill 1945:

“Mental Health Reform Act of 2015”

Major difference in the bill is that it does not include the House provisions about the Protection and Advocacy program, and it does not offer a two percent funding increase for states that have an assisted outpatient treatment law in effect.

Variations in its parallel provisions include:

Involuntary Treatment

- ▶ Does not offer a two percent funding enhancement to block grant for states that adopt “assisted outpatient treatment,” but would authorize 2-year extension of the “assisted outpatient treatment” pilot program that passed as part of the Medicare “doctor fix” bill last year.

Extending Medicaid Funding to Institutions

- ▶ Funding would be extended to psychiatric hospitals or units with average length of stay of less than 20 days rather than less than the 30 days in the House; does not cover psychiatric residential treatment facilities.

Defining Peer Specialist

- ▶ Contains similar but not identical provisions to the House bill. Assistant Secretary to do report on best practices and certification standards for peer specialists and make recommendations.

Privacy of Health Records

- ▶ Adds factors to be considered as part of determining when disclosure is in a person’s “best interests” in situations where person is not present or lacks capacity to consent or object to disclosure:
 - ▶▶ Timely intervention for treatment of a serious mental or general medical illness
 - ▶▶ Safe and stable housing for the individual
 - ▶▶ Increased daily living skills that are likely to allow the individual to live within the community
 - ▶▶ An increased capacity of caregivers to support the person to live within the community
 - ▶ Health and Human Services Administration to develop model training programs for healthcare providers, lawyers, individuals with psychiatric disabilities and their families concerning federal confidentiality law application to mental health.
 - ▶ Would permit single authorization for disclosure and redisclosure of electronic health records in integrated care arrangements like health homes, accountable care organizations, and health information exchanges.

Increase in Discrimination Feared Under New Child Protection Law

(Continued from page 1)

of first observing or receiving information about the abuse or neglect;

3. Encouraging information sharing among the various professionals dealing with an abused or neglected child;

4. Replacing the rigid custody hierarchy in 33 V.S.A. § 5308 with a “best interests” standard and a shorter, and less rigid, list of custody options for courts to consider [parts of this section of law removed by Act 60 had been enacted just a few years ago to prioritize family caregiver options when consistent with a child’s best interests];

5. Allowing legally enforceable post-adoption contact agreements between adoptive and birth parents for children in DCF custody;

6. Clarifying the jurisdiction of Special Investigations Units and what allegations DCF must report to law enforcement;

6. Amending 13 V.S.A. § 1304 (cruelty to a child) to provide for an enhanced sentence if a child is killed, or suffers serious bodily injury or sexual assault;

7. Establishing a legislative oversight committee that will sunset in 2018;

8. Establishing a working group to recommend improvements to child in need of supervision (CHINS) proceedings.

The redefinition of “risk of harm” broadens application to situations of parents using drugs. The post-adoption contract agreements are limited to birth parents who agree not to contest a termination of parental rights.

There was little discussion about issues of discrimination in the lengthy hearings on developing a bill to improve child protections.

Then, this past summer, the national television program Al Jazeera America reported on Alice Goltz, a Montpelier mother with a mild intellectual disability who lost parental rights to her daughter. The case brought greater public awareness to the issue of potential discrimination.

When Goltz gave birth to her daughter in 2007, a nurse notified DCF that she had a disability, Goltz told *Counterpoint*. Within hours of the baby’s birth, she thus found herself stigmatized as someone not good enough to be a parent. From there on, she said, DCF was determined, in her terms, to steal the child from her.

DCF commissioner Ken Schatz told *Counter-*

point that when families are wrestling with cognitive disabilities, “the parent’s mental health is not involved at all, except to the extent that this is making conditions for the child unsafe.”

The Goltz case ended up before the Vermont Supreme Court, but did not address disability discrimination because DCF did not use her impairment as a part of its case findings.

One expert familiar with the case, who did not wish to be identified out of concern regarding her work with the Department, said that the finding that Goltz didn’t have a disability “is an easy way to get out of the obligations for accommodations.”

A second discrimination case was making its way through the Department of Justice at the same time.

The head of Disability Rights in the Office of Civil Rights of the Department of Justice had invited advocates to find a case that showed clear discrimination, said Susan Yuan of the Vermont Coalition for Disability Rights.

A case involving a termination of parental rights in Massachusetts was filed. Nicole Brisson

(Continued on page 7)

Advocates Describe Challenges Parents Face

by DONNA IVERSON

Counterpoint

BURLINGTON — Trine Bech, executive director of Vermont Parent Representation Center (VPRC), is one of the advocates that fears that the new Act 60 (*see article, above*) will result in more situations where children are unnecessarily removed from their homes.

The issue of child custody is more complicated than the two toddler deaths that led to Act 60 would indicate, according to Bech.

“Vermont will soon be number one in the nation in the removal of infants,” Bech said in an interview. “Child abuse panic has hit Vermont hard.”

The Vermont Parent Representation Center (VPRC), according to its website, is a law, social work, and public policy organization that provides legal advocacy and family support services for parents at risk of having their children placed in state or other out-of-home custody.

The social worker on the Center’s Family Intervention Team, Sandi Yandow, said that “100 percent of the women” she works with have a mental health diagnosis. “Most were diagnosed as adolescents if not as children.”

The Department of Children and Families released its annual report this summer, which showed more than 1,300 Vermont children in state custody, a number that continues to grow.

The report states that the “upward trend is primarily being driven by parental opiate addiction, which reduces a caregiver’s ability to parent safely.”

Bech disagrees with that assessment and argues that children are being taken into custody with no solid evidence of harm and only suspicion of harm.

Under the new legislation, any past record of drug use can be cited as a potential “risk of harm” to a child, and can be used to take that child into state custody, Bech said.

“If a parent has had a past history of substance

abuse and that has the attention of DCF, that may be enough to remove an infant.”

“And that includes women who are in recovery,” she added.

The majority of the Center’s clients have suffered trauma which contributed to the mental health diagnosis, Bech said. She described the trauma as “horrendous” in many cases.

When a child is taken away from a woman with a history of trauma, she is, in effect, re-traumatized, Bech said. She may lash out, use bad language, and then be perceived by authorities as being “noncompliant,” thus a danger to her child.

Yandow added that in fact these behaviors have nothing to do with compliance, and are “coping strategies” — but an understanding of trauma and its effect on behavior are not really understood by many in state government.

In custody cases like these, the mental health of the child is also jeopardized.

“The child suffers trauma when removed from parents, but we don’t talk about that,” Yandow said. Even though the child may be too yet to understand what is happening, the “body does remember it.”

“We are doing a lot of damage,” she said. The child is in danger of not forming a secure attachment, which is leading factor in mental health issues in childhood, adolescence and adult life, she explained.

“There is a direct correlation with the next generation. The majority of our women clients have been in foster care themselves or in out-of-home placement as children,” she added.

Yandow said that “all women in a medication-assisted treatment program get referred” to DCF when they are pregnant. Women who are in recovery who are using methadone or suboxone are put in the same category as heroin users by the state, she said.

Medical records are being shared across agencies so any negative data entry about a pregnant woman gets DCF involved, she added. Encour-

agement to share information was emphasized in Act 60.

The Center believes that the impact of poverty is the other elephant in the room. “All of our families are poor,” said Bech.

“Upper and middle class families never come under the scrutiny that poor families do. A lot of our clients are homeless or precariously housed.”

According to Yandow, the parent often doesn’t have bus money to get appointments, like those at the DCF office in Williston. Even if they get transportation money, the bus drops them off blocks from the DCF office building and they have to walk uphill, even in winter’s cold icy conditions.

They can’t bring children with them, so they need child care, which they also cannot afford. If they are 15 minutes late, the appointment is cancelled, Yandow added.

Not only are they under intense scrutiny, but often parents are treated with disrespect and just not believed, Bech said.

Often they are intimidated into signing documents that they don’t understand, she said. She gave as an example a prenatal agreement that the UVM Medical Center requires before treating pregnant women with drug histories.

By signing that agreement, they give up some parental rights, but they are told if they don’t sign, they will be denied prenatal care which is required by DCF in potential custody cases, she added. “The release document is so complicated, a PhD, MD, or JD would not understand what the hell it said,” she said.

Poor women on DCF’s radar are up against a class system that pits them against well-to-do educated upper and middle class parents, wanting to adopt, who “are hoping the parents fail” to meet DCF requirements for keeping their child.

“Some social workers look at foster parents who are educated and have money, and forget their legal duty to make an effort to return the child to its parents,” Bech asserted.

Increase in Discrimination Feared Under New Law

(Continued from page 6)

of Sage Haven Associates in St. Albans served as expert witness.

The federal Department of Justice and the Department of Health and Human Services issued a letter in July stating that the termination violated both the Social Security Act and the ADA, which calls for “reasonable modifications in policies, practices or procedures when . . . necessary to avoid discrimination on the basis of disability.”

In August the agencies released guidance to states on their responsibilities to provide accommodations to parents with disabilities. “The goals of child welfare and disability non-discrimination are mutually attainable,” the document said. Yuan and Brisson worked with DOJ and HHS to formulate the guidance.

When presented with the July letter, Schatz stated that the federal action would not change any specific aspect of his agency’s provision of services to parents with mental disabilities.

Vermont’s new Act 60 has a general finding that “Vermont must invest in proven strategies to support and strengthen families” but does not directly reference the right to accommodations under the ADA.

“What I hope is that we don’t create an atmosphere where we overreact and cast judgment on folks who may have legitimate needs for assistance and accommodations due to their disabilities, and paint them with the same brush as people who are neglectful and abusive of their children,” Ed Paquin, executive director of Disability Rights Vermont, commented in reference to the new law.

Rep. Vicki Strong (R-Albany) was one of only three legislators who voted against the bill. She said she believed there was a lack of support for families facing neglect or abuse proceedings.

“I would like to see us strengthen the resources young parents need to succeed – resources such as mentoring, drug treatment, and affordable housing,” she said.

The Senate passed the legislation unanimously. Sen. Dick Sears (D-Bennington), one of six senators who sponsored the bill, said he didn’t agree with critics who feel that the rights of parents, including those with disabilities, were being placed at risk.

“There are always advocates that oppose and support everything you do. You can’t make them all happy,” he said.

Retreat Faces Fraud Investigation

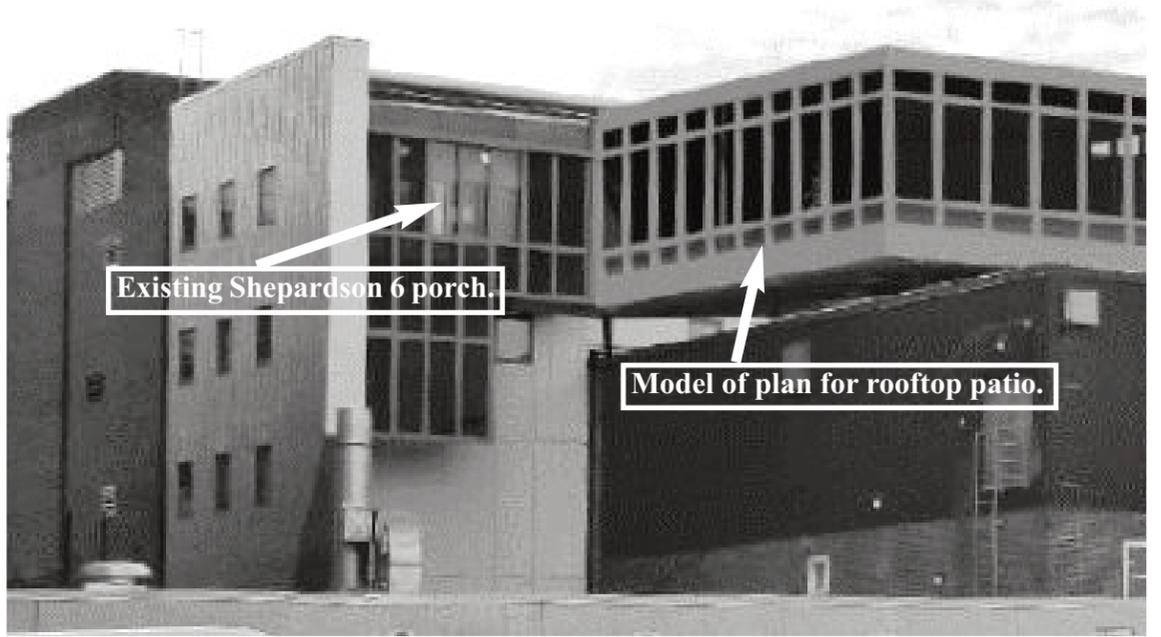
BRATTLEBORO — Statewide news media have reported that a criminal investigation is underway by the Attorney General’s office to review allegations of Medicaid billing fraud at the Brattleboro Retreat.

Retreat officials said the private psychiatric hospital was “fully cooperating” with the investigation.

The investigation was sparked by reports from a whistleblower who had worked in the hospital’s billing office, according to the media reports. A federal judge dismissed a lawsuit last year brought last year by former hospital employee Thomas Joseph.

The Retreat remains under special conditions for improving quality and safety of patient care after investigations last year by the federal Centers for Medicare and Medicaid Services.

Retreat spokesman Jeff Kelliher said the Retreat takes the fraud allegations “very seriously,” but was “not provided any further detail regarding the scope of the investigation except to say that the Attorney General’s office would be contacting our attorneys in due course.” AD



MEDICAL CENTER PLANS ROOFTOP PATIO — This design model shows a rooftop patio design planned for directly off the Shepardson 6 inpatient psychiatric unit at the University of Vermont Medical Center in Burlington. Although psychiatric unit renovations in 2000 included a small outdoor garden at ground level, it was difficult for Shepardson 6 patients to have access to it. The plan will go before Burlington city officials in September for design review approval. The rooftop patio will be enclosed by screening and include seating areas, and faces the Green Mountains. It is modeled after the rooftop design at the Rutland Regional Medical Center. Additional plans are under development to increase activity space on Shepardson 6 by moving support staff space to the floor immediately below the unit.

