

Counterpoint

Vol. XXX No. 4

From the Hills of Vermont

Free!

Since 1985

Winter, 2015

‘Psycho Hell’ Spurs Advocacy



HOLDING ROOMS — Bennington’s Southwestern Vermont Medical Center established what it calls an “emergency care area” last fall with three rooms and an enclosed nursing station for patients in the emergency room who are waiting for an inpatient psychiatric bed to open up somewhere in the state. The hospital initially refused to allow photos. (Photo Courtesy of SVMC)

Bennington Hospital Agrees To Listen To Input on Emergency Holding Area

BENNINGTON — In February, Greg Burda, 60, of Bennington, felt suicidal, and went to the Southwestern Vermont Medical Center (SVMC) Emergency Department for evaluation, and referral to an appropriate facility. While there, a nurse told him that after he met with a doctor and completed his lab work, he would be moved to the hospital’s new “Emergency Crisis Area (ECA).”

SVMC created the area in response to the lengthy delays that Vermont patients in mental health crisis face when they visit hospital emergency rooms. Emergency Department waits for such patients vary unpredictably from a few hours to a few weeks.

“I thought it was going to be wonderful,” said Burda, who in the late 1990s ran SVMC’s nighttime clinical lab. Burda, who holds a Bachelor of Science degree in Medical Technology from North Adams State College, was soon led to the far recesses of the Emergency Department and through a large metal door.

“As soon as that large metal door closed behind, it was as if I were snow blind,” Burda said, in recounting his experience. “Everything was painted white. Lights blared as if at a Hollywood grand opening... The three rooms have only a bed, a tray side table, no pictures or words of encouragement hung on the walls, not even a used, outdated magazine from one of the hospitals many waiting rooms. There was a TV hung high on the wall, set at an angle, so you can only view it while lying in bed. To control the lights or sound on the TV, one needs to ask, through the small, glassed-in nurse’s station. The toilet was metal and had no seat.”

Burda, who said he felt more like an inmate than a patient, found the experience so upsetting that he “B-S’d a little just to get out of there.” That night, back at home, he turned to the Internet to research how SVMC could improve the area. He found information about wall colors, artwork, positive-attitude posters, and other techniques that have been demonstrated to speed recovery.

The following day he contacted the hospital’s Patient Advocate, Maryanne Cushing. They met in person and Burda says he gave the results of his research to Cushing, including names, email addresses and phone numbers of people with whom SVMC could consult to improve the ECA. He stayed in touch with Cushing who assured him that SVMC had made improvements.

However, in June, he learned from a friend who had spent time in what Burda calls “psycho hell,” that SVMC had not made any visible changes. Burda again contacted Cushing. Unsatisfied with her response, he asked if there was someone else with whom he could speak.

The person to whom he was referred informed him that the hospital had improved the ECA by adding a cart of art supplies, sounds and white noise machines, and other “articles of distraction and comfort.” However, a patient has to ask for the (Continued on page 5)

A ‘Travesty,’ as Bill Moves in Congress

by ANNE DONAHUE
Counterpoint

WASHINGTON — The proposed federal legislation that its sponsors say will reform the country’s mental health system, and prevent mass shootings, was voted out by a subcommittee of the U.S. House of Representatives in November.

The 18-12 vote moves the bill forward to be considered by the full committee and the House, and would then require Senate action. A separate bill with some of the same components is under consideration in the Senate. It has had one subcommittee hearing but no vote yet.

The Executive Director of Vermont Psychiatric Survivors called the House subcommittee vote a “travesty.” Wilda White called the bill the greatest civil rights attack in a generation and said that it “legislates our second-class citizenship.”

The so-called “Murphy bill” would make major changes to the federal system of oversight and funding of mental health and substance use services. It places its emphasis on medical and involuntary drug interventions and has been cited repeatedly as being a response to gun violence.

Its lead sponsor, Rep. Tim Murphy (R-Penn), while asserting it fights stigma, introduced the bill saying it would help “ensure the suffering of the Newtown families is not in vain” — a reference to the Sandy Hook school shootings. The Speaker of the House, Paul Ryan, was quoted as saying at a news conference in early December that approval of the bill should be “a priority.”

Although the bill’s 172 co-sponsors include 124 Republicans and 48 Democrats, the Health Care Subcommittee vote was split almost entirely on party lines: “yes” votes from 17 Republicans and a single Democrat, and “no” votes from the other 12 Democ-

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Opportunities for Peer Leadership and Advocacy

Meeting Dates and Membership Information for Boards, Committees and Conferences

State Committees

Adult Program Standing Committee on Mental Health Seeks Members

We are currently seeking people with lived mental health experience, family members, & professionals. This is an exciting, insightful committee that meets the 2nd Monday of every month at 26 Terrace Street, Montpelier, at the Department of Mental Health from noon-3 p.m.

The Commissioner of Mental Health, experts in the field, and those involved meet & discuss the most up-to-date mental health topics in Vermont. The committee is also involved in the redesignation process & review of all of the designated mental health agencies in the state. We expect that members attend all scheduled meetings.

The committee reviews membership applications & we suggest that you attend a couple of meetings to see if it is a good match. Ultimately the Governor approves membership for this committee. If you become a member there is mileage reimbursement.

We welcome hearing from you! If you feel you would like to be a part of an intelligent committee & be on the cutting edge of changes & information, please contact Melinda Murtaugh (melinda.murtaugh@vermont.gov) or Clare Munat (claremunat@msn.com) or Marla Simpson, M.A. (marla.simpson@ymail.com) for further information.

Local Program Standing Committees

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

Notes from the National Peer Clearinghouse 'Key'

NARPA Calls for Presentations

The National Association for Rights Protection and Advocacy (NARPA) has issued a call for presentations for its 2016 conference, to be held at the Pointe Hilton Squaw Peak Resort in Phoenix, Arizona, from August 25-28 (Thursday evening through Sunday noon). The theme is "Rights Under Siege: Fighting Back." The deadline to submit a proposal is March 1, 2016. For the call for papers, go to <http://www.narpa.org/2016-RFP-NARPA.pdf>. "Rights Under Siege: Fighting Back."

Peer Views Sought on Voc Rehab Qualities

The Boston University Center for Psychiatric Rehabilitation writes that it is "conducting a study which aims to identify the competencies needed by vocational providers (for example, employment specialists, vocational counselors, among others) to help people with psychiatric disabilities to get and keep jobs. We are seeking feedback from individuals with the lived experience of a psychiatric condition who have worked with a vocational provider. We invite you to participate in the survey." To participate, go to https://bostonu.qualtrics.com/jfe3/form/SV_ea403j2lhq9HE45

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

Recruiting 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 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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Robert Crosby Loomis (1943-1994)

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Joanne Desany, Allen Godin, Clare Munat,
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Have News To Share?

Send It to *Counterpoint!*

Your peer newspaper

The Service Building, 128 Merchants Row
Room 606, Rutland, VT 05701
email: counterpoint@vermontpsychiatricsurvivors.org

Counterpoint Deadlines

Fall (September delivery; submission deadline July 7)
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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@vermont.gov

Don't Miss Out on a Counterpoint!

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Back Issues can be accessed at www.vermontpsychiatricsurvivors.org

A 'Travesty,' as Bill Moves in Congress

(Continued from page 1)

rats. The subcommittee spent two days on "mark-up," a process of reviewing revisions to a bill.

The subcommittee's minority leader, Rep. Frank Pallone, argued that the bill "takes us back to outdated and biased treatment." He proposed a substitute that put greater emphasis on early intervention and crisis prevention, but it was rejected.

There were 36 other unsuccessful efforts to make changes to the bill, ranging from attempts to be more protective of existing patient rights, making policy statements about the need for greater expansion of Medicaid, and adding funding for various community services. All of the proposed amendments and videos of the mark-up session can be found at <http://energycommerce.house.gov/markup/markup-hr-2017-hr-2446-hr-2646-hr-3014-hr-3537-hr-3716-and-hr-3821#sthash.peoM095.dpuf>.

Meanwhile, Murphy disputed an estimate from the Congressional budget office that the bill would increase direct federal spending by about \$3 billion over the 2016-2024 period, despite the spending restrictions it includes.

Without those restrictions, the bill would increase direct spending by between \$46 billion and \$66 billion in that time period, the CBO estimated. A high price tag could put the bill in jeopardy with Republican supporters.

Impact on Advocacy Described in Vermont

MONTPELIER — The Murphy bill's restrictions on types of cases handled by the Protection and Advocacy for Individuals with Mental Illness program would have blocked many recent initiatives of Disability Rights Vermont, according to Executive Director Ed Paquin.

Among the examples he gave were:

- Legislative advocacy about the violation of due process when patients are held in emergency rooms;
- Work with a client who was subjected to what appeared to be a misuse of a Taser weapon in the community;
- A current lawsuit over a prisoner's right to be free from discrimination based on a psychiatric disability;
- A settlement for a woman fired because she needed an adaptation to her schedule because of her diagnosed mental illness.

Some clinicians and the largely family-member organization NAMI praised the vote of the health subcommittee, but advocates and psychiatric survivor groups vowed to fight against passage.

"It takes away human rights," White said. "The bill is fundamentally, to its core, bad. It can't be redeemed. That's going to be our position."

She and others have met with the Vermont Congressional delegation, which includes Rep. Peter Welch (D) and Sens. Patrick Leahy and Bernie Sanders (D). Welch has stated his opposition to key parts of the bill.

White said that the name of the bill itself, "Helping Families in Mental Health Crisis Act," underscores that the bill "positions us... as problems to our families," and is designed to help families "instead of trying to help people with mental health challenges navigate [what is possibly] the scariest time of their lives,"

Although being "tout[ed] as major reform" of the mental health system, it was written "without

any people who use that system" — something she said would be "inconceivable" with any other group. She opposes it as a person with a family member in the system because "it dehumanizes my family member."

The further steps necessary for the bill to become law include a vote of the full Energy and Commerce Committee followed by a vote before the full House. Then it would need to be reconciled with a similar bill being considered by the U.S. Senate, if that one passes in the Senate. A final bill would then have to be signed into law by President Barack Obama.

Share Your Opinion

Those interested in expressing views on the bill can contact the office of Rep. Peter Welch at (888) 605-7270. For comments on the Senate companion bill, contact the offices of Sen. Bernie Sanders at (800) 339-9834 and Sen. Patrick Leahy at (800) 642-3193.

Vermont Congressman Speaks Out

WASHINGTON — Vermont's sole representative to the House, Peter Welch, joined 19 other Democrats in a letter to their committee chair to express "concerns with specific provisions we believe would do more harm than good if enacted" in the Murphy bill.

"We strongly oppose provisions that would restrict patients' civil rights," the letter said. "We can't say in the same sentence that mental illness should be treated equally to physical illness, but that patients with mental illness should be treated differently than patients with physical illness..."

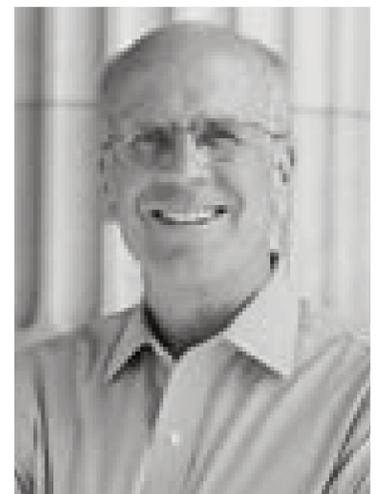
"Regressive reforms to the mental health system that diminish patient rights and create a less welcoming treatment environment will result in worse quality of care." Three such changes were cited:

It would be the "first and only diagnosis-specific exception to HIPAA's [medical] Privacy Rule that would leave individuals with serious mental illness with fewer rights and protections than other patients."

"We should not support such discrimination against any population," the letter said.

The letter said they also opposed provisions that would encourage states to pass or implement assisted outpatient treatment (AOT). It noted that many AOT laws did not require risk of harm, but only "need of treatment" as a standard. "The use of

the court system and law enforcement to force individuals into care is a dramatic departure from how individuals, particularly those who pose no imminent threat to themselves or others, obtain health care services in this country."



Congressman Peter Welch

The letter said the 20 Congressmen also opposed "provisions that would weaken the Protection and Advocacy system (P&A) for individuals with mental illness... In particular, we are deeply concerned about limiting P&As' ability to fight for individuals with mental illness who are the victims of discrimination, to inform individuals of their rights under the law if that information conflicts with the wishes of their caregivers, and to use their non-Federal resources to lobby government officials on policies affecting individuals with mental illness, which is their First Amendment right."

Retreat Restored by CMS Despite New Violations

BRATTLEBORO — The embattled Brattleboro Retreat has been restored to full status with the Centers for Medicare and Medicaid Services, according to a letter from the federal agency in December.

The finding of full compliance came despite several regulatory deficiencies found during a 4-day, unannounced survey in late November. Surveyors said they found that the hospital failed to protect the safety of a highly suicidal patient who was able to ingest an overdose of medication and some of the contents of a heat wrap. The patient was not harmed in either incident, according to the report.

A hospital can have "standard level" deficiencies but be still be in compliance with the conditions of participation required by CMS, according to Suzanne Leavitt of the state's Division of Licensing and Protection. A Plan of Correction was submitted and accepted, she said.