(Artist Rendition Courtesy of Lavallo/Brensinger Architects)

Legislators Question Treatment of Prisoners

by C.B. HALL
Counterpoint

MONTPELIER — Members of the Joint Legislative Justice Oversight Committee expressed frustration at their August meeting about how to provide appropriate care for individuals with critical mental health needs in the custody of the Department of Corrections.

“This is not the first time we’ve confronted the problem of DOC being viewed as the institution of last resort” in providing care to persons with mental disabilities, said Sen. Dick Sears (D-Bennington).

The committee had requested a report about a death by suicide that occurred earlier this year at the Southern State Correctional Facility in Springfield.

Defender general Matthew Valerio said that Patrick Fennessey, 34, had “severe mental health issues” and that at various times and places, his care was the responsibility of four different agencies as he was shifted between Corrections, inpatient psychiatric care, and community services.

All four — Corrections, the Department of Mental Health, the Agency of Human Services as a whole, and the local community mental health agency — “to some degree contributed to not preventing this guy’s suicide,” he said.

“They didn’t have a caregiver or a place to keep him outside, so they brought him back in,” Valerio told the committee, explaining why Fennessey was returned to Southern State after he was released from an admission to the Brattleboro Retreat.

Sen. Tim Ashe (D/P-Burlington) asked Valerio if policies and procedures were broken, and if legislators should revisit them.

“Yes and yes,” Valerio responded. He stressed that his investigation of the case was continuing, and that the information he had pre-

sented was preliminary, but that he doubted that his conclusions would change.

The Executive Director of the community agency involved, George Karabakakis of Health Care and Rehabilitative Services (HCRS), later questioned whether Valerio should be drawing such conclusions before finalizing his investigation.

“We were dealing with this back in the 1990s,” said committee member Rep. Alice Emmons (D-Springfield) observed, yet the issue of mental health needs among inmates continues to resurface.

In fiscal year 2014, according to DOC data, almost half of the prison population, or 738 inmates, received regular mental health care at prisons within Vermont. (Prisoners housed out of state were not included in the data.)

Mental health services were requested in 8,700 instances in 2014, an increase of 76 percent since 2008.

“Should we build a new [mental health] facility in Vermont?” Sears asked rhetorically at the close of the meeting. “I think many of us favor that. It’s just, whose backyard does it go in?”

“And who pays for it,” Emmons added.

In Fennessey’s case, there was a long trail of service failures that Valerio recounted. The man had a lengthy criminal record but relatively minor offenses.

At one point after his release on furlough in December 2014, his outpatient placement failed because a caregiver was found drunk by a DOC Field Services Unit monitor.

Back at Southern State, Fennessey grappled with a lack of adequate attention to his mental health and his homosexuality – for which, Valerio said, guards reportedly mistreated him.



PERSONS WITH DISABILITIES got a boost from an economic development bill, signed this summer by Gov. Peter Shumlin, which increased the amount that can be earned while keeping eligibility for Medicaid. Sam Liss (right) from the Vermont Center for Independent Living, lobbied for the change for years. (Counterpoint Photo: Anne Donahue)

News from the Vermont Center for Independent Living Workforce Group Has New Website

MONTPELIER — The Wellness Workforce Coalition announced the launch of a new website this past summer, www.wwcvt.org.

The Coalition is a program of the Vermont Center for Independent Living that supports training and advocacy for the workforce of persons with lived experience of mental health issues. Member organizations are all peer-run, which means that they are run by persons with a lived experience.

WWC Coordinator Julie Brisson said in the news release that while the coalition has been around and doing good work for a while, it will now be easier to share information about that work.

“The site allows us to spread the word about advocacy events and news about what’s going on in terms of peer services in Vermont.”



Peer Cadre Program Begins in Lamoille

MONTPELIER — A new peer cadre has begun in Lamoille County designed to offer support to people in crisis at the hospital, modeled after a Northeast

Kingdom Human Services Peer Cadre. The program is sponsored by the Wellness Workforce Coalition under the umbrella of the Vermont Center for Independent Living.

“We believe that people who have psychiatric disabilities themselves and have been through mental health systems can offer support to someone currently having similar experiences and we call that peer-to-peer support,” said Sarah Launderville, executive director of the Vermont Center for Independent Living, in a news release.

“Oftentimes we hear that people feel scared and alone and talking to someone who truly understands those feelings from their own personal experiences is invaluable.”

The peer cadre that was formed in April is a partnership between Lamoille County Mental Health Services and Copley Hospital in Morrisville. The existing Northeast Kingdom cadre is a partnership between Northeast Kingdom Human Services and Northeastern Medical Center.

Julie Brisson, the WWC coordinator, explained that the cadre assists in situations such as when a person is waiting to be seen in the emergency room who may be very upset.

All of the peer cadre workers have lived experience and have received specialized training. Brisson said, “Sometimes just having a conversation with someone who is in crisis, or offering them something as simple as a beverage and a snack, can change their whole focus.”

UVM To Research Integration

BURLINGTON — A research team at the University of Vermont has been approved for an \$18.5 million funding award by the Patient-Centered Outcomes Research Institute (PCORI) to study Integrating Behavioral Health and Primary Care.

The group states that its project aims to identify the best means for addressing the behavioral problems underlying many chronic diseases that cause the majority of illness, disability, and death, which it identifies as being issues such as tobacco use, diet, physical inactivity, alcohol abuse, drug abuse, failure to take treatment, sleep problems, anxiety, depression, and stress.

Benjamin Littenberg, M.D., Professor of Medicine and his team, which includes experts from across the country, will conduct a study of 30 practices where they will compare the level of integration of care and its outcomes.

Information From Across the Nation

Compiled by *The Key*,

National Mental Health Consumers' Self-Help Clearinghouse

New Publication on Trauma-Informed Care For Youth and Young Adults Is Available

Pathways Research and Training Center at Portland State University in Oregon has published Trauma-Informed Care, a 40-page magazine with articles focusing on youth.

Among the articles are “The Impact of Toxic Stress on the Developing Person: Becoming a Trauma-Informed Service Provider,” “Through a Darker Lens: The Trauma of Racism in Communities of Color,” and “SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach in Youth Settings.”

The publication is available for free download at <http://www.pathwaysrtc.pdx.edu/pdf/fpS15.pdf>.

Comics and Graphic Novels Raise Awareness of Mental Health Issues

Studies have shown that there is a link between creativity and recovery. Evidence of this can be found at Broken Frontier’s website, which has reviewed nine comics and graphic novels that raise awareness of mental health issues. For more information, see: <http://www.brokenfrontier.com/world-mental-health-day-hoax-psychosis-blues-psychiatric-tales-comics-graphic-novels-raise-awareness-mental-health-issues/>

Submit Graphic Art: For a website which accepts submissions of graphic art comics drawn by people with experience of living with long-term mental illnesses, go to: <http://better-drawn.tumblr.com/>

Transgender Youth Depression, Anxiety Improve When Able To Identify With Gender

An article in ThinkProgress reports that a new study has found that when transgender young people are allowed to fully identify with their gender and take steps toward transition, it significantly improves their depression and anxiety. “This study adds to the growing research showing that affirming transgender identities at a young age yields positive results,” the article said. Download at <http://thinkprogress.org/lgbt/2015/03/10/3631788/letting-transgender-kids-transition-is-for-their-own-/>

Survey of Certified Peer Specialists Identifies Job Titles and Job Descriptions

The Temple University Collaborative on Community Inclusion surveyed 275 Certified Peer Specialists in paid CPS positions across the country, and created a document covering the wide variety of job titles that CPS staff work under, and the varied descriptions — in the CPS respondents’ own words — of their roles. The free 44-page document is available at: <http://tucollaborative.org/wp-content/uploads/2013/11/Results-from-a-national-survey-of-certified-peer-specialist-titles-and-job-descriptions.pdf>

National Survey Look at Employment Of Individuals with Disabilities

The Kessler Foundation and the University of New Hampshire (UNH) have presented the results of the Kessler Foundation 2015 National Employment and Disability Survey. It identifies strategies that Americans with disabilities use to search for work and navigate barriers, accommodations that are helpful to obtain and maintain employment, and factors that contribute to unemployment. The executive summary is available at http://kesslerfoundation.org/sites/default/files/filepicker/5/KFSurvey2015_ExecutiveSummary.pdf

Outgoing Retreat President Honored

BRATTLEBORO — The Brattleboro Retreat Board of Trustees has announced that outgoing President and CEO, Robert E. Simpson, Jr, Ph.D., will be presented with the hospital’s 2015 Anna Marsh Award at its gala in October. Named for the founder of the Retreat, the award is an annual recognition that was established in 2009 to honor individuals for their advocacy on behalf of people with mental illness and addiction. Simpson recently announced his plans to step down as the Brattleboro Retreat’s President and CEO at the end of 2015.

Hospital Architecture Awarded

BERLIN — The work of the architectural firm that designed the Vermont Psychiatric Care Hospital has received an international award for its design. The design was developed together with numerous stakeholders, including peers, family members and advocates. The International Academy of Design and Health, in conjunction with World Health Design Magazine, selected the hospital for two awards that were presented this past summer at the 11th Design and Health World Congress and Exhibition in Hong Kong. The awards included “overall winner” for interior design, and one of three winners for mental health projects.

25th Anniversary of Disabilities Act Is Celebrated

Mental Health Raised In Burlington Address

BURLINGTON — Residents came on foot, crutches, prosthetics and wheelchairs to the North Beach Pavilion this past summer to celebrate the 25th anniversary of the signing of the Americans with Disabilities Act, which protects disabled people from discrimination.

A news release from the city offices reported on the event, and said attendees were joined by city staff, activists for the rights of disabled people and Mayor Miro Weinberger.

Speakers included Sarah Wendell Launderville, executive director of the Vermont Center for Independent Living, who focused on psychiatric and addictions disabilities.

Launderville said that for many residents, the ADA “allows access to the beach, recreation, transportation, housing and more.” However it goes beyond physical access, she noted, saying that before the signing of the ADA, she had been kicked out of college, fired from a job and even locked away as a result of a psychiatric disability.

“But today,” she said, “I’m proud to be a part of the independent living movement, which accepts me and others for who we are, and we embrace our differences.”

Despite the effectiveness of the ADA, Launderville said that there was still a tremendous amount of work to be done to combat a continuing bias against disabled people.

“When we are fired from employment or not given employment opportunities, because employers do not understand, or want to understand how to accommodate or provide equal access, that’s a bias. When we still need to seek financial support in a systematic way that makes us feel worthless or powerless, that’s a bias.

“When a person is sexually assaulted and is not believed, or the examination room is not accessible, that’s a bias. When we go to give birth at our local hospital, and a sign language interpreter isn’t called, and I can’t speak to my doctor, that’s a bias,” she said.

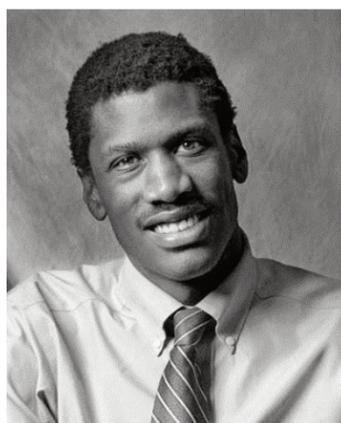
“Our biases are deep and they’re real, they’re hurtful and oppressive,” she continued, “but they’re also part of that bond in our shared history, right? Today, 25 years after the signing of the Americans with Disabilities Act, they’re only one part of our story.”

Weinberger addressed the crowd with what the news release said was a modified quote from George H.W Bush, who was president at the time of the ADA’s signing.

“Let the shameful wall of exclusion finally come tumbling down,” Weinberger said.

“Our problems are large, but our unified heart is larger. Our challenges are great, but our will is greater. And in America, the most generous, optimistic nation on the face of the Earth, we must not and will not rest until every man and woman with a dream has the means to achieve it. Once again, we rejoice as this barrier falls for claiming together we will not accept, we will not excuse, we will not tolerate discrimination in America.”

CHAMPION — Worcester resident Max Barrows was one of nine disability advocates honored as “Champions of Change” at the White House this past summer. The event celebrated the 25th Anniversary of the Americans with Disabilities Act. A press release from the Vermont Coalition for Disability Rights said that since 2007, Barrows has led the way at Green Mountain Self-Advocates by mentoring youth and adults with developmental disabilities who belong to 21 self-advocacy groups throughout the state. The self-advocacy movement is the civil rights movement for people with developmental and intellectual disabilities.



CIVIL RIGHTS AWARD — The executive director of Disability Rights Vermont, Vermont’s protection and advocacy system, was honored at a national civil rights conference this summer. Ed Paquin (right) was the recipient of the National Council on Independent Living Region 1 Advocacy Award for his dedication to promoting the rights of people with disabilities and advancing the independent living movement in New England. (Photo Courtesy Vermont Center for Independent Living)

VPS Gains United Way Grant

RUTLAND — Vermont Psychiatric Survivors has received a \$20,000 grant through the United Way to provide supports in the hospital and in public housing with a goal of demonstrating that peer support can prevent psychiatric admissions and emergency room visits. The funding will support expanding a current part-time staff person to full-time.

Using a peer — a person with lived experience of mental health issues — for the planned intensive services is something “we’ve never done before,” according to staff member Joe Gallagher. The grant requires that research be provided to show there will be a positive community impact, he said.

The work will focus in two areas. An advocate will be trained to provide one-to-one services in developing Wellness Recovery Action Plans (WRAP) to persons on the most intensive unit at Rutland Regional Medical Center. After discharge, they will be supported in the ongoing WRAP group at RRMC.

The VPS staff person will run a wellness group there on Sundays, when inpatient groups are generally not available.

The second area will be to work with individuals at Rutland’s two public housing units selected by the Support and Services at Home (SASH) program. Many of the residents there are persons with disabilities. The staff advocate will help persons with using Mary Ellen Copeland’s “Loneliness Workbook.”

Gallagher said that the impact of the initiatives will be reviewed after 12 weeks, with adjustments made after that.