The other violations identified in November were the failure to revise a plan of care after newly diagnosed diabetes, and two kitchen violations.

The Retreat had been operating under special oversight through CMS after being threatened with the loss of federal funding resulting from a number of violations in patient safety and rights in 2013 and 2014. The agreement allowed the continued operation of the hospital since last October while implementing changes.

The hospital has been released from that systems improvement agreement, according to a letter from CMS' Northeast Regional Administrator, J. William Roberson which cited "the impressive progress and strides the hospital has made over the past year."

The Retreat has also announced the appointment of a new president and chief executive officer. Louis Josephson, Ph.D., will start on March 1. He has

been president and chief executive officer of Vista Del Mar Child and Family Services in Los Angeles since 2013, according to the Retreat. Prior to that he served for eight years as president and CEO of Riverbend Community Mental Health in Concord, N.H. and was also vice president of behavioral health at Concord Hospital. Before joining Riverbend Community Mental Health he served as assistant commissioner in the Office of Child and Adolescent Services for the New York City Department of Health and Mental Hygiene. AD



Louis Josephson, Ph.D.

Standing Committee Concerned on Role of Input For Selecting New Mental Health Commissioner

MONTPELIER — The stakeholder advisory committee for the state's mental health system has written to express its desire to see broader input into the selection of a new commissioner for the Department of Mental Health.

Clare Munat, a rotating chair and multi-year member of the State Program Standing Committee for Adults, said that at its June meeting, the committee had approved drafting a letter to request involvement with the recruitment process.

"In my humble opinion I think it is not good practice" to fail to solicit broader input, Munat said. "Listen to others and you will learn."

The appointment of former Deputy Commis-

sioner Frank Reed by Governor Peter Shumlin was announced before she was able to complete the letter, Munat said.

The letter was then rewritten in October to focus on future involvement.

"I actually had a lengthy conversation with [Reed] about my concern that neither our committee nor staff was asked for input," Munat said, but she was addressing him in his role as Deputy Commissioner rather than as a potential candidate at that time.

The letter to Agency of Human Services Secretary Hal Cohen said that the Administrative Rules on Agency Designation state that the com-

mittee should have input involving the hiring of "key management" in the Department.

"Our suggestion is that [the hiring committee] include a peer and family member," the letter said. It also referenced seeking input from long-time staff and prior Commissioners.

Appointment of departmental commissioners is in the sole discretion of the Governor.

According to the minutes, at its September meeting Adult Operations Director Trish Singer noted that Standing Committee members participated in interviews with candidates for positions for leadership some years ago. Munat could not recall how long ago that practice ended. AD

Reed Identifies His Perspectives and Priorities

Frank Reed, appointed by Governor Peter Shumlin in August as the new Commissioner of Mental Health, was offered an opportunity to identify his perspectives and priorities to Counterpoint readers. The questions were asked by Counterpoint reporter Donna Iverson. Answers were edited for length only.

What are your priorities as the new Commissioner of the Vermont Department of Mental Health?

Looking ahead, Vermont is in the midst of health care reform that hopes to improve how and where services are delivered, how those services are paid for, and better understanding how the services are changing people's lives. Whole person care really calls for integrated treatment. These reforms need our attention so that mental health and physical health services are equally considered and provided for in our service delivery system.

Also ahead of us, we have an ongoing and growing demand for health care services that may not be sustainable with current resources... The gains our system has made are still fragile and subject to erosion if there are inadequate or diminishing resources afforded to support them.

Additionally, we need to continuously review our current state statutes pertaining to mental health proceedings both civil and criminal to assure that language, intent, and authority are clear and in place to protect the rights of individuals, provide timely review and treatment, and prevent unnecessary confinement in inappropriate levels of care.

What can Vermont do to address the issue of stigma around mental illness?

Ongoing education, informed dialogue, and respectful advocacy and engagement go a long way in connecting and establishing relationships with individuals or groups who share a different understanding of mental health conditions or any dividing issues...

Addiction and homelessness are on the increase in Vermont. How can the state better care for these people?

Vermont, like other states, has unmet substance use and abuse treatment needs. Homelessness can also be a direct outcome of a struggling economy, limited state entitlement programs, and limited affordable housing options for low income Vermonters. Both of these issues, when paired with a mental health condition, are further compounded by public judgment regarding poverty and stigma still attached to mental health and substance abuse issues...

DMH has a fairly strong history of supporting co-occurring treatment capacities across the publicly funded designated agencies and for promoting innovative housing options, including the Housing First model and partnerships with state housing authorities for more permanent housing and supported living options.

What progress is being made in providing more emergency beds and treatment for people having a mental health crisis?

As I write this, it has been 1500 days since the former Vermont State Hospital closed. What has been a challenging period is still so recent and countable in days; so I would direct our attention to the progress we've made...

(The response goes on to cite replacement inpatient bed capacity at Brattleboro Retreat and Rutland Regional Medical Center, the 25-bed Vermont Psychiatric Care Hospital in Berlin, the 7-bed secure residential recovery program in Middlesex, and the 5-bed peer-supported Soteria House in Burlington; it references a total of 188 adult inpatient beds, 37 crisis beds and 42 residential recovery beds across the state.)

For a public mental health system, we have been moving at lightning speed; and we have increased capacity and treatment options for individuals experiencing a mental health crisis. Yes, there is still more to do but this revitalized system of care has only recently been completed and does need time to demonstrate its full capacity for meeting the need of Vermonters.

In your very busy schedule, what is taking up most of your time?

There are day-to-day service delivery issues for both inpatient care and community-based services. There are always two sides to any issue that need to be appreciated and addressed in as balanced a way as possible.

There are always new challenges being identified at the federal level with regard to health care reform and federal resources, which in turn have implications for state level health care de-

livery. Staying apprised of all of the prevailing issues and concerns is more time consuming than many might appreciate...

How are financial restraints affecting the delivery of mental health services in Vermont?

The State has historically supported our community-based system of care, and since 2012, has made more significant investments in funding both community and inpatient mental health services...

The more current and added challenge is the projection for a level funded budget and ensuring to the best of our ability that we protect services, even strengthen them to the extent possible, within the constraints of this difficult economic climate...

Can you tell us a little about your background and how you ended up working in the mental health field?

I am a native Vermonter, so think I was gifted with the typical characteristics of common sense, dry humor, an understanding that talking a lot doesn't always convey intelligence, and an appearance that might not suggest as much left-leaning thinking as you might presume at first blush...