The grant was solicited by the staff at VPS. Gallagher said he heard about it in passing in a meeting and contacted United Way to follow up. It is a federally funded initiative administered by United Way. AD

‘Voices’ Study Challenges Assumptions

Voices in people’s heads are far more varied and complex than previously thought or recognized, according to an article in *Science Daily* that summarized the findings of a new study.

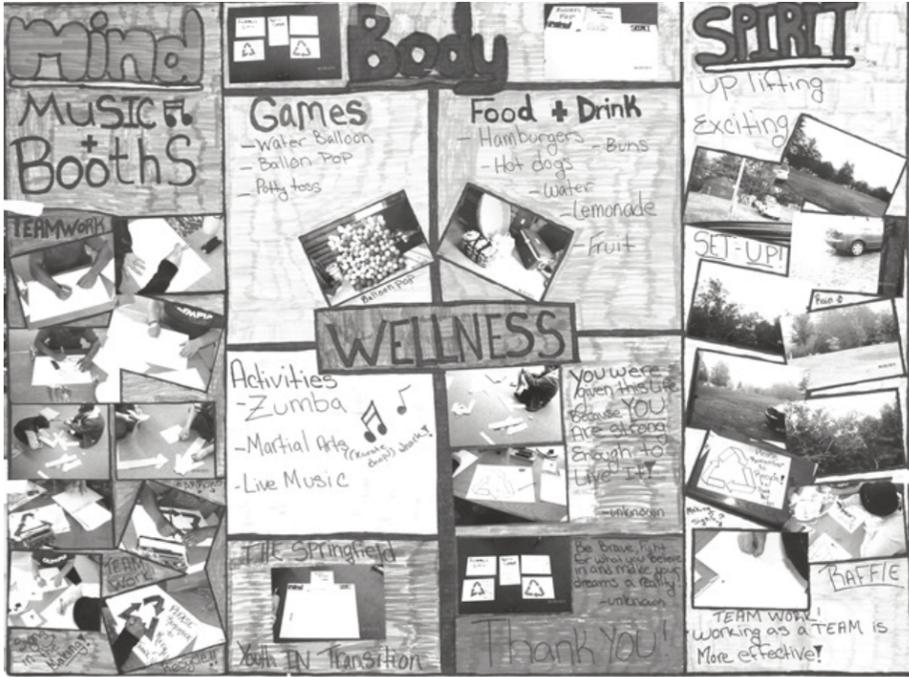
The article called it “one of the largest and most detailed studies to date on the experience of auditory hallucinations” and said that the study confirmed that both people with and without psychiatric diagnoses hear voices.

The *Science Daily* article said the findings question some of the current assumptions about the nature of hearing voices: “The majority of voice-hearers hear multiple voices with distinct character-like qualities, with many also experiencing physical effects on their bodies.”

According to the article, the researchers say this variation means different types of therapies could be needed for voice-hearers, such as tailored Cognitive Behavioural Therapy (CBT) geared towards distinct voice sub-types or patterns of voice hearing.

The full study in *The Lancet Psychiatry*, “Experiences of hearing voices: analysis of a novel phenomenological survey,” can be accessed online at <http://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366%2815%2900006-1/fulltext>

Suicide in Vermont:



U MATTER YOUTH INITIATIVE — Young people from throughout the state were on hand at the annual Vermont Suicide Prevention Symposium to share information about the school Wellness Day projects they developed. The poster at left was created by Springfield High School students to promote their “Wellness Carnival.” At right, students Nicholas Nilsen and Wyatt Shippe from Twin Valley High in Wittingham address news media while faculty advisor Cindy Hayford (right) observes. (Counterpoint Photos: Anne Donahue)

Importance of Connection Is Stressed

FAIRLEE — A keynote speaker at the annual Vermont Suicide Prevention Symposium stressed the importance of connection with people.

Susan Wehry, M.D., said the goals of her talk were to “promote continued openness of mind and heart” to the issue of suicide and to identify specific action steps that can make a difference.

Wehry, who has specialized in geriatric psychiatry for much of her career, is the recent past Commissioner of the Department of Disabilities, Aging and Independent Living.

She told the packed conference room that the narrow view in the past was that suicide was an individual issue that should be addressed on a person-by-person basis. That view has now expanded to recognize that suicide is a population and public health problem.

Wehry noted that suicide takes a high toll, not only on the individual whose life is lost but also because of the impact the death has on others. A later speaker went into detail on the issue of grief and trauma among survivors of suicide loss.

There are more deaths every year from “self-directed violence” than from war or homicide, Wehry said.

In Vermont, deaths by suicide of those older than 70 occur at four times the national average, and suicide is the second leading cause of death of those ages 15 to 34.

These deaths are preventable, but the role of the community is critical, she said.

Wehry identified a number of “social level” risks that apply broadly. The first, she said, was lack of access to both mental health and primary health care.

The availability of means — of items that can be used for injury — is another social level risk factor, she said.

She also identified “inappropriate media” as an influence. She cited “the way suicide is portrayed” among celebrities, for example, as creating the “copycat phenomenon.”

Finally, stigma is a social issue that adds risk, both “in how people treat those who seek help” and those who attempt suicide.

Individual risk factors are better known and include depression or other mental illnesses, a

history of attempts of suicide among family, and isolation.

“The period of time right after discharge [from inpatient treatment] is critical,” Wehry said, and continuity of care is a key element in prevention.

Caregivers should focus on protective factors, rather than just risk, she said, and that is where the importance of connection comes into the picture.

Strong personal relationships are “absolutely bedrock essential” as a protection against self-directed violence. Another is the existence of per-

sonal belief systems, whether based upon religion or other sources. Life is “driven by our will to find meaning... [by the] search for meaning,” Wehry said.

Having positive coping strategies is another importance protective factor, she said. Those skills help a person respond to stressors.

Wehry stressed the “importance of compassion” to create human connections in suicide prevention work.

That includes the importance of “self-compassion” while seeking to help others.

‘Caring Contacts’ Can Make A Difference, Research Shows

FAIRLEE — Emerging research is demonstrating the significance of making simple connections with patients after a hospital discharge in preventing suicide attempts or completed suicides. David Luxton, PhD, a research scientist at the Naval Health Research Center at the University of Washington School of Medicine, is in the middle of a multi-year project that is looking at the effect of followup email messages by inpatient providers.

He presented an overview of the project and its preliminary, interim findings. In the first two years, there have been nine confirmed suicide deaths among discharged patients. All but two of them were patients who were receiving “usual care” rather than the email outreach.

The research project is building on earlier, less broad research that showed positive impacts when patients received even a single postcard after a psychiatric hospitalization.

Luxton’s research enrolled patients who agreed to participate from military hospitals.

Those receiving the “caring contacts” were sent 13 emails in the first two years after a hospital discharge. The messages were personalized based on information shared during the hospital experience.

Why focus suicide prevention research on per-

sons recently discharged from a hospital? Those persons are a greatly increased risk, Luxton said.

Such individuals are in a high risk group to start because their illness was at a level requiring hospitalization, he noted. In addition, inpatient treatment is often not very effective, in part because it is very brief, Luxton said. There is often limited staffing, particularly when the hospital intervention is only in the emergency room or is mostly over a weekend.

Furthermore, care transition from inpatient to outpatient setting is usually weak, Luxton said. Finally, most individuals return to the same environment with the same stressors that led to the hospitalization. Those factors heighten risk, but also may be why the “caring contacts” can make such a difference, he said.

A New Place To Turn For Peer Support

A new ‘Alternatives to Suicide’ Peer Group is aiming directly at creating mutual support for those experiencing suicidal feelings. For more details, see the reflection piece, ‘We Don’t Have To Be Silent,’ on page 15.

Annual Symposium Seeks To Make Impact on an Increasing Problem

High Risk 'Queer Youth' Need Safe Space

FAIRLEE — Caring people can show they are “a safe person to talk to” and make a difference for a particularly high risk group of youth: those who identify themselves under the umbrella term, “queer.”

Participants in a workshop led by staff from Outright Vermont were told that youth who identify as gay, lesbian, bisexual, transsexual or questioning — sometimes referred to as LGBTQ — usually prefer the term queer, considered as an umbrella term.

However, the opening to show empathy and acceptance can often begin by simply asking a person how they identify themselves or, “what pronouns do you use?” rather than assuming “he or she.”

That was one of the tips offered by Melissa Murray and Dana Kaplan during the annual Vermont Suicide Prevention Symposium.

They also explained the difference between gender identity (the innate, deep psychological identification as man, woman or other gender, which may or may not correspond to the sex assigned at birth) and sexual orientation (the physical and/or emotional attraction to persons of the same or opposite gender.) The needs for support were applied to both in the presentation.

Murray and Kaplan led participants through several exercises to reflect upon how difficult and

isolating it is to be queer and unable to discuss such topics with others. Gender identity, for example, is a key aspect of what “makes us who we are as people.”

Sharing one’s self-identity, or “coming out,” means a “risk of losing all” in terms of people in one’s life who are important, “when you don’t know what reaction you’ll get,” Kaplan said.

The isolation such youths feel is a significant contributor to the much higher rates of suicide attempts, six times the rate of others in Vermont, Kaplan said.

“If you can’t see a future for yourself, suicide [becomes more] an option to consider,” he noted.

Kaplan said factors affecting queer youth can include “coming out” issues, experiences of victimization and constant threats, unique developmental stressors, such as not having dating opportunities, or the daily pressure of gender non-conformity.

The Vermont Youth Risk Behavior Survey shows the impact: in 2013, 19 percent of lesbian, gay or bisexual youth reported that they had attempted suicide in the prior year, compared to three percent of other youth; 46 percent had hurt themselves, compared to 13 percent of others. The survey addresses sexual orientation but not gender identity.

LGB youth were four times as likely to have

skipped school because of feeling unsafe, more than three times more likely to have been bullied, and were three to four times more likely to have been assaulted, the survey showed.

Kaplan said studies have shown that having one supportive person can reduce the risk of suicide by 30 percent.

“One adult. That is a big deal,” he said.

So “how do you help to allow people to bring themselves into the room” and recognize that you represent a safe environment to receive support?

The Outright Vermont staff reviewed the importance of using inclusive language, rather than language that assumes only two distinct genders and using inclusive questions and examples in conversation, rather than those based upon gender stereotypes.

They also pointed to the heightened need for confidentiality, and that is was “never OK” to tell someone “when, whether, where or how to come out.”

Many of the ways to address suicide risk parallel standard practices: to not be afraid to talk about possible thoughts of suicide directly; to remove dangerous items (suggesting, “can I hold it for you,” for example); to “listen, accept, acknowledge”; to express concern; to empower to get help; and to connect to resources.

The most valuable resource is the Trevor Lifeline, because it is a crisis line staffed by persons with in-depth experience in helping LGBTQ youth, the workshop leaders said. The number is 866-488-7386.

They encouraged participants to examine personal beliefs and biases about gender, and to recognize how they might interfere with creating a safe environment.

Kaplan said that it was “really important to try” to reach out to queer youth. “Everyone wants to be an ally” and people don’t want to be offensive, but that can mean being “afraid of messing up” and thus staying silent. Silence, he pointed out, “is its own message.”

Kaplan is the Director of Education and Murray is Executive Director of Outright Vermont, an organization founded in 1989 with a mission to “build safe, healthy and supportive environments for gay, lesbian, transgender, queer, and questioning youth (ages 13-22).”

Task Force Says Suicide Prevention Must Include Aid for Survivors of Loss

FAIRLEE — Addressing the needs of survivors of a suicide loss “should be a part of every suicide prevention program,” John Jordan, PhD, told participants at this year’s symposium.

Jordan is Co-Chair of the National Action Alliance for Suicide Prevention Survivors of Suicide Loss Task Force, and presented a keynote address on “Responding to Grief, Trauma, and Distress After Suicide.”

Exposure to suicide elevates a person’s own risk, he said. In the past, the impact was estimated as extending to about six persons closest to the death.

Now, it is recognized as a continuum that extends from those who were closest psychologically to the person who died, to those with a short-term bereavement over a loss, those affected more generally, and then to persons with any connection to the death.

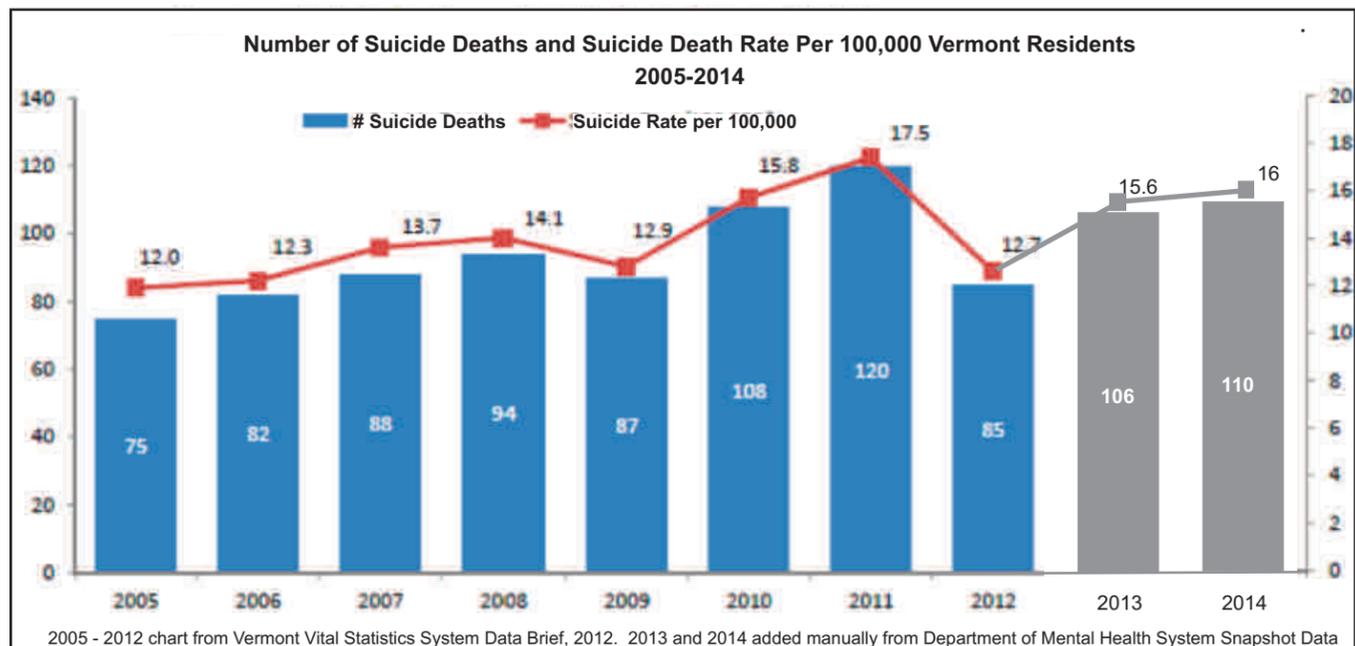
Those experiencing a long-term bereavement experience a “protracted struggle, with diminished functioning.” They need treatment resources for what is often becomes a Post Traumatic Stress Disorder or depression, Jordan said.