Over my 30+ years in human services I've worked with teens and adolescents, developmentally disabled, elderly, medically compromised and end-of-life care, and a spectrum of mental health services from both community and hospital vantage points. I feel this broad exposure to mental health and support needs across the life span provided a solid grounding when I entered state government and the roles I've had with the Department since that time.

Do you have any personal mental health issues that you would be willing to share?

I don't want to make light of this question; but I am human, so I have mental health issues just like everyone else. It is the gradation of issues that separates me from every other person. Some of these issues have certainly been personal, while others have been experienced through family and friends struggling with their own wellness and recovery.

This blend of experience, learning, and growth over time has been valuable to me in better understanding the shades of gray that make up our world and our relationships with one another. The lens on the world that I have today has undoubtedly been crafted from all of my own lived experiences, personally, peripherally, and vicariously; and therefore I live each day with the personal mental health challenges and vulnerabilities like everyone else.



Commissioner Frank Reed

‘Psycho Hell’ Spurs Advocacy

(Continued from page 1)

cart and there is no signage alerting patients to the availability of the cart.

Burda said that he began to feel that the hospital saw him as just a “psycho” who would forget and just go away. Rather, Burda shared his concerns with his peer support group and with Vermont Psychiatric Survivors which led to an interview with *Counterpoint*.

When *Counterpoint* contacted the hospital in October, officials there refused an interview and refused to allow *Counterpoint* to photograph the ECA. In a written statement, the hospital defended the ECA, writing that it provided safe care and that the “leaders of Vermont Department of Mental Health have endorsed the purpose, design and policies” of the ECA.

When *Counterpoint* pressed for an interview, the hospital’s Communications Director, Ray Smith, replied that “it was a decision here” to issue only a statement and “unfortunately, it is what it is.”

In an email to the Chair of the hospital’s Board of Trustees, *Counterpoint* complained about the denial of an interview and alerted the Board of Trustees’ Chair to likely adverse publicity because of the hospital’s “stonewalling.”

Counterpoint also followed up with the Department of Mental Health to verify the hospital’s claim that DMH had endorsed the ECA. DMH Commissioner Frank Reed denied any endorsement.

“I confirmed with all staff that DMH has not been asked to review any policies at SVMC. Additionally, DMH was not asked to review design of the ECA at SVMC,” Reed said. “I would anticipate a clarification will be forthcoming from the hospital.”

The day after *Counterpoint* contacted the Chair of the hospital’s Board of Trustees, the hospital offered to set up an interview with the hospital’s President Thomas Dee, and to allow *Counterpoint* a tour of the ECA.

During the tour, *Counterpoint* noted no apparent changes to the ECA. The area still consists of three rooms, each empty of anything but a bed and a tray table. There are no visitor chairs. There are no windows. The walls are blank. The rooms are monitored from an enclosed nursing control station located across the corridor. During the tour, *Counterpoint* was shown a cart with activity items that was stored in a closet.

Dee explained that the ECA arose out of the hospital’s “growing concern” that patients and others were being put at risk during the lengthy delays in the emergency room while awaiting a psychiatric inpatient bed to become available somewhere in the state. Dee said that the hospital had made a major investment in its effort to create improvements over the use of the busy emergency room which lacks privacy for patients who may be waiting for days for an inpatient psychiatric bed to become available.

He said that the hospital consulted both with local mental health professionals and architects experienced in psychiatric uses, and that there has been patient feedback that it is a significant improvement over the past.

During the interview, Dee agreed that DMH had not endorsed the ECA. “It was our fault on that,” he said of the discrepancy.

The entire emergency department at SVMC is out-of-date, Dee said. “We are working with a very sub-optimal space,” which was contributing to the negative impact for mental health patients, he said. Plans for renovation to the emergency room will include new space for psychiatry, not reuse of the current ECA, he added.

Dee said one problem the hospital confronted was the fact that it did not have its own psychiatric resources to rely on because it does not have its own inpatient unit. “Not being a mental health provider has probably limited” the hospital’s perspective, he said. There are now expanded efforts to partner with United Counselling Service to access some of its resources, and that has included supports in the emergency crisis area. United Counselling Service is the Bennington County community mental health center.

Dee acknowledged that the hospital “hadn’t done a good job” in listening to the community. He committed the hospital to meeting with Burda and others to improve conditions at the ECA. “Our intent here [is] to be much more collaborative” in moving forward and to solicit feedback, Dee said.

Burda, who developed mental health challenges late in life after suffering a traumatic brain injury while working as a carpenter for the Massachusetts Turnpike Authority, feels that it is his job to serve as an advocate for those who can’t do it for themselves.

“If someone offered me a pill that would make all of my mental health problems go away, I would say ‘no thank you,’” Burda said. “I would be afraid of losing my focus,” he said. “It’s my destiny to do [advocacy]. I like it and I’m not going to give up.”



SMALL COMFORT — A closet stores items for “patient comfort” in the holding unit.

(Photo Courtesy of SVMC)



OUTSIDE LOOKING IN — Greg Burda of Bennington stands outside the emergency room of Southwestern Vermont Medical Center after the hospital’s initial refusal to allow *Counterpoint* to take pictures of its rooms for patients who are waiting for a transfer to an inpatient psychiatric facility. (Counterpoint Photo)

New!

**Counterpoint
Telephone Poll**

Issue: Emergency Room Waits

Question: Should Vermont add more psychiatric hospital beds?

Vote by calling 888-507-0721

Toll Free

**To vote “Yes”
Dial Extention 12**

**To Vote “No”
Dial Extension 13**

Results of the poll will be published in the next issue of *Counterpoint*.

Workshops Explore Stopping Medication

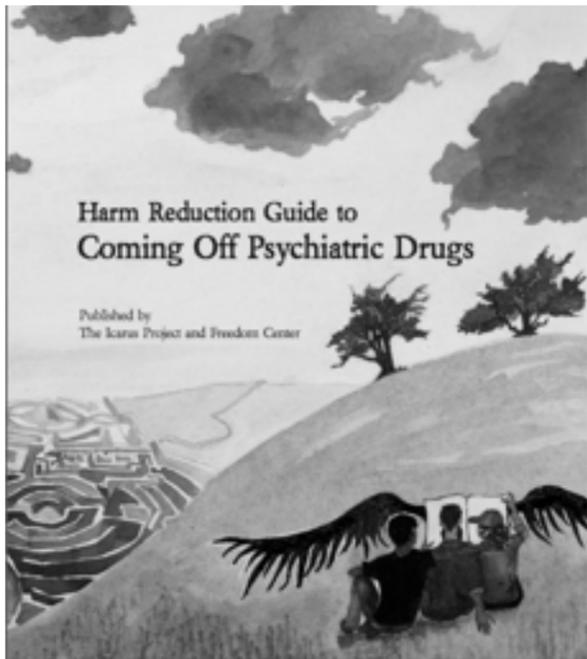
by ANNE DONAHUE

Counterpoint

BURLINGTON — Users of psychiatric medications, along with assorted care providers and community members, gathered here recently for a workshop on a topic once considered taboo: getting off psychiatric medications.

Under the title of “harm reduction,” participants brainstormed their own desires and fears and discussed how to support individual choices. “Becoming suicidal” led one group’s list of the risks of getting off prescribed medication. “Avoid putting unknown poison into body,” was the starting item under a list for “why stop medication?”

The training for facilitators came from the



Front cover of the Icarus Project guide, “Coming Off Psychiatric Drugs.”

Icarus Project, which defines its “harm reduction” approach as meaning “not being pro- or anti-medication, but supporting people where they are at to make their own decisions, balancing the risks and benefits involved.”

The web-based Icarus Project says it is a “support network and media project by and for people who experience the world in ways that are often diagnosed as mental illness.”

Psychoactive substances, whether prescription medications or “recreational” [illegal] drugs result in “producing an effect that either is or isn’t helpful,” said Makenzey Smith, one of two facilitators.

Becoming informed about choices doesn’t mean medications are not sometimes helpful, she told participants.

Similar workshops are taking place around the state. They are the result of a training offered by the Wellness Workforce Coalition after one of its member organizations suggested it as a topic. The Coalition is a statewide group of peer-run organizations funded by the state to provide support and training for Vermont’s peer workforce.

The new discussions come at a time when initiatives in Congress are pressing for more reliance on formal psychiatry and psychiatric medications, even as research suggests that less medication and more talk therapy may produce better results.

In Vermont, however, the legislature has directed a course that included both the creation of Soteria House — a residence “for individuals seeking to avoid or reduce reliance on medication” — and a requirement added in 2013 that the Department of Mental Health report annually on

“progress on alternative treatment options across the system of care for individuals seeking to avoid or reduce reliance on medications, including supported withdrawal from medications.”

The value of such initiatives was underscored by the keynote speaker at the Department’s fall conference, who shared research that began 60 years ago in Vermont showing that psychiatric drugs were not necessarily a vital or sole component of long-term recovery.

Calvin Moen, a facilitator with Vermont Psychiatric Survivors, said he was aware of the Icarus Project’s work on medication several years ago. He is seeing something once considered as “radical” and discussed only among peers “emerging into [being] more recognized in Vermont” through the workshops.

The Burlington workshop was hosted by Pathways Vermont as a part of its Community Learning Series. Pathways is a nonprofit organization that runs recovery services, including Soteria and housing support.

The two facilitators, Smith and Cameron Mack, described their own experiences with psychiatric medications and withdrawal, and what they learned from those experiences, and led the audience through a give-and-take discussion.

Smith said she came off three medications abruptly, an approach “I don’t recommend.” She has now experienced “almost five years of being off almost all my prescription medications.”

Mack said he reduced many of the medications he used gradually, and still takes some.

The 20 or more different kinds of medication he has been on were “a lot of times helpful” but

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New Gun Ban Notices Sent Without Explanation

RUTLAND — Individuals under an existing court commitment, either to the hospital (OH) or under an order of non-hospitalization (ONH), began receiving court notices about registration with the National Instant Background Check System in November without any information to explain what it meant.

According to Jack McCullough, Director of the Mental Health Law Project, 279 individuals received the orders. The notices were the result of a new law passed by the Vermont legislature requiring courts to send the names of persons with an order of hospitalization or ONH to be listed on the federal database of persons who are not allowed to have firearms.

All of the notices, in error, said that the person named in it has been subject to an ONH dated October 27, 2015, McCullough said. That was actually the date the court issued the order for registration, he said.

McCullough met with the administrative judge for the court system, Brian Grearson, and “they are going to fix the date issue,” he said. The process for complying with federal rules to provide the names “turned out to be more complicated than they thought it would be,” which created some of the data software problems.

Although the notice informs the person that they are “not permitted to possess a firearm” as long as the notice is in effect, it provides no further information about what being registered in the background check system means. McCullough said he is working on drafting a letter to send his clients to explain the orders.

Existing federal law has banned possession of

firearms by anyone with a court-ordered mental health commitment (including an ONH) for many years. Prior to the new law, however, Vermont was not sending the names of those persons to the federal database.

Under federal law, when someone goes to a gun shop to buy a gun, the gun shop owner is required to make an inquiry about whether a person’s name is on the database. If it is, the gun shop is prohibited from selling the firearm to that person. The information is not available to the

public. The new law for registering names applies to anyone who has an active OH/ONH as of October 15, 2015, going forward. The law requires that they be notified.

The new law also created a method for persons who have been banned because of a mental health commitment to apply to have the ban lifted after the ONH has expired.

That process is available to anyone with a past ONH, regardless of whether their name was sent to the federal background check list. AD

STATE OF VERMONT	
SUPERIOR COURT Rutland Unit	FAMILY DIVISION Docket No.
In Re:	
ORDER FOR REGISTRATION	
<ol style="list-style-type: none"> is subject to an Order of Non-Hospitalization dated 10/27/2015 issued pursuant to Title 18 section 7617 (b)(3); Pursuant to Title 18 V.S.A. § 7617a, is subject to registration on the National Instant Background Check System; That a copy of this Order shall be mailed by first class mail to the last known address of _____; That _____ is not permitted to possess a firearm as long as this Order for Registration remains in effect. That this Order for Registration is made in accordance with 18 U.S.C. § 922(g)(4). 	
Electronically signed on October 27, 2015 at 09:31 AM pursuant to V.R.E.F. 7(d).	
 Brian J. Grearson, Superior Court Judge By Tina de la Bruere, Superior Court Clerk	

Why Stay on Medication?

- risk of becoming suicidal
- loss of employment and relationships without the medications
- continuation of symptoms by stopping
- my medications make me feel my "real" self
- a return of symptoms after getting off, but then the previous medications don't work trying to go back on them
- difficulty of withdrawal: physical and mental
- loss of social support for recovery; condemnation by others
- staying on allows more involvement in life

Why Stop Medications?

- avoiding putting unknown poisons in body
- more able to address underlying causes of distress, instead of just addressing symptoms
- avoid stigma of taking medication
- save money
- better sex life (and ending other negative side effects and contraindications with food or other medications)
- not knowing who you are without drugs
- end risk of problems developing that weren't there before
- long term health effects, like diabetes or tardive dyskinesia
- over dosing

Brainstorming by Participants of 'Reducing Harm' Workshop in Burlington

Workshops Explore Stopping Medication

(Continued from page 6)

"a lot of times hurtful," and taken without a "fully informed decision," he said.