Even those only exposed to the death need to receive “essential and

appropriate information” as a part of a systemic response to suicide.

There is a need for a coordinated community response, Jordan said. Homicide victim survivors receive an array of victim advocacy services, and survivors of suicide loss need similar help in addressing their needs. Other system needs include training for first responders in providing a more uniform compassionate response, as well as help for those first responders in coping, he said.

Additional recommendations from the task force included peer support, access to professional mental health care, and reducing the stigma associated with deaths from suicide.



Articles on the Symposium were written by Anne Donahue.



Point →

A Presentation

The Approach Is Often Misunderstood

by Anne Donahue
Counterpoint

RUTLAND – Sometimes, what something is not, can be as important as what it is.

“Open Dialogue,” the alternative approach to addressing severe mental health episodes that began in Finland, is not anti-medication, is not anti-psychiatry, and does not ignore risk assessment.

That was only a small part of a presentation this summer hosted by the Vermont Cooperative for Practice Improvement and Innovation,* but perhaps a part that will make the American mental health system less suspicious of Open Dialogue. Indeed, its primary premise – that treatment needs to be patient-driven and family-centered – is fundamental to newer directions in the United States as well. The approach has research showing significantly better outcomes.

Based upon the presentation, it appears that the key elements of listening instead of directing, involving the “person of concern” in every meeting, and involving family from the beginning, are more like fully implementing recovery-oriented care than taking radically new directions in care.

The presentation featured Dr. Jaakko Seikkula, Ph.D. of the University of Jyväskylä, Finland and Dr. Mary Olson, Ph.D., a colleague from the University of Massachusetts Medical School. The approach is “reincorporating” that mental health issues are psychosocial, not merely biological, Olson said.

The critical shift is in who holds the power.

“When we are the healers [there is] an impasse,” Seikkula said. “We are the ones who have the control.”

Healers need to be ready to “lose control of the process,” no longer establishing a treatment plan based on an assessment and assumed diagnosis, but instead to become a part of a dialogue with a patient and family, he said.

By focusing on generating dialogue and listening to what the person is saying, instead of “to force [it] to my understanding,” a new understanding of the issues can be created. That prevents a premature response based

solely on a narrow diagnosis, and “seems to open possibilities” in how to mobilize resources that can help, Seikkula said.

“We do not aim at rapid conclusions,” he said. The focus is not on intervention to decrease symptoms, but “to understand what has happened” in a unique and individualized way. There are “no ready-made responses.”

Olson observed that psychotherapy became marginalized in the United States during the advent of managed care. “To be heard is to be in a dialogic relationship,” she said, and that can lead to “amazing sudden movement toward wholeness and healing.”

The “center of Open Dialogue is to reduce isolation... the basic condition [one needs] to address,” while a focus on “15 minute med checks” isolate someone further, she said.

“You don’t begin by classifying symptoms”; it is about “responding to someone by responding, rather than responding by assessing,” Olson explained.

Open Dialogue is not a form of treatment, Seikkula said. It is a “way to identify what is the best response,” and makes it no longer possible to divide planning from treatment. There is a place for professional discussion, but not a “professional agenda.” Everyone is present for every conversation, discussing all elements of treatment. The traditional experts speak last to reflect on what has been heard, and return to the client to ask, “What are your thoughts about what we have been saying?”

Seikkula said there is a place for medication, and it is “always evaluated as part of the conversation,” but medication is not used unless there is a need for it. The avoidance of medication when possible is a benefit, he said, because medications alter the central nervous system and decrease the brain’s ability to make use of its psychological resources. Studies have shown better long-term outcomes when medication use is minimized to the extent possible.

**The Vermont Practice Improvement Collaborative identifies itself as “a statewide membership cooperative, representing mental health and substance abuse providers, state agencies, hospitals, professional associations, peers, families and more working to support practice improvement and workforce development in the Vermont system of care.”*

What Research Says About the Value of ‘Open Dialogue’

What are the benefits of an open dialogue approach? Seikkula said that the outcomes have been carefully researched, and are striking.

Hospitalization was reduced significantly. Often, a crisis does not result in the need for hospitalization when there is enough support at home. Long term outcomes showed fewer relapses and much higher employment.

There has also been evidence of an actual decline in the incidences of schizophrenia in the part of Finland where open dialogue began.

Seikkula also said that while the research has focused on schizophrenia, it is being used successfully for all types of mental health crises, in particular when they involved psychotic features.

Open dialogue had its roots in the 1980s as Finland embarked on deinstitutionalization from long-term facilities. “We all had an idea that we wanted to develop a family-centered system,” but that was not possible in the existing system, where a treatment plan was developed first and then family was invited in afterwards. Thus “from the beginning” the emphasis became having open meetings where everyone was invited, and “every conversation about the patient happens in the presence of that patient.”

An article in 2011 in *Psychosis: Psychological, Social and Integrative*

Approaches (“The Comprehensive Open-Dialogue Approach in Western Lapland: II. Long-term stability of acute psychosis outcomes in advanced community care”) provides a summary of some key findings:

“In a two-year follow-up of two consecutive periods during the 1990s (1992-3 and 1994-7) it was found that 81 percent of patients did not have any residual psychotic symptoms, and that 84 percent had returned to full-time employment or studies. Only 33 percent had used neuroleptic medication.

“A third inclusion period, covering 2003-2005, was organized to determine whether the outcomes were consistent 10 years after the preliminary period. Fewer schizophrenia psychotic patients emerged, and their mean age was significantly lower.

“Duration of untreated psychosis had shortened to three weeks and the outcomes remained as good as for the first two periods. It is therefore suggested that the new practice can be related to profound changes in the incidence of severe mental health problems... Professionals had learned to make early contact in the event of crisis, and by this means prevent problems from developing into more severe cases.”

What Do You Think? Share Your Point or Counter-Point!

Send your comments to Counterpoint, The Service Building, 128 Merchants Row, Room 606, Rutland, VT 05701 or counterpoint@vermontpsychiatricsurvivors.org. Include name and hometown.

Counterpoint

on ‘Open Dialogue’

Core Principles Drive the Practice

Despite how much Open Dialogue rests on an individualized context, Seikkula said that the research that shows the success of Open Dialogue relies upon seven core principles that make it a true dialogic practice and faithful to the approach:

Immediacy

The first meeting needs to be within 24 hours, with everyone participating from the outset, so that the team “becomes a part of the strategy” of response. “Psychotic stories are discussed in open dialogue with everyone present,” which leads members “to discuss issues that have never been discussed,” Seikkula said. “Psychosis is not an illness,” he said. “It is more a response to a crisis.” If it is a survival strategy that is kept to oneself, it can become chronic. The immediacy “takes advantage of access to the emotional crisis” to learn more about it, instead of waiting until after the psychosis has abated to listen to the client.

Social Network

All voices in a person’s life need to participate, because “everyone has a need to be heard.” That needs to always include family, but may also be friends, fellow workers, or authorities. All aspects of the process happen in open discussions; there must be “space for everyone to be heard.” Even the doctor no longer has admission interviews with the patient alone, and there are no separate meetings among providers.

The result is that a “kind of community” is created, that “becomes an essential part of the system [of support] for as long as needed” by the individual. “If you come together in a crisis... it’s very different” from participating afterwards. There is less resistance by the patient to inclusion, and it becomes assumed as part of the ongoing process.

What about when a person has no family? There is “no one who doesn’t have family,” Seikkula replied. “We all have family,” no matter how distant. Connecting with and involving distant family members is a part of the process.

Flexibility and Mobility

Even the place that meetings are to be held are decided upon jointly. Treatment may involve psychotherapy; it may include medication. The focus of each meeting is open-ended, beginning by asking, “How do you want to use the meeting?” The process responds to the “unique needs of every family and every client” using the therapeutic methods that best suit each case. Although a common image of Open Dialogue is that of a team staying at a home on a 24/7 basis, that would actually be exceptionally rare, Seikkula said.

Responsibility

Regardless of where a first contact occurs, the response is, “You have come to the right place.” That person assumes the responsibility to arrange

the first meeting – the client is “never left alone” to negotiate the system. Then, regardless of the place of treatment, the assembled team takes charge, integrating different response roles and services.

Psychological Continuity

Though it usually begins as a result of a crisis, Open Dialogue is not a crisis service. A team is integrated with inpatient and outpatient members, and stays the same regardless of the setting, meeting “for as long as needed.” The team does not “refer [the person] out... [it] takes responsibility for treatment.” Even if a new crisis occurs later, the core of the same team is used.

This is a “radical shift in the system” in not separating hospital and community practices. Building up the new system in Finland has meant moving hospital staff to crisis intervention work in the outpatient setting.

Tolerance of Uncertainty

The process must be safe, with a focus on promoting “psychological resources for the patient” and being open to avoiding “premature decisions and treatment plans.” In the traditional model, speaking about feelings often creates an immediate response that is negative to the patient, such as hospitalization or an increase in medication.

“We do not aim at rapid conclusions,” even if that feels as though the direction for treatment is ambiguous at first; it is more important to understand. People “open up more and more” when the environment is safe for speaking.

That can be challenging when it appears that no progress is being made, and the uncertainty may be most difficult for a provider. The availability of immediate meetings and the opportunity for frequent meetings help in tolerating the uncertainty: “having the possibility for meeting every day at least for the first 10 to 12 days appears necessary to generate an adequate sense of security. By so doing, both the tolerance of uncertainty and a possibility for some certainty increase.”

Use of Dialogism

Dialogue means to “listen to what people say, not to what they mean” – not to put one’s own meaning on it. “Try not to look at what is behind” what is being said; take it very concretely, and repeat the words back, so “they can hear what they said.” This is “responding to someone by responding rather than by assessing,” which is a core to “being heard,” even if the meaning is ambiguous.

That allows for ways of speaking about “things that were otherwise unspeakable” in the past, and allows new information to come from the conversation. It includes “nonverbal utterances” and inviting not just all team member voices but also eliciting conflicts among someone’s inner voices.

After the presentation, audience members asked questions, and these were among them:

What About Confidentiality?

What about rights to confidentiality and informed consent, if a person doesn’t want others there?

Because of the stress on “working with the whole family,” several audience members raised concerns about the right to informed consent, particularly if a client doesn’t want the participation of family members.

Seikkula said that the choice of participants in the meetings does require patient consent, but often even if someone is unwilling, they will still agree to allow the family to meet with the rest of the team. He then added that he would still hold such meetings without consent “if believed necessary.”

That, he acknowledged, was a legal difference in Finland regarding confidentiality. As long as a family member does know about the crisis, providers “cannot be restricted on who [they] might meet with.” Certain topics might not be able to be shared, but the purpose is for them “to speak

of their concerns” and be a part of the process. There is “no general rule” about how one decides that others should be allowed to step in even when the client is unwilling to consent, he said.

What About Involuntary Treatment?

If this is patient-driven, what about involuntary treatment issues?

There are sometimes issues of court-ordered treatment, but transparency is the key in open dialogue. Decisions about a need for involuntary treatment happen in the meetings. The presenters acknowledged it was “something we really need to solve” because of the conflicts that can occur when an agency is invested in enforcing a court order – because they are legally liable for it – but the individual or family doesn’t want it.

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

Editorial

Words Do Matter

The Associated Press stylebook is the guide used by most news media to lead the way on appropriate use of language. It offered new directions this year on references to suicide.

“Avoid using ‘committed suicide’ except in direct quotations from authorities. Alternate phrases include killed himself, took her own life or died by suicide,” the guide says.

Why? A stylebook editor explained:

“‘Committed’ in that context suggests possibly an illegal act, but in fact, laws against suicide have been repealed in the US, at least in certain states, and many other places, so we’re going to avoid using that term...”

We are deeply familiar with the stigma connected to suicide, and while wording isn’t everything, it does contribute to it.

The Vermont Association for Mental Health and Addictions Recovery, which is sponsoring a workshop in September on, “A New Way to Talk about Addiction and Recovery — Stigma Reduction through Language Replacement,” observes that, “We cannot change stigma overnight but we can reduce it by the language we use about and to persons in these vulnerable populations.”

The fact that the Associated Press recognizes the negative implications of “committed,” and wants to avoid those implications, is a positive step in the changing of attitudes. The Associated Press is recognizing that words do matter, and can convey inaccurate information. Misinformation is exactly what plays such a major role in creating and perpetuating stigma.

The guide also states that, “Generally, AP does not cover suicides or suicide attempts, unless the person involved is a well-known figure or the circumstances are particularly unusual or publicly disruptive. Suicide stories, when written, should not go into detail on methods used.”