Participants at the workshop included about a third who identified themselves as persons with a mental health diagnosis who use medication. About half said they were Pathways staff or other providers.

Mack began the presentation portion of the workshop by talking about the cultural and media perception that a chemical imbalance is the "cause" of mental illness and medications address this. That isn't a proven theory, he said.

Hearing it that way "led me to think I was broken" and that "there was a medication that would 'fix me,'" he said. In fact, he added, we don't actually know what medications do in the way they address symptoms.

Smith noted that in producing their effect, significant factors include the relationship to the person who recommended the medication (trust level) and the "placebo effect." This is a known factor for all drugs: the expectation that something will work can alone cause it to work.

Mack then addressed the issue of whether a person who has been helped by medication needs to be on that medication for life. He referenced studies that raise questions about that and that suggest that some people will do better in the long term if they are not using medication.

He stressed that people need to have enough information to make their own informed decisions about "what to put in [their] own bodies."

The group then divided into small teams for discussion. Individual differences emerged: some commented that medication made them unable to "know who they really are without medication," while others said medication made them feel back to being their "real self."

Smith then reviewed effects that can occur when attempting to reduce or discontinue medications. They included change in sleep patterns, appetite (with the possibility of weight gain), sexual functioning, thinking (perhaps feeling more

clear in one's thoughts), and effects on emotions, energy levels and thoughts. They could be short- or long-term, she noted.

Mack went over some practical tips that the Icarus Project identifies. A very slow process is recommended, such as a 10 percent reduction per month, and only a reduction of one medication at a time. The longer someone has been on a drug, the slower the reductions should be. It is helpful to find a pharmacy that does compounding and can thus create smaller reductions in doses, he said.

He said that it was important to know that there are differences among withdrawal effects among different types of drugs. Sleep habits must sometimes be relearned. "Listen to yourself" in the process, he said, with awareness that other life impacts may be affecting changes in how one feels; it may not be medication changes.

A supportive doctor is an asset, but it is "your choice" in making an informed decision about medication risks and benefits, he said.

Getting off *all* medication may not be the goal, Smith noted. A person needs to recognize that plans to withdraw "don't work every time," and one needs to have a "plan for distress" when it occurs, he said.

During the question and answer period at the end of the workshop, one participant asked, "How do you know it's the right time to try?"

"You might not know," Smith said. It may be because a medication is causing significant damage in life, and it may be a matter of trying and needing to go back on the medication. That's not a sign of failure, she said. "Maybe it just wasn't the right time." There are also "times when it's not going to be possible," when the risk of harm through stopping medication is too great.

New Research Supports 'Talk Therapy'

Just in the past year, new research has again raised questions about whether heavy reliance on medication is the best treatment path.

The research, as reported in *The New York Times* in October, studied a program intended to keep dosages of antipsychotic medication as low

as possible and emphasize one-on-one talk therapy and family support. The study followed symptoms and "quality of life" indicators of patients at 34 randomly assigned community care clinics in 21 states who were provided either treatment as usual or the combined package.

Initially, those in the alternative program did not score as well, but both groups showed steady improvement and at the end of the two-year study, "those who had been in the combined program had more symptom relief, and were functioning better as well," the *Times* reported. The study was funded by the National Institute of Mental Health and published in *The American Journal of Psychiatry*.

Old Research Identified the Same Issues

Those results were in line with one of the earliest studies to review long-term recovery and to raise doubts about whether it is necessary to remain on high levels of psychotropic medications. The research started in the mid-1950s and followed former state hospital patients for decades as they were supported in community and vocational rehabilitation.

Courtney Harding, Ph.D., of Boston University, shared the outcomes in a presentation this fall at the Department of Mental Health annual conference in Fairlee. Twenty years after discharge, between 62 and 68 percent had "reclaimed their lives" – 68 percent with little or no signs or symptoms of illness, and 64 percent with fewer than two relapses over the 20 years since discharge.

Eighty-one percent were caring for themselves, and 40 percent were employed, with another 20 percent involved in volunteer work, Harding said.

Of the total, 20 percent were on no prescriptions at all, and another 30 percent acknowledged that they were receiving prescriptions but were not using them at all. Among the others, 25 percent used medications on a "targeted basis" and the final 25 percent used them consistently. That last 25 percent did not want to attempt to reduce a dosage or were too afraid to make a change, the interviewers found.

SSDI Report Galvanizes Advocacy

'They Have It All Wrong,' Recipient Says



Christina Colombe of Barre (Counterpoint Photo: Anne Donahue)

by ANNE DONAHUE

Counterpoint

BARRE — When a new study disclosed that Vermont has one of the highest and fastest growing rates of young persons on Social Security Disability Income, some felt it would shine a light on the obstacles Vermonters face.

But Christina Colombe was furious, and it has spurred the 47-year-old former pharmacist to take on an advocacy role to challenge the lack of rehabilitation services in the state.

"They have it all wrong," she said of the report. "It really burned my butt." She believes the report was too focused on the state's recent drug abuse problems and didn't look at the barriers to returning to work.

Worse yet, news reports resulted in editorial comments saying in effect that the state should be ashamed of the high rates, and "we [persons on disability] should be doubly ashamed." It is the system itself, not individuals, who are failing, she said.

She reached out to several legislators, and has now committed to being a voice for change in the state. "People like me... have literally turned over every rock to [get off] all benefits," she wrote in an email. "I cannot be alone."

"I hope other efforts will be made to find PwDs [People with Disabilities] for input while crafting policy change(s) that will affect them," she added. Colombe said there are key things that people need to know that can help them avoid or get off disability, but that she wasn't told, including the ways that the Americans with Disabilities Act (ADA) can help in getting employment.

The report was published by the legislature's Joint Fiscal staff, and it reviewed state and national data on Social Security Disability Income (SSDI). SSDI is the federal disability insurance program for persons with a work history — something different from Supplemental Security Income (SSI), which is a "safety net" minimum payment for persons with disabilities whether or not they have a work history.

Joyce Manchester, who wrote the report, said that federal data show Vermont has the second highest rate of persons under age 35 receiving federal disability insurance income, more than twice the national average. The analysis also showed that between 2000 and 2013, the rates of people under age 45 on SSDI in the three northern New England states increased at a rate four times higher than the national average.

One theory Manchester listed for the growth rate was the growing rate of opiate addiction among young Vermonters, which the report said

can exacerbate pre-existing mental conditions and create new ones. Mental disorders are among the most common reasons people end up on SSDI, amounting to almost half of all SSDI recipients in Vermont, the report said.

Colombe said she feels Manchester "had a conclusion [already] and went to find facts to support it."

"No one was mentioned but the people with substance abuse problems," she said, and "that's not everybody." Colombe has a neurologic disorder that results in visual impairments and in obtrusive arm and leg sensations. She was stunned to later discover that a psychiatric disorder ended up being listed as the primary diagnosis to get her disability determination. She said she has no idea how she was diagnosed with "Bipolar I," nor why it was listed ahead of the neurological disability — she does have an anxiety and depressive disorder diagnosis "which I agree with."

Although she had fought being steered to SSDI for two years, she felt she was in no place to then argue and attempt to amend the record, placing the income and medical insurance that it provided at risk.

Colombe said that the system fails to provide true vocational rehabilitation and ignores the most fundamental obstacles: the lack of access to needed medication and to transportation. The attitude is to "get you a check" and then say "get out of my face," Colombe said. Work opportunities through the Vocational Rehabilitation office are limited to low paying, dead-end jobs instead of working with people's skills, she said.

The report noted that once on disability, only 0.5 percent ever get off. Increasing workforce activities must be balanced with eligibility for benefits because there can be "a lot of risk" for people leaving benefits, it said.

The low rate of graduating from the program is something that Voc Rehab repeatedly tells people, Colombe said. "How defeating to hear that," she said. "It's basically code for 'give it up.'"

Most of the problems are in federal rules, which the state can do little to change, Colombe noted. But she thinks the state should try to establish a pilot project that would allow higher incomes progressively so that a person does not face the "trap" of losing disability support without reaching an adequate income.

She reached out and learned on her own through a national organization that individuals can "use the ADA" for work accommodations that could get them back into the workforce and off benefits.

In her case, her diagnosis means that she is unable to work full time, but her occupation would give her a good income even with a half-time job. She learned that "parttime work is a disability accommodation," when employers can split a job between two employees.

"I've wasted half my life" with 18 years on SSDI as a result of not knowing that, and the state's Voc Rehab office should be informing people of that opportunity, she said.

Hurtful Comments Online

Colombe cited both the report and public reactions as hurtful and stigmatizing, in particular through

blaming the high rates on drug abuse.

A comment on the VT Digger web site illustrated the perceptions created about addictions, saying that, "Just because you like to use drugs or alcohol, doesn't mean you can't have gainful employment... this is another example of a necessary social program being abused and destroyed by those who really don't need it, just like with most of our state-run welfare benefits."

When another writer said that, "Perhaps, the safety net is more like a safety hammock in Vermont?" a reader replied, "Safety Hammock – Hell, it more like a Safety Lazyboy recliner with a safety belt installed to make sure they cannot accidentally get thrown off."

"No one wakes up one day and says 'I want to be on Social Security,'" Colombe objected.

She also pointed to a Caledonia Record editorial that said that in Vermont "legislators [have] worked hard to create an environment that richly rewards people for living off of government and made Vermont world-famous for top-shelf welfare benefits."

Identifying the Cause of Getting Stuck

Colombe said that in contrast to the suggested conclusions in the report, she could identify her own list based on her 18 years of experience with the system. Among them were "agencies' first instinct" to have clients obtain ben-

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According to the Social Security Administration, 72 percent of individuals who apply for disability income benefits (SSDI) are denied on their initial application. Three percent are approved after a request for reconsideration, and 13 percent are awarded benefits after an administrative hearing. Thus the total percentage of those who receive benefits after all levels of appeal remains less than one half. The averages are from data from 2001 through 2010.



ABUZZ IN BRATTLEBORO — Members of the Hive, a mutual support network based in Brattleboro, used yellow T-shirts with black tape and played kazoos to carry out the bee theme as they staffed a table at the Wellness in Windham health fair this fall. They offered pre-printed “prescription pads,” inviting attendees to diagnose something other than an individual — for example, a system or part of the culture — and prescribe a solution or change. Some wrote prescriptions for affordable childcare, others for respect and autonomy for psychiatric and medical patients, and others for alternative economies like the Time Trade. Members also passed out flyers and brochures. More information can be found at <http://hivemutualsupport.net/> (Photo Courtesy of The Hive)

Stakeholders Raise Need for Input When New Legislation Considered

MONTPELIER — As Department of Mental Health Commissioner Frank Reed discussed policy areas he thought the legislature should consider, members of a statewide stakeholder group focused on one issue: how do members of the public get to weigh in on laws that DMH is thinking of proposing to the legislature?

“I would like to know how to direct people” who might want to give input, said Malaika Puffer of the Statewide Program Standing Committee on Adult Mental Health. “How are decisions made?” by the department, she asked.

The committee, made up of consumers, family members and providers is appointed by the governor to advise the department.

Reed provided an answer that pointed to input to legislators after bills are introduced, rather than a route for input into the Department’s own decision-making process. “Tell your legislator” how you feel about proposals, he said. He noted that anyone could ask a legislator to sponsor a bill, whether the commissioner of a department in

state government or a private individual.

The “timing is now” to seek changes in law for next year’s legislative session, which runs from January to early May of 2016, Reed said.

With the prospect of a level-funded budget — which has the impact of program cuts — there will be a great deal of focus on money issues, he said, leaving less time for policy issues that are not brought to legislators early enough.

He also noted that a great deal of legislative time is likely to be diverted by a proposal to legalize the use of marijuana.

Reed did not give specifics about the issues the Department might want addressed, but referenced the need to provide timely review and treatment, and to be able to move individuals to “the right place” so that they do not “block beds” that are needed by other patients.

He later clarified to *Counterpoint* that DMH was not proposing any specific legislation at this point, but could be asked to weigh in on such discussions. AD

SSDI Report ‘All Wrong,’ Recipient Says

(Continued from page 8)

efits, not work or education, “even above protestations of the client.”

On top of transportation obstacles and, for her, exorbitant medication costs, there are housing issues, she said. “When your income comes primarily from Social Security, regular landlords will not consider you, and Vermont has not done enough in the arena of housing discrimination.”

She also cited a lack of educational opportunities for PwDs. “I am currently taking a free class at [Community College of Vermont]. After four years on Barre VR’s caseload, I am curious why I was never told about these free workforce development classes,” she wrote to legislators. She learned about it in the *Times-Argus* rather than from Voc Rehab, she said.

Manchester said that she was only reporting

the data and presenting theories for Vermont’s high rates, so that the legislature could look at the issues more closely. Theories offered in addition to the opiate-addiction crisis included that social service agencies push applicants to apply for the federal program because it costs less state money. Since SSDI is paid for by the federal government, and beneficiaries are covered by Medicare, the state has a big incentive to move people away from state assistance programs, including Medicaid, and onto federal programs, she said.

The numbers could also reflect that many able-bodied young Vermonters leave the state for job opportunities, Manchester wrote in the report. The state has seen an out-migration of 20-year-olds and 30-year-olds, which might leave a higher percentage of those with disabilities among those who remain in the state.