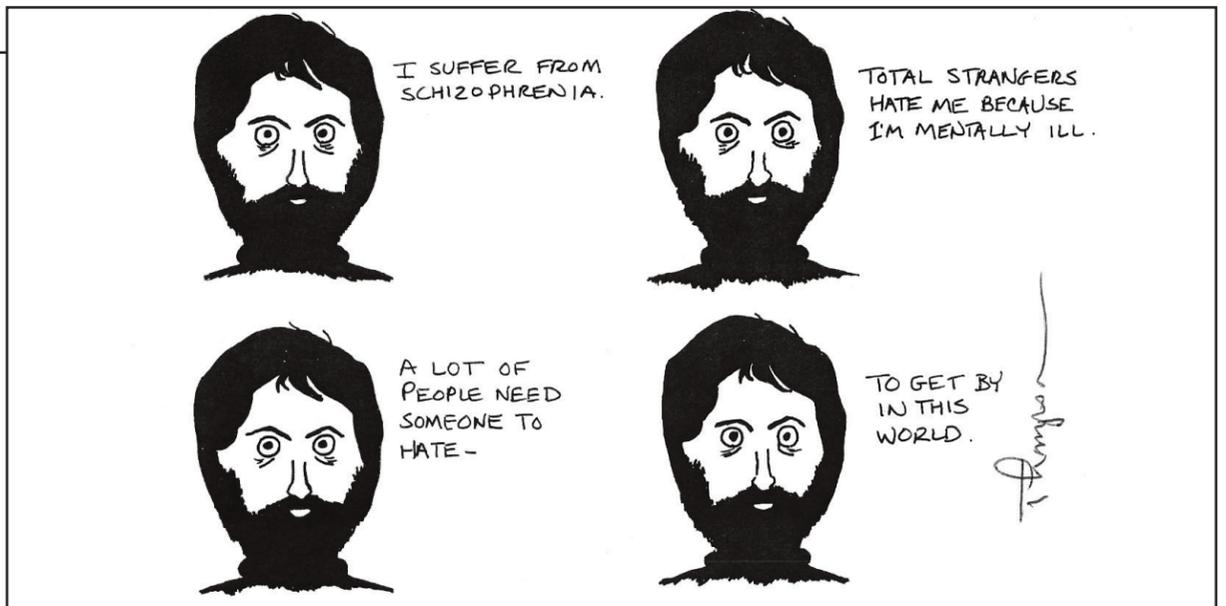
The AP is right: the mere fact of a suicide death should not suddenly make it newsworthy, any more than a headline would announce, John Doe Dies of Cancer.” So the recommendation to avoid discussion of details — unless relevant to the story itself — is also a good idea.

However, care must be taken to not allow avoiding sensationalism to turn into avoiding awareness of a serious issue. The number of lives lost to suicide every year is staggering, and lack of knowledge can mean lack of action.

A prominent Vermont psychiatrist mentioned at a recent conference that she had only recently learned the grim statistic that suicide takes the lives of more people every year than from all deaths from war, or all deaths by homicide. As staggering as that may sound, it is inaccurate. According to the World Health Organization, suicide deaths worldwide are greater than deaths from war, homicide and natural disasters, combined.

If knowledge is power, then lack of knowledge disempowers.

The Associated Press is on the right path, and is to be congratulated for greater accuracy in language. It must also maintain a focus on the truth about mental health: it needs greater attention in today’s world if we are to change the toll of mental health disability.



‘Back to the Asylum’: A Patient’s Perspective

To the Editor:

In response to your report on “Back to the Asylum” and the proposal by some researchers to return to long-term psychiatric institutions (Summer 2015 Edition):

As a person who struggles with complex PTSD, Dissociative Identity Disorder, Panic Disorder, Major Depressive Disorder, self harm and a multitude of physical medical issues, I would like to say that when in crisis, trips to an overwhelmed, overcrowded emergency room did not work for me and were highly triggering.

Having been hospitalized for previous suicide attempts, I found the institutionalization experiences highly triggering and more damaging rather than helpful for me.

My complex PTSD was due to a life of trauma and severe abuses. The first thing when in a crisis the ER did for me was to take my clothes and place me in soft restraints. *Highly triggering.*

Once admitted, your stay is for five days. By day two you learn to just say what they want to hear, nod and smile and agree to their terms on everything just to get released. Then the next time you consider suicide you try to come up with a better plan and the cycle repeats.

I tried IOP’s [intensive outpatient] that pushed CBT/DBT methods that did not work for me and frankly I found to be condescending and offensive. I tried group therapies via the counseling

center I was a part of and these too, were more triggering rather than helpful.

What eventually worked for me was finding The Wellness Co-op: a peer-run center where I felt wow, here are others who “get it.”

I advertised and found a private peer, live-in support person. A peer that had understanding, compassion and knowledge of what it was like to struggle with chronic physical medical health issues and mental health issues.

Lucky for me she also had medical background as an LNA. Someone who could go to all appointments with me, who could help with my ADL’s [Activities of Daily Living], my medication management, finances. etc. I have gone from struggling daily to find reasons to survive to being able to grow, heal and thrive... All because of Peer Support.

Based on experience from a patient’s perspective, I would like to see more funding given to Peer Support Agencies like the Wellness Co-op, Soteria, Pathways Vermont, rather than to “institutions and re-invented Asylums.”

Just as there are Visiting Nurse/Home Health agencies in place to support those with physical medical issues, maybe money can be found to build up Peer Support agencies where live-in’s and other supports can be found.

BONNIE L. BARROWS
Shelburne

Frustrations? Challenges? Share Your Thoughts Here!



That’s What the Opinions Pages Are For!

Send comments to: *Counterpoint*, The Service Building, 128 Merchants Row, Room 606, Rutland, VT 05701, or to counterpoint@vermontpsychiatricsurvivors.org. 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.

We Don't Have To Be Silent

by Tanya Vyhovsky



I made my first suicide attempt when I was 15 years old. It came from nowhere. I had been in pain and completely miserable for years, but I hadn't really thought of suicide before.

I felt as though nobody could hear me, as though nobody cared to stop and listen or could possibly begin to understand the depths of the pain I was feeling. So on that day when I was 15, I overdosed.

I didn't actually want to die, but I couldn't think of another way to get the people who were supposed to care for me to stop for one moment and listen to the immense amount of pain that I was in. This gesture started a train barreling down the tracks.

My cry for help didn't get me the understanding and empathy I so desperately needed. In fact the exact opposite happened. I was entered into a system of care where I felt that I was constantly being judged, monitored, criminalized and cast aside like human garbage.

And still nobody heard me.

Somewhere along the way this desperate desire to be heard and understood was overtaken by the desire to die. I was no longer hoping that someone would stop and listen, I was no longer expecting empathy from people. I felt so different from everyone else, so alien that I no longer believed there was any hope for me.

For a long time I struggled with thoughts of wanting to end my life on a daily basis. Each day battling a compulsion to end my suffering and the seemingly pointless existence that I had been living.

My previous experiences had taught me that I couldn't talk openly about these feelings, even with the people that were supposed to "help." So I struggled; alone and filled with shame.

I wish I had known at that time that I really wasn't so different. I wasn't so alone. In fact, my feelings were shared by many. It is estimated that nearly four percent of American adults seriously consider suicide each year.¹ To put it in perspective, that is about 8.2 million people.

Yet there are very limited resources out there that offer support for individuals in handling these thoughts and feelings. There are simply not enough safe spaces to talk about them, to explore their meaning, to find solidarity and support.

Without such spaces these thoughts are si-

lenced out of a very real fear, of being judged, of being monitored, of being vilified — like I had been. That silence nearly overwhelmed me and allowed these feelings to win. We don't have to be silent.

Alternatives to Suicide is a mutual support group for individuals who are struggling or have struggled with thoughts of suicide. It is a dedicated space where these thoughts are not just accepted but acceptable; a place free of judgment or stigma.

Developed by the Western Mass. Recovery Learning Community, this amazing resource is a radical attempt to change the way we talk about suicide and to support individuals struggling with suicidal thoughts.

The Wellness Co-op is hosting a weekly Alternatives to Suicide group at the Fletcher Free Library in downtown Burlington.

The group will be facilitated not by licensed professionals, but by individuals with lived experience of suicidal thoughts and feelings who have completed an intensive training to facilitate this group by the developers of the approach themselves.

It is my hope that this first step is the beginning of changing the conversation about suicide in our community.

It is my hope that before long everyone who is struggling knows that there is a place that they can go where they will not be judged, will not be punished and most importantly, where they can know that they are not alone.

Tanya Vyhovsky works at Pathways Vermont in Burlington

¹ Crosby, A., et al. "Suicidal Thoughts and Behaviors Among Adults Aged ≥18 Years — United States, 2008–2009." Accessed via Centers for Disease Control website on 6/3/2015. <http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6013a1.htm>

Rutland Mental Health Woes Are Very Sad and Frustrating

To the Editor:

It is very frustrating to read and hear news accounts of the troubles at Rutland Mental Health.

Several years ago, I called the State and told them that RMH should be decertified and expressed my reasons why. As one who has depression I used their services a few years back. I was deeply concerned then and this was about 2007 or 2008.

Now that is not meant to paint all RMH employees with the same brush. They had some excellent staff members back then. However for the State to now tell RMH they are in danger of being decertified is almost pathetic.

First, let's all be honest. There isn't a snowball's chance in Texas on a 100 degree day that

the State will decertify RMH. There aren't enough mental health workers in the state now let alone losing a regional one for the county. And the State sure as heck isn't going to take it over.

So people are stuck. Not only is the current situation Mr. [Dan] Quinn's doing but also the Board of Directors and senior management, the State on various levels including the AHS Secretary as well as our current and likely former Governors.

Where have all of these people been all of these years? And what did they do besides apparently sit on their butts collecting money for jobs they did not properly perform?

The sad and frustrating thing is that vulnerable people suffered and will continue to suffer because of the situation as it exists at RMH. However, we with mental illness are second class citizens, and the way the programs have been run show this attitude by many people as mentioned above. If memory serves me correctly it was noted that a possible suicide might be the cause of the lack of appropriate care and management at RMH.

Where is the outrage over this?

Personally, I feel that the Board of Directors should all resign and any government official who had some oversight in these areas should do the same thing.

However that means accepting responsibility for one's actions, or lack thereof. And I believe the sun will stop shining for a full summer before that would ever happen.

So, so very sad.

BRIAN FILLIOE
Proctor VT

Veterans' Home Seeks Volunteers

To the Editor:

We, at The Vermont Veterans' Home, are seeking individuals interested in volunteering with weekly shopping trips (our transportation), bingo, off-campus events, weekly in-house calendar events and much more. Trained by our superb Activities Department, you would be considered as a "force multiplier." We have opportunities for weekday volunteers as well as the weekends. Additionally, if you have a skill or talent that you would like to teach or entertain our Veterans with, bring it on! For more information, please contact Michele Burgess at 802-477-6520.

COL. AL FAXON, Chief Operating Officer
Vermont Veterans' Home, Bennington

The Squash: An Affirmation of Life

To The Editor:

I have a gigantic acorn squash growing in my compost bin, which sprouted from seeds that I discarded last winter. It is ready to bear several blossoms. I saved it by driving out to Home Depot and purchasing another compost bin to put in another area.

This giant squash represents the beauty and persistence of life. I expect to harvest several acorn squash this fall. I will take photos of the blossoms after they open.

RICHARD A. WILLIAMS
Bennington

Come to Alyssum's Open House and Lunch

To the Editor:

Please come visit, see our house and have lunch at Alyssum's annual Open House. Everyone is welcome.

We're at 827 Rte 100 North in Rochester. The open house will be on Wednesday, October 28 from 10 a.m. to 2 p.m.

See our facebook page or website (www.alyssum.org) for more information.

GLORIA VAN DEN BERG
Executive Director



A VERMONT TREASURE — That's how Clare Munat (right) of NAMI-VT introduced keynote speaker Mary Ellen Copeland (left) at the Wellness Conference it hosted. (Counterpoint Photo: Anne Donahue)

Finding A 'WRAP' Is a

by ANNE DONAHUE
Counterpoint

FAIRLEE — "She is a Vermont treasure that we all should celebrate." That's how Clare Munat, Board President of NAMI-VT, introduced keynote speaker Mary Ellen Copeland of Brattleboro at its annual conference this spring.

Copeland's WRAP — Wellness Recovery Action Plan — has become an international guide for self-directed recovery and wellness, and it all started in Vermont some 20 years ago.

Copeland provided both an overview of the guiding principles of WRAP and its history as a grassroots effort to put together ideas from different people around the country.

She had been given "dire diagnoses and dire prognoses" about her mental health status, and "I didn't like that very much." She felt that others must have figured out "pieces of it, how to get by," and that she might be able to assemble those pieces and share them.

So Copeland used a Social Security Pass Plan to get money to do a study, and built a series of surveys, each built based upon answers from the other, and compiled the responses.

When she presented what she found at a NAMI conference, she suddenly received invitations to speak around the country.

"That's really how it all started," she said. The work was all "built from that."

Copeland shared the fact that her psychiatrist had told her, "I never could lead a conference." He was right, she joked. She couldn't lead just one — she has led thousands by now.

The WRAP is now not only widely recognized, but listed on the national registry of evidence-based programs and practices.

Her workbooks are designed to be used as part of a group process

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Putting the Teeth in Your WRAP

FAIRLEE — Mary Ellen Copeland's presentation on developing a WRAP gave the perfect "jump on the subject" of advance directives, said Ed Paquin, who spoke at a workshop at the NAMI-VT annual Wellness Conference.

Paquin is the Executive Director of Disability Rights Vermont (DRVT), which helps guide persons through development of an advance directive.

Like a WRAP, it is a way for individuals to "figure out mechanisms that help them out." It uses self-reflection and responsibility in the same way, planning in advance and "not leaving it up to someone else" to address your own crisis.

The heart of the difference between the two, however, is that an advance directive is a "very specific legal document" that can be enforced in court, Paquin explained.

"You can lay out those things that are important for the providers" who are giving care.

Paquin explained that an advance directive is based on the principle in law that "individuals have the right to determine their own medical care."

It "can get tricky," he said, because that right is based upon a person having the ability to make decisions. However, a person can direct in advance what kind of care they want if they lose that ability.

An advance directive is "a way to tell two kinds of things," Paquin said: the treatments that you want to accept or not accept, and who you want to make the decision. A person can do one or both of those things, by naming an agent to make decisions, and by listing specific treatment information.

Although there is no specific form that is required under Vermont law, many forms are available as a guide. Only Disability Rights Vermont offers a form that is specifically designed to help consider decisions about psychiatric care.

Although it has a number of pages, "you don't have to fill all of it out," he said: just fill out what matters to you.

Although not required, DRVT recommends talking with your health care provider to help them "understand your thinking" in the directives you write out, so that it doesn't cause confusion later. The same language could mean something to a provider that is different from what was intended, Paquin pointed out.

After Paquin's introduction, DRVT attorney AJ Ruben went into details on the law itself.

The original intent of the law on advance directives was for a person who was unconscious or unable to communicate, often because of being near death.

It told doctors, "what she would have wanted... if she was able to talk to us right now."

Because of the "movement to empower people with disabilities," advance directives began to be used for situations when a doctor finds that a person does not have the legal ability to make decisions, even though they are conscious, Ruben explained.

For details on writing your own advance directive, go to www.disabilityrightsvt.org, or call DRVT at 1-800-834-7890

To be legally enforceable, it must be signed at a time when the person does have legal capacity, he emphasized. For that reason, when DRVT assists a person with an advance directive, they have a physician verify at the time that the person does have that capacity. Because of that rule, a person who has a health care guardian is not eligible to create an advance directive.

The only other requirement is that two witnesses sign the directive. (If a person is in a facility at the time, there is an additional witness requirement to protect against coercion, Ruben said.)

The law does not require that a person appoint an agent to make decisions for them — an advance directive can simply provide direct instructions. DRVT recommends that a person does appoint an agent, so that if found to lack capacity, there is someone "in your shoes" to make decisions that might not have been identified.

The advance directive becomes effective when a person is found to lack capacity, but it can also be effective immediately, if a person wants. Doing that enables the agent to have access at any time to patient information to help with decisions.

The DRVT form also helps distinguish between the kind of decisions that can be legally enforced, and those that can only be "preferences."

Preferences give guidance in situations where the law permits a decision by health care providers without a person's consent, Ruben explained.

This includes involuntary hospitalization. Emergency involuntary procedures are a

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Your Path To Wellness

Tool of Self-Determination, Copeland Says

(Continued from page 16)

of individuals discovering what works for them, and there are now “thousands of people who facilitate these groups all over the world.”

WRAP workbooks are available for all kinds of issues, she said, with those that focus on trauma, addictions, families, veterans, kids, and more.

What they all hold in common are the core values:

- That everything is done with a sense of hope;

- A foundation of self-determination and self-advocacy;

- Everyone in a WRAP group is an equal;
- There are no limits on personal goals, only the support for, “what can you do to get there?” and

- Recognition that “everybody is an expert on themselves.”

The facilitated group process is essential to WRAP, Copeland said. The tools are available on the web on how to develop a WRAP, and there is even a “WRAP App,” but it works best when modeled on its early roots of individuals who talked together to identify what could be learned from the studies Copeland had done.

Those long discussions led to developing a guide on “how to put this [the ideas] together in my life.”

“We maintain the integrity of that” to this day, she said: that it “came from the very grass roots” and cannot be changed without a grassroots process.

The WRAP model doesn’t take a position on the pros or cons of the use of medication, Copeland said. “WRAP does not say, ‘no medications.’”

What it does say is, “Let’s use WRAP first,” before turning to invasive treatments.

Although WRAP had its start in Copeland’s

project in the 1990s, she said the story really began 50 years earlier with what she learned from her own mother.

Her mother spent eight years in a state psychiatric hospital after being found to be “incurably insane.” Copeland recalled her mother’s symptoms, rocking and crying for days on end, and walking on top of furniture, babbling nonsense.

One volunteer at the hospital took an interest in her, however, and kept simply listening to her talk, and talk, and talk.

As she began to get better, she eventually led groups of other patients in talking about their experiences — perhaps the first peer support groups ever. After her own release, she continued to return to lead groups.

Her story “could have happened differently,” Copeland said, and “it can happen differently now” for others.

We need to let people “talk and talk and talk... have private space... time away” to get better, she said.

What’s In a WRAP?

There are seven core elements to a WRAP — a Wellness Recovery Action Plan — which Mary Ellen Copeland described to participants at the conference.

1. Build a personal list of what works for you. “We need to figure out all the things we have... that keep us well or help us feel better.” They are often things you may not think about routinely, so there is value in having that written list.
2. Create a daily maintenance plan. What is “life when well” for you? What do you *need* to do “every single day to stay as well as possible?” What are the things you might need to do?
3. Identify triggers. There are things for each of us “that throw us into a tizzy.” Identify what those are for yourself, big or small, and the option you have to respond to them.
4. Early warning signs. Find the signs that tell you “when things start feeling really off,” and have a tool list to turn it around.
5. Signs that things are really bad. Create a list that identifies for you, “when things are going to hell in a handbasket” and breaking down — that would identify “this is when I needed to go to the hospital” in the past. With a WRAP, we found that “people could work themselves back from that,” Copeland said. The tool becomes much more directive at that point. It identifies “what I’ve *got* to do” to turn things around.
6. A crisis plan. Identify, “when do I really want people to take over,” versus when that would be harmful. What are the signs? Who do you want, and who do you not want at that point? List your medications, insurance plan, doctors, or treatment that is “OK or not.” What should the plan be “when things get that bad,” and where will you go? What can others do to help? What shouldn’t they do?
7. Post crisis. This last part of the WRAP was a later development, Copeland said, when the planning group realized it needed to add a piece on how to heal from a crisis, and “to get back” to the state of wellness.

Putting the Teeth in Your WRAP

(Continued from page 16)

“mixture between preference and directive,” he said, because hospital staff are authorized to act in a safety emergency.

Since staff are required to use the “least restrictive alternative” to resolve the emergency, they “should be looking” at the preference in an advance directive to see what that individual considers to be least restrictive for them, Ruben said, whether that be a shot, “being tied to a bed,” or seclusion.

Every hospital is required to check the database of advance directives to determine whether a person without capacity has one, he said.

When it comes to non-emergency, court-ordered medication, the advance directive is legally binding and must be followed, he added.

The presentation then returned to Paquin, who explained a different way that an advance directive can be used. Ordinarily, under the law, “we always give the person the ability to say yes or no” if they change their mind, he said.

In other words, a person’s advance directive must be followed if they cannot communicate their wishes, but if they can communicate — and

they say they no longer want what the advance directive says, the document no longer controls.

An advance directive “is not there to stop you from changing your mind,” but is only to give directions when the person does not have the legal ability to choose a treatment.

However, sometimes a person knows themselves well enough that they know they will refuse something at a “moment in time” when they are not able to think clearly.

A certain “medical intervention may very well be what helps them get through the crisis,” and would be what the person wants, but “at the time [they know] they’re going to say something different” and refuse it.

For someone who can say, “I know myself well enough to understand” that he or she may say “no” when they actually would want that treatment, it is possible to create an advance directive that cannot be changed.

The person is “giving permission now” for that future decision, and is agreeing that it cannot be changed if the situation comes up later, after a loss of decision-making capacity, Paquin explained.

This is called a “Ulysses clause,” based upon an ancient Greek legend, he said. It includes special protections. The advance directive must name an agent (which is not normally a requirement), and the agent must authorize the treatment to go forward if the person is saying, “no.” There are also added witness requirements to ensure the person understands that they will not be able to change their mind if that situation arises.

The Greek legend of Ulysses included a story of a ship’s voyage that passed an island with mythical creatures who lured sailors to destruction by the sweetness of their songs.

Ulysses knew that he and his men would come under that power, and so he stopped the ears of his crew with wax so that they could not hear the song.

He had himself tied to the mast so that he could not steer the ship off course, and told his men not to release him no matter what he said when they passed the island.

Sure enough, when they passed the island, Ulysses ordered his men to untie him. They followed his original directions to disobey him, and so the ship was saved. AD

RUNNER-UP — PROSE

Fields of Northfield

by VESNA DYE

It's getting close to Christmas now and snow is covering Mt. Mansfield. There are also a few inches of snow in Jericho. We rent a farmhouse, the apartment downstairs and our landlord lives upstairs.

Yesterday, our landlord cut us a spruce tree; it's almost touching the ceiling. I don't like to climb up to the attic where I keep the box with Christmas decorations, but I want to make my son happy.

Once I'm up, I can't resist opening a box of photographs covered by a black velvet cloth. My wedding picture is on top of other photographs in the box; I'm wearing a silk blue summer dress floating around my body, and a pink rose in my hair. I never liked white color; it reminds me of snow. Although I'm a true Vermonter, the dazzling whiteness of snow makes me sad. It paints everything in ghastly color; it almost suffocates life. If it were my choice, I'd let everyone wear white at funerals, not black.

My husband, David, on the other hand, loved white. Here, on our wedding picture, he's bottom to top dressed in white, as if he's ready to go skiing. He wanted a winter wedding, right under the snow-covered spruce trees — but there was no time to wait. In August, our baby was already kicking in my belly when David was deployed for Iraq.

"Don't worry, they'll let me go home for Christmas," David tried to comfort me. But when I heard an owl hoot on our wedding night, I wasn't so sure...

"It's not so bad here," he wrote from Iraq. "They feed us good, we have warm showers and we can watch TV at night. It's quiet now, but it's not going to stay that way. They're training us to join forces in Kirkuk, some fighting broke out there."

David's letters were affectionate, full of detailed descriptions of his everyday life. He was excited about learning to shoot an M-16. He didn't seem afraid or worried; he always sounded enthusiastic.

"He's lying, just to make you feel at ease," my mother said. I disagreed — I have always known David as a man who could turn a funeral into a happy celebration. The only thing that could make him miserable was a badly cooked meal. Food always had to be perfect — a medium rare, juicy steak in mushroom gravy with mashed potatoes, lots of steamed vegetables; chili with home baked garlic bread; barbecued chicken with baked squashes smeared with maple syrup — and everything followed by two bowls of ice cream with apple pie, and of course, two cups of coffee with cream, no sugar. Only regular exercises kept him fit and trim.

I always laughed when he wrote about the cook's talent to make a feast for soldiers out of rice, dates and pieces of freshly slaughtered chickens. As long as they kept him well fed, I knew David would happily go into any combat. He never called Iraqi soldiers "The enemies." "War teaches men to have enemies. For me, they're all friends who are forced into unnatural circumstances."

From then on, he never mentioned the word "war"; he kept calling it "unnatural circumstances."

"I found a wonderful friend here," he wrote in one of his letters. "He trains horses and likes American poetry. His name is Muhammed; this would be a great name for our son, don't you think?"

I wasn't sure what my Jewish father would have thought about that, so I decided to give our son two names — one Muslim and one Jewish. With our Christian surname, our son would always be a global friend and no one's enemy.

David and I met in Northfield High School. He was a farmer's kid, my parents were teachers. He spent a lot of time around animals, so the kids started to call him "Animal whisperer." "Love your animals as much as you love your neighbors," was his favorite saying. As for me, I was happy in a library surrounded by books.

But when I started visiting David at his parents' farm, I came to love animals, too. We had planned to get married and start a small farm as soon as we graduated from high school and raise our children there, outside of the noise and pollution of big cities.

For us, Vermont was not only our home, but the best place on earth. We didn't care about travelling like other young people did; everything we needed, we had here in Vermont: open fields, mountains, trees, rivers, lake, animals... We belonged here and we didn't have to search for anything else. But the fairy tale we lived in had to be spoiled. Like the two children in a fairy tale, we got lost in the woods and the bad witch was after us...

A friend of David's parents followed us one sunny morning on our hike in the woods. "Here, try this — the stuff dreams are made of," she handed us a joint. I refused, but David enjoyed it. "The first two are free, then you can pay me half price if you keep it our little secret," she said.

David was enchanted. The police caught him one evening near the old mill, drunk and stoned, damaging the property. He was kicked out of school and put on probation; still, he didn't lose his enthusiasm.

"It's going to be okay, Sarah, I'll go back to school when this is over, we'll get married and become farmers. See there — all those fields covered with daisies — that's where we're going to build our farm."

I wasn't so sure about his dreams. I knew how hard it was for him not to ride his horse for a

year, a punishment his father gave him, but he was too proud to show his feelings. That summer I ran every day over fields of Northfield, praying that David would be free again to ride his horse.

When winter came and snow started to fall, I thought I saw white horses galloping near the river. But when I came closer, I realized it was only mist. I ran back home, stumbling in the snow...

A year went by and David was free again. "My soul is not free," he told me. "I'm ashamed of what I've done. I must do something to wash off my guilt." That was the first time he opened to me like that.

His chance came. I let him go to Iraq. Maybe I shouldn't, maybe I should have asked him to stay; but I know I wouldn't have been right. He needed to be free by doing the service for others.

"Iraq is as beautiful as Vermont, just in another way," he wrote in his last letter. "I never knew the desert can be so mesmerizing, with sand blowing all over like a fairy dust. You and I didn't have a longing to travel — but now, I'm glad I have the opportunity to see a part of a different world and different culture — even if it's not exactly a tourist trip. Don't worry about me; if I get killed, they'll give me a Purple Heart medal. You can hang it over our son's crib. Remember how we always said Vermont is our home and the best place on earth and we'll never move anywhere else? I still think that way. But if I get killed, leave my ashes here in Iraq; I don't want you to be sad, crying over my grave. I want you to celebrate my life through our son, Muhammed-Aaron."

I sent David our son's photo, but I'm not sure whether he ever received it. An hour after I emailed him, a military officer came to my door. "My condolences. Your husband was killed today while trying to save an injured horse. They couldn't move fast enough to escape a bomb..."

I was not surprised; in my heart, I always knew. As soon as the officer left, I climbed up to the attic to look again at our wedding photo. For me, David will always remain young and happy. I'm not sure if he'll ever get his Purple Heart medal; he tried to save a horse, not a human being. But this I'm sure — when our son Muhammed-Aaron grows up, he'll never go to any war.

That's the only thing that matters now.

Vesna Dye is from Burlington.

2015 Louise Wahl Creative Writing Contest Winners

(Winners were published in the summer Counterpoint.)

Prose: Tied for First Place *The Dress*, by Pamela Spiro Wagner; *Stranger*, by Steven Morgan
Third Place *Nine Out of Ten Doctors Approve This Message*, by C.P.

Poetry: First Place *There Comes a Time*, by David Young;

Second Place *Mosaic*, by Pamela Spiro Wagner; Third Place *Trauma*, by Ocean Chance

Runners-Up, Prose: *Fields of Northfield*, by Vesna Dye; *Shattered*, by Laura Lee Saorsa Smith;

Stone Wall and Bridges, by Anonymous; *The Words I Could Have Said*, by Jill Tuttle

(*Stone Wall* and *The Words* will be published in the winter Counterpoint)

Runners-Up, Poetry: *The Hidden Face*, by Jan Abbott; *Daddy*, by Nikisha Davis

Creative Writing Contest

RUNNER UP — PROSE

by LAURA LEE SAORSA SMITH

The mirror reflects back a face I have known all my life, but the light behind the eyes is somehow very different. It seemed as if it happened all at once, but actually it was a cumulative effect.

I find that I am sifting through old and mostly forgotten memories and I don't quite know who I am anymore. I thought I knew, but I was always trying to be someone else, anyone else but me, so tragically damaged was I.

It is as if everything I ever knew about myself was a lie and now out of the shattered pieces of what is left I am trying to rebuild a new and better me, which seems to be happening ever so slowly. It takes work and facing things I have no wish or inclination to face. It takes practice moving outside my comfort zones and taking leaps of faith that I can indeed survive the changes that are coming and have come.

Friends, my true friends and adopted family, have stuck by me even though I am going through the transformation. There was a core piece of me that was saved from the ravages of abuse. Some part of me remained constant. Perhaps my stubbornness, or should I call it, determination? The support that I have received has been such a comfort. I don't have to go through this alone.

I have acquired new tools to emotionally deal with the day-to-day things and medication, though I hate to have to take it, is working quite well for me. I have learned my lesson well to not mess with my medication.

I am trying ever so hard, persevering to eat well-balanced and regular meals as I am worth taking care of even if it means I am the one who has to take responsibility for myself entirely.

I am still learning that spending money to excess isn't beneficial to me in the long run, but rather causes a much bigger problem. So I am learning to be addicted to saving, rather than spending, and hoping with continued

therapy that I will end up in the happy middle of the river, saving enough and spending a little within reason.

To be happy, really happy, is my goal, and as good a goal as any. So far, I have come to be graciously thankful for all that is already good in my life, and it seems that the amount of good increases each day I say to myself, "I am open to the infinite abundance in this infinite Universe!" I also say before I go to bed, "I am so very grateful for all the lessons I have learned this day, thank you!"

I have learned that I am not my mental illness; I am an individual with many talents and skills. I am me. Oh, I am still picking up pieces and experimenting, stepping outside that comfort zone and jumping back, but it has all been worth it. I don't regret this journey, but am proud of it. Maybe the shattering was meant to happen, and instead of a breakdown it was more of a breakthrough as I have never been happier. I am doing more things that I had forgotten I

RUNNER UP — POETRY

The Hidden Face

Why.

Is it that a smile
can touch the lips
and the throat can laugh
when the pain of depression lies
hidden in the soul.

If that can be,
Does that mean
It's not valid?
Less intense?

No.

Perhaps a desperate bid to
conform to society's expectations,
a protective mask against the pain
of rejection,
more isolation.

An erroneous practice that erodes
the soul.

Until they say in
shocked voice "I never knew."

Depression kills

by Jan Abbott

wanted to do and I am finding the me I want to be. I want to be the best me I can be for all my loved ones and myself.

It does not go gently, this therapy, but I am learning to be gentle to myself and know that everyone has issues, and it's not what the issues do to us that counts but what creative, tremendous, amazing person we can make in spite of the issues or perhaps because of them.

Laura Lee Saorsa Smith is from Marshfield.

RUNNER UP — POETRY

Daddy

When I was a little girl it was just me and you
fried bologna at noon
working in the shop
not caring about the clock
it was just me and you
riding around in that big truck
why did you have to go and get drunk
no more me and you no fried bologna at noon
no more working in shop
or worrying about the clock
no more big truck
you went and got drunk
no more daddy
where did he go
I didn't know
he didn't come get me anymore
no more big ol' ford
now I know where daddy is
he thought he was so big
what about his kids
he had to go get drunk
had to drive his truck
I never got to say good bye
All I do is cry
I was so young
There wasn't anything that could be done
No more me and you
No more anything
Sixteen years have gone by
And every year I still cry
Seems like just yesterday
You would take me out to play
Wish things were different
Wish you were still here
But it's just another day another year
You've missed so much
You've missed us all growing up
You got grandbabies now
But you're six feet in the ground
Don't think they won't know who you are

by Nikisha Davis

The Louise Wahl Memorial Writing Contest is named for a former Vermont activist and encourages creative writing by psychiatric survivors, mental health consumers and peers, and their families. Entries are judged by an independent panel. **Next Contest Deadline: March 15, 2016.** Only one entry per category; 3,000 word preferred maximum. Repeat entrants limited to two First Place awards. Send submissions to: *Counterpoint*, Louise Wahl Writing Contest, The Service Building, 128 Merchants Row, Room 606, Rutland, VT 05701 or to counterpoint@vermontpsychiatricsurvivors.org Include name and address.

Perspectives

Getting Through a Moment of Life's Clutter

by Melanie Jannery

I was sitting in my room one day amidst the mess, really grasping to gain energy to get through that moment and I started writing in my journal...

What's not wrong?

- My messy drawer has a bedroom in my house
- My dirty rugs keep my feet warm
- Money exists today to buy new things when needing to
- Clutter is stuff I once wanted that I now have
- Pandora plays pretty music anywhere
- Dog toys add up over time
- Water is drinkable and hydrating
- Numbness provides rest and distance to gain strength
- I love myself
- Winston is always able to be with me
- I have slippers and socks
- Doghair is cool
- Sheets can be washed over and over like towels
- Burlington has free music often enough
- Jeans look relaxing

I had this nightstand that was such a mess, and the room, and me a mess, too. Writing this way took brain energy I didn't realize I had. What's depression when one can still see beauty and positivity?

Clinically, I once learned that "they" might not believe me if I smiled when was I struggling. This was when I felt validation with every added label and changing chemicals coming into my body. My life, really, in every aspect is here for me to enjoy the best I can as time here is quite limited.

Coping with depression certainly is a journey. (You can replace "depression" with "life experience/trauma" if you wish.) When I began actively utilizing Wellness Recovery Action Plan (WRAP) I was told that the system was hoping to veer away from using the word "trigger" since when people identify triggers there is often a similar result.

I wholeheartedly disagreed as I find using the word trigger quite empowering since I am often able to produce a different outcome over time utilizing WRAP. Trigger external... early warning sign internal... got it!

In a relatively influential and ungrounded state I found myself spending money more easily than I like. Spending money is relative to a person's situation. I am far better off in my spending habits than in my 20s and my 30s. Understanding myself and my tendencies over time has proven beneficial.

I quite easily bought stuff felt I "needed" and often I couldn't stay in the present moment until the purchase was made (early warning sign). Spending money has led me down some hard roads, not only financially but clinically.

Having been clinically assessed for spending money as *manic* in the past has been difficult (trigger). When I finally got the confidence to buy a washer and dryer, a vacuum cleaner, new pots and pans and a knife set, there was concern I was "manic" which hurt since I was really proud of myself for making the decisions in feeling again "I am worth it."

Yet, when I purchased a car, my house, lawn mower, snow blower, garden hoses, and a woodshop I was clinically assessed at "high functioning" and "healthy." The variable degrees of living with simple me.

This year was different, as I just really struggled to be and was quite flowy in many moments. I would try to do something in my woodshop and realize I still didn't have a tool I needed, having had a woodshop in the past that I lost in the system of poverty.

Then, it would happen when I would be on my phone thumbing through facebook and link to a blog post about bone broth and I hopped on Amazon and purchased the exact pressure cooker they recommended. Then, same thing with fermenting jar lids.

But I would get the purchases in the mail and there they would sit, overwhelming me because I didn't feel well enough to use them. I would then order a book on something—something I had an idea on that would help me to connect to reading again. And, there the books sat.

Doing a "What's Not Wrong" list reminder came to me in a partial hospitalization program, as the tool of "coping cards" also came back into my realm. After attending the program for twenty-five days, I found myself sitting on my living room floor with my binder actually looking at my coping card (a proud moment of self-acceptance).

NOT following *idea* of something I "need" to purchase:

- Wait a day
- Explore other options
- Use something else I have bought that I haven't really used
- Invest my desires/needs into the present moment
- Recognize that a "purchase" is an investment in the future... future thoughts are anxiety promoting and take away from the present moment
- What do I have to keep me focused in the present moment that I would enjoy? Build Mastery with an already purchased item

Also brought back into my realm of thinking during the program was "Build Mastery" which is really just a Marsha Linehan Dialectical Behavior Therapy (DBT) that reminds us to focus on improving on doing something we already know, in the moment, to build self confidence and self esteem.

The puzzle was made and my brain started to make sense again, the inner calm resulting from the external energy of clinical language of "coping cards" to manage my "symptoms" to "using my DBT Skills."

After the energy of radical mental health and peer support, how could this be? It had to be, as everything else had been a flop! I stopped spending money and started learning how to completely cook a pork roast in the time it took me to draw and take a bath and get dressed.

Experimenting with fermentation led me to creating a whole new flavor out of radishes. Areas of my woodshop began being used for more than five emotional tearful minutes at a time. A couple of unread books, no longer "needed," were donated to Fletcher Free Library.

Rest is now welcomed in when fatigue hits and focus appreciated when energy strikes at 2:30 a.m. "Radical Acceptance" — a phrase that has, again, gained back its worth to me accepting myself where I am at — struck so incredibly true.

Today I wonder, does mental illness exist? Is that term so bad to use when we feel so far from our feeling good space?

Certainly, trauma opened me back up and came at me full force with trauma triggers everywhere I go, so who knows.

I am guilty of getting sidetracked in the language which can really create separation between two people who struggle. There are no real answers, but many questions plus the breath, this moment, spirit and death!

Back today to appreciating organic peer support aka "friendships" (a community word) with belief again, in my own world of what I need, of what's helped, what's been hard, oh, have you experienced this from that, too?

Being human is a beautiful gift to cherish, we all need friends who will embrace us because of all our flaws and appreciate the incredible value of family of choice.

And, certainly, clutter is stuff we once wanted that we now have (and can enjoy.)

Melanie Jannery is from Burlington.

Have some thoughts to share? Share them in *Counterpoint!*

Email to counterpoint@vermontpsychiatricurvivors.org
or mail to *Counterpoint*, The Service Building



by Louis Gagner, Saint Albans

There Need Always Be Two

There need always be two
calendars
in my house. Best to have
one in the kitchen
and another
in the hallway to where
we sleep. Always
there must be two
calendars in our house.
One is for the first and most
apparent
reality. The second
is for the billion others
that whisper beyond
the walls
and whimper outside the door.

by Dennis Rivard
White River Junction

Grief Is a Thief in the Night

Grief is a thief in the night,
tearing at my soul,
trying to get it all right,
leaving me shaking & cold

Crying tears of anguish
Sending cries, just I wish
make it all go away
but my grief is here to stay

Thinking of my losses,
like pennies in the stream she tosses....
her tears, her dreams, her hopes,
around the house I seem to mope

Grief is a thief in the night taking my joy
When you really thought it was a boy
taken from you, like fire in the night
I just want to cry, I don't really want to fight

I want to surrender my pain
in order so that I remain sane
Will I carry this grief until I carry a cane?
You all know for all of us it's not exactly the same

Grief came as a thief in the night to take my mom
22 years have passed & I rely on my dad, Tom,
I don't want to cry again, as if this sadness will never end,
Some days are happy, joyous, & free

Thief in the night, just let me be me, just let me be free..

by Marla Simpson, M.A.

The middle of water

Look at the middle of water
Past the highest surface of water where
Waves of determined energy entertain conflicted
See past the tympanic gurgles and the foam
And we'll look at the middle of water
Before the heavy plane at the bottom where
Light waves perform unconnected to anything
Don't let your eyes fall so far to the weighted base
Where everything is more or less decided
Look at the middle of water now
To its undetermined depth to see
If it will tell us anything, something
About the meaning so fluid
Look at the middle of water

by ERIC JENSEN
Rutland

#47

*dependence; addiction
attachment!...attachment?
needing with resistance
personal but separate

anxiety then panic
stress overflowing
pain overwhelming
physical and emotional

closeness; wanting
fear, rejection*

by m. a. wakeman
north bennington

The Last Kiss at VSH

by MARLA SIMPSON

This article is a true story written in the present tense for effect: The Last Kiss at the Vermont State Hospital.

Summer 2011: Help! I have woken up in a prison death camp... I feel this is Nazi Germany. I have woken up and am in the bowels of the Vermont State Hospital. I walk around, being supervised.

I notice everyone sleeping, passed out. They seem as if they are dead. So over-medicated and drugged they do not move. Still. Silent. Prisoners, like me. I am so drugged that I lose control of my bowels. The horror, the embarrassment.

The best way to discredit anyone society does not want to value is to involuntarily place them in a psychiatric ward. I had committed no crimes, yet was held captive. Prisoner.

Tortured physically and psychologically. I desperately told the visiting Catholic priest that VSH needed "seven spiritual people to come through and cleanse the place." Why? There was evil energy there.

Across the room from my cell 14 a deranged woman crying and yelling the whole night that she was being raped. How can anyone try to sleep in this dungeon?

There were a few staff I liked very much. They were my saviors there. I was on a one-to-one the whole time, so I would walk with them. Exercise was the cure for this maddening sit-

uation. If I laughed too much I was put in restraints, tackled, bruised and battered. Terrified. Forcibly drugged into submission.

I understand why there were suicides at VSH. One time out of sheer hopelessness and desperation I tried to hold my breath and die. I was trapped in an asylum. No way out.

Only an act of God could save me. When bad weather was coming my male friend, a patient, my saving grace, told me with a twinkle in his eye that "bad weather was coming." Could this be our escape? I had indeed tried to escape the dungeon/asylum before. To no avail. I tried to write complaints, grievances about my horrible torture there. I never got a response. I was being held hostage.

Then, one night, my attraction to my male friend led to fate. I stole a kiss from him. Intense, sharp, wanting. The final kiss at VSH. Of course we were punished for something so human... a final quest for some humanity in a very dark place. I have no regrets about kissing him.

Then, finally the Act of God: Hurricane Irene. She, blessed mother earth, saved us all from the torture camp. I awaited my release like I was leaving Auschwitz. If it were not for some of the kind staff ("you know who you are") and my friend, the whole experience would have been a total nightmare.

Instead, I recall it like the most dramatic movie scenes from my life. Once, singing "Hotel California" there with a group "you can check out anytime you like but you can never leave..." The solitary confinement, not being allowed to use the bathroom, the assaults on my body, soul, and mind.

The Hurricane that to the state was devastating: But to me it was a miracle. It saved me from the torture there. All summer long, covered in bruises all over my body from their "medical treatment." It was torture.

I am one of the last people alive to tell the truth, to have lived the experience from the inside. I am a survivor of VSH.

Today I live a very good life. This is intended to be an article about advocacy for better treatment. It is also acknowledging that if someone is given an involuntary label they can later be discredited. I am a Middlebury College and Antioch University New England alum. I have a Master's Degree in Counseling. If something like this could happen to me, I give this as a warning: it could happen to anyone.

The government and the media would like to say that forced treatment and forced drugging is "medical treatment." I call it assaultive and even abusive. Each day, week, and month that I live as a "free" woman I am full of gratitude.

I am a very good and intelligent woman working to bring awareness and bring to light the darker side of "treatment."

So I am probably the last person on earth who stole a moment of humanity at VSH. A brief but passionate kiss. "The Last Kiss at VSH."

This is my authentic account of a true story.

Marla Simpson, M.A., is from Randolph.

Foliaged Fantasy

The sunshine washes in gold

The verdant mountains bold

Of autumn-hued Vermont

So beautifully smeared by countless colors from Artist

God's great font!

Divinity shows its infinity

Of endless tints and tones of trees in countryside and city!

Glory to every awed person's eyes

As each this earthly rainbowed vision fully realizes!

The skies are cobalt blue that stuns

As bold background for radiance from a golden sun that only shuns

Its shining and fantastic tableau for the occasional shroud

Of a passing philistine thundercloud!

And when ebony-felted nighttime darkens this foliaged fantasy of color,

A universe of stars is pinned upon it in sparkling diamonds for each lover!

by PATRICK W. BRADLEY, Jr.

St. Albans

Share Your Art!

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Counterpoint

Is About Peers Sharing With Peers

Email to counterpoint@vermontpsychiatricsurvivors.org
or mail to *Counterpoint*, The Service Building,
128 Merchants Row, Room 606, Rutland, VT 05701

Please include name and town



by Pamela Spiro Wagner, Brattleboro

Just a Mental Health Consumer (the leaf)

Optimism sometimes fleeting
a prism aloof from the silted
day to day grind of things.

A brief feathery tinkling
sparkle of shining success
flashing then
nestling
into the void
the abyss
into bittersweet nothingness.

I walked today in the
sprinkling rain
clouds not cumulus, they were
salt and pepper
in carriage
my head bowed to the
concrete ground
and i saw a beige leaf
weighed down by so many
raindrops
that it could not take to the air
and fling itself gingerly
against them with the wind.

That leaf can be compared to
the mental health consumer
said leaf has the ability to fly
though a rainy day will pin in to
the ground

Some days i feel like just
a mental health consumer
nothing more nothing less.

Seen for illness only
unseen are the words
you want to be known for.

by GEOFFREY L. MCLAM
St. Albans

Old Glory

*High on a long white pole
Waves the spirit of the free
Forever may she wave there
So that everyone can see*

*That she has flown for many years
And will fly for much, much more
She stands for all blood lost
On native lands and foreign shores*

*Stars and stripes forever more
I heard one brave man call
As he picked up Old Glory
And stormed the stone wall*

*Old Glory flew in many a battle
And lasted through the cannon's roar
She flew at the battle of Gettysburg
Stood fast on the sandy shores*

*So wave her high, wave her proud
She flies for peace and liberty
She flies for those of wars past
And for the future souls to set free*

by REBECCA FARLEM
Wells River

My Grandfather

My grandfather loved the little things in life
He loved his children, maple syrup and his wife.
He loved the brook and sugarhouse.
But most of all, he loved his spouse.
She gave to him one girl and boy,
which were to both a kindly joy.

The children played upon the floor
Their kiddie cars, their dolls and more.
They helped their mother with the cows
And feeding all the fatted sows.
They went to school and the boy to war —
The family worried that they might not see him
anymore.

But they did again, for back he came,
And once more they were all the same.
Four in the family and one telephone,
A radio, some pretty paintings were things that
they owned.
In the barns they had some hay,
And there the children would romp and play.

Across the road, there was a pretty sight —
Grammie's flower garden so cheery and bright.
And in the house so fine and dandy
One could find more than one pink candy.
Outside the house was a porch so nice
That to tear it down would be a sacrifice.

The woodshed was cool when the summers
were hot.
Miriam and Robert liked to swing there a lot,
For you see there was a swing and on a rainy
day
You could see them happily play.
When years flew by, the grandchildren came,
And so did great-grandchildren, name by name.

Kieve and Josh, two dear little boys,
Added to his numerous joys.
He also met two young men,
One named Floyd, the other Ken.
He never met great-grandson, Ben,
Because his life did come to an end.

A fire swept the lovely house,
The woodshed and Grammie's lifetime spouse.
Even though the smoke did come and finish his
last breath,
It isn't so and can't be true, it wasn't really
death.
For Grandpa loved the little things in life,
But most of all, he loved his wife.
And when she died
Grandpa cried.
For he missed her
And now he's with her.
Now there's an empty space that remains
Where the house used to stand through the
storms and the rains.

Oh, my grandfather loved the good things in life,
But most of all, he loved his wife.

by CHRISTY HERWIG
Randolph

Resources Directory

National Suicide Prevention Lifeline 1-800-273-TALK (8255) 24/7 confidential support

Vermont Psychiatric Survivors 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

Northwestern

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

Rutland

- Wellness Group, VPS office, Suite 605, 128 Merchants Row, every Wednesday, 5-7 p.m. Call Beth at 802-353-4365

Springfield

- First Congregational Church, 77 Main St., every Thursday from 2-3:30 p.m. Call Diana at 802-289-1982

VPS is a membership organization providing peer support, outreach, advocacy and education; Suite 606, 128 Merchants Row, Rutland 05701, 802-775-6834.

www.vermontpsychiatricsurvivors.org

Community Mental Health

Counseling Service of Addison County

89 Main St., Middlebury, 95753; 388-6751

United Counseling Service of Bennington County;

P0 Box 588, Ledge Hill Dr., Bennington, 05201; 442-5491

Chittenden County: Howard Center

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

Northeast Kingdom Human Services

181 Crawford Road, Deery; 334-6744; 800-696-4979

2225 Portland St., St. Johnsbury; 748-31817;

800-649-0118

Orange County: Clara Martin Center

11 Main St., Randolph, 05060-0167; 728-4466

Rutland Mental Health Services,

78 So. Main St., Rutland, 05702; 775-2381

Washington County Mental Health Services

9 Heaton St., Montpelier, 05601; 223-6328

Windham and Windsor Counties: Health Care and

Rehabilitation Services of Southeastern Vermont,

390 River Street, Springfield, 05156; 886-4500;

51 Fairview Street, Brattleboro, 05301, 254-6028;

49 School Street, Hartford, 05047, 295-3031

24-Hour Crisis Lines

(Addison County) Counseling Services of

Addison County 802-388-7641

(Bennington County) United Counseling Service

(Bennington) 802-442-5491

(Manchester) 802-362-3950

(Chittenden County) Howard Center

(adults) 802-488-6400; First Call – Baird Center:

(children and adolescents) 802-488-7777

(Franklin and Grand Isle Counties)

Northwestern Counseling and Support

Services 802-524-6554; 800-834-7793

(Lamoille County) Lamoille County Mental

Health Weekdays 8 a.m.-4 p.m.: 802-888-4914;

Nights and Weekends: 802-888-4231

(Essex, Caledonia and Orleans) Northeast

Kingdom Human Services 800-696-4979

(Orange County) Clara Martin 800-639-6360

Rutland Mental Health Services 802-775-1000

Washington County Mental Health Services

802-229-0591

(Windham, Windsor Counties) Health Care and

Rehabilitation Services 800-622-4235

Peer Support Lines

Vermont Support Line (Statewide):

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.

Washington County Mental Health Peer Line: 262-353-3540; Wednesdays, 4-6 p.m.

Crisis Respite

Alyssum, 802-767-6000; www.alyssum.org; information@alyssum.org

Crisis Text Line

Around-the-clock help via text: 741741 for a reply explaining the ground rules; message routed to a trained counselor.

LGBTQ Youth Crisis Hotline:

The Trevor Lifeline now at 866-488-7386. Trevor-Text - Available on Fridays (4-8 p.m.). Text the word "Trevor" to 1-202-304-1200. Standard text messaging rates.

Trans Crisis Hotline

The Trans Lifeline (dedicated to the trans population) can be reached at 1-877-565-8860.

Brain Injury Association

Support Group locations 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. 802-241-3222.

Vermont Center for Independent Living

Peer services and advocacy for persons with disabilities. 800-639-1522

Vermont Family Network

Support for families with child or youth with mental health challenges. 800-880-4005; 802-876-5315

Adult Protective Services

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

Vermont Client Assistance Program

(Disability Law Project)

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

Health Care Advocate

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

Drop-In Centers and Employment Support

Another Way, 125 Barre St, Montpelier, 229-0920; info@anotherwayvt.org; www.anotherwayvt.org; see web site for events calendar.
The Wellness Co-op, 279 North Winooski Avenue, Burlington, 888-492-8218 ext 300; thewellnesscoop@pathwaysvermont.org; www.thewellnesscoop.org; check web site for weekly calendar; Drop-In hours 10 a.m.-7 p.m. Monday - Friday; 10 a.m.-9 p.m. Tuesday

NAMI Connection

Peer Mental Health Recovery Support Groups

Bennington: Every Tuesday 12-1:30 pm; United Counseling Service, 316 Dewey Street, CRT Center

Burlington: Every Thursday 3-4:30 pm; St. Paul's Episcopal Cathedral, 2 Cherry Street (enter from parking lot);

Rutland: Every Sunday 4:30-6 pm; Wellness Center (Rutland Mental Health) 78 South Main St. (enter from Engrem St.)

St. Johnsbury: Thursdays 6:30-8 pm; Universalist Unitarian Church, 47 Cherry 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 at 1-800-639-6480 or email us at info@namivt.org. The Recovery Support Group is also being offered at the inpatient units at Rutland Regional Medical Center and Brattleboro Retreat.

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

provides support, education and advocacy for families and individuals affected by mental illness. 802-876-7949 x101, 600 Blair Park Road, Suite 301, Williston, VT 05495; www.namivt.org; info@namivt.org

Pride Center of Vermont (formerly RU12? Community Center)

LGBTQ Individuals with Disabilities Social and Support Groups

Connections and support around coming out, socializing, employment challenges, safe sex, self advocacy, and anything else!

Burlington, Wednesdays, 4:30 p.m. at Pride Center, 255 S. Champlain St.

Other locations currently reorganizing. Call or watch for future announcements.

DBT Peer Group Peer-run skills group. Sundays, 4 p.m.; 1 Mineral St,

Springfield (The Whitcomb Building). <http://tinyurl.com/PeerDBTVT>

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; tcavt@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; tpfdirection@gmail.com

St. Johnsbury, Kingdom Recovery Center, 297 Summer St; 751-8520; n.bassett@stjkr.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>

Contact us if your group schedule changes: counterpoint@vermontpsychiatricsurvivors.org

Vermont Veterans Outreach:

Bennington Outreach: 802-442-2980; cell: 802-310-5391
Berlin Area Outreach: 802-224-7108; cell: 802-399-6135
Bradford Area Outreach: 802-222-4824; cell: 802-734-2282
Colchester Area Outreach: 802-338-3078; cell: 802-310-5743
Enosburg Area Outreach: 802-933-2166; cell: 802-399-6068
Jerico Area Outreach: 802-899-5291; cell: 802-310-0631
Newport Area Outreach: 802-338-4162; cell: 802-399-6250
Rutland Area Outreach: 802-775-0195; cell: 802-310-5334
Vergennes Area Outreach: 802-877-2356; cell: 802-881-6680
White River Area Outreach: 802-295-7921; cell: 802-881-6232
Williston Area Outreach: 802-879-1385; cell: 802-734-2123
Outreach Team Leader: 802-338-3022; cell: 802-881-5057
Toll-free Hotline(24/7) 1-888-607-8773

www.MakeTheConnection.net

Web site sponsored by The Department of Veterans Affairs with testimonials by veterans to help connect with the experiences of other veterans, and with information and resources to help transition from service, face health issues, or navigate daily life as a civilian.

Homeless?

Vermont Veterans Services (VVS) program for homeless veterans with very low income, call 802-656-3232.

VA Mental Health Services

VA Hospital: Toll Free 1-866-687-8387
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; (White River Jct) 802-295-2908

Veterans' Services:

www.vermontveteransservices.org

Homeless Program Coordinator: 802-742-3291
Brattleboro: Morningside 802-257-0066

Rutland: Open Door Mission 802-775-5661

Rutland: Transitional Residence: Dodge

House, 802-775-6772

Burlington: Waystation/Wilson 802-864-7402

Free Transportation: Disabled American Veterans: 866-687-8387 X5394

Vet-to-Vet groups: contact www.vtvettovet.org