Inmate Sues State For Discrimination In Housing Access

MONTPELIER — Disability Rights Vermont brought a lawsuit this fall on behalf of an inmate who alleges that the state violated the Americans with Disabilities Act by keeping him in prison based upon a lack of housing that could accommodate his needs.

The case brings to four the lawsuits pending against the Department of Corrections and its medical services contractors for failures in mental health services. The earlier three have had no major change in status since reported on in the spring issue of *Counterpoint*, according to Supervising Attorney A.J. Ruben.

The new lawsuit says that the inmate has been incarcerated long past his minimum sentence and is being treated differently from other inmates in that regard because of the lack of transitional housing and supports for prisoners with disabilities.

The inmate has been diagnosed with schizoaffective disorder and depression, according to court papers. He has experienced “exacerbated mental, emotional, and physical harm and trauma” as a result of his continued incarceration and has made one “significant suicide attempt,” the court papers say.

The Departments of Mental Health and Disabilities, Aging and Independent Living are also named as defendants in the case. Ruben said the state had not yet responded to the claims.

In the lawsuit that alleged an inmate was held in segregation for two months after the need for an inpatient psychiatric bed was identified, Ruben said the court has rejected a motion to dismiss the suit immediately.

Also pending are lawsuits related to the suicide death of an inmate at the Springfield correctional center, and the inadequate treatment plan for another inmate. AD

Group Floats Ideas For Hospital Peer Roles

MONTPELIER — The state’s inpatient psychiatric units are now in the second year of implementation of strategies to reduce the use of restraint and seclusion, and new ideas like creating peer specialist positions have “bubbled up” as the project progresses, according to Sarah Squirrell, who directs the Vermont Cooperative for Practice Improvement and Innovation (VCPI).

She raised the topic at a meeting of the Emergency Involuntary Procedures (EIP) Work Group. VCPI is a collaborative that provides training, education and consultation to help implement and improve practice to help individuals with mental health issues. It is coordinating the restraint and seclusion reduction initiative under a contract with the state.

Squirrell said that as members of VCPI discussed the importance of peer involvement, the concept emerged for a comprehensive program across the state to create peer positions in the hospitals.

“How do we create something?” the group asked itself. Squirrell said it is now brainstorming options with the Department of Mental Health and the Wellness Workforce Coalition, a group that focuses on workforce development for peers.

“You want to do it right” if new positions and job descriptions are being created, she said. It also needs to be financially sustainable. AD

Voices of Recovery: Receiving, Then Being, Peer Support

by DONNA IVERSON
Counterpoint

BURLINGTON — Jared Haage of Burlington took his first drink when he was 12 years old.

By 16, he had a job as a cook in a Newport restaurant, had quit school and was drinking heavily three or four times a week. By 19, he was drinking every day. In his 20s, he began to get arrested for minor offenses that were all alcohol-related. And it went downhill from there until he ended up in recovery at Maple Hill Farm in Vermont.

Today, Haage is sober and employed, helping others with mental health issues at Vermont's newest alternative program, Soteria. He credits that same kind of peer support in his life with getting him to this point in his own recovery.

Haage said he had suffered even as a pre-teen from depression and anxiety. He remembered “dark thoughts of suicide even at a young age. The alcohol stopped feelings of impending doom.” As an adult, he sees alcoholism and mental health issues as co-occurring, but it has taken him twenty years to put “two and two together,” he added.

Today, he doesn't put alcoholism and mental illness into two separate categories, he said. “Alcoholism is a mental health issue,” he continued. “It is a disease that centers in the mind.” Many alcoholics — an estimated 85 percent of them — come to sobriety to find they have mental health issues, he added.

Peer Support

After being given a choice of prison or treatment in his early 20s, Haage ended up calling the Maple Leaf Farm treatment center in Underhill during one of his blackout binges.

He admitted to being scared. “I didn't know what rehab meant,” he said. “I thought it meant that getting sober was the end of my fun... that it meant constant agony of craving for alcohol and drugs.”

At the center, a group of sober 20-year-olds came in and “they were happy,” he said. That was



Jared Haage

the turning point for him. With peer support, he got sober and these people remain his friends to this day, he said. Vermont is a mecca for young recovering addicts, he added.

Later, he began attending meetings at Turning Point, a peer-support center near City Market in Burlington where Hannah Rose was the director. She talked openly about lived experiences and how beneficial intentional peer support was to her, Haage said.

Meeting someone who discussed her experience “allowed me to open up,” he said. “It opened my eyes and showed me a new way of interacting with people.”

Previously, conversations had been about how “I was broken and they needed to fix me,” he said. Now his interactions with people became a “mutual thing... we were both getting something out of it.”

He began working as a volunteer, and “I was given trust,” which made all the difference, he said. Haage went on to working as a recovery sup-

port person at Turning Point, an assistant director of education at the Vermont Association of Mental Health and Addiction Recovery (VAMHAR), an employment specialist at Another Way in Montpelier, and most recently as resident support staff at Soteria, on Manhattan Drive.

Soteria is an alternative living environment for people experiencing a psychotic break, who are seeking to avoid hospitalization.

Speaking on a panel at a recent conference, Haage said he now identifies as being a “peer.” “What does that actually mean?” he asked. “Why use it” as a term?

He said he believes it helps “to bring people in,” and “gives a voice to those who haven't had one for a very long time.”

A Focus on the Non-Traditional

Even when he was young, his mother, who was a recovered alcoholic herself, “veered me away from them giving me labels, diagnoses and medication,” Haage said.

Since then, doctors have “persistently tried to give me medication,” he continued. He called the prevalence of giving medications to people with mental illnesses an “epidemic.”

“I work with people whose doctors dictate medication,” he continued, “who say, ‘you have to take this.’”

Although not totally opposed to the option of medication, Haage argues that people need choices and options and a say in their treatment. They need to be well informed about side effects and understand that “one size does not fit all,” he added. “It is not a cure-all magic fix.”

Soteria is presented as an environment for those looking to minimize or avoid reliance on psychiatric medications.

It offers free residential housing without “clinical demands,” Haage said. Residents decide for themselves when they have recovered enough to move on, he added.

“What a beautiful blessing [to] sit there with these people navigating difficult experiences” at Soteria, he said. “I just see it growing.”

Research Rules Consider Expansion of Surrogate Consent

BETHESDA, Md — The federal Department of Health and Human Services is seeking public comment on whether to allow wider interpretation of who can give substitute consent to research for a person who lacks capacity to consent on their own.

Current rules say that only a “legally authorized representative” created in state law can consent to research on behalf of another person. The HHS proposal for rulemaking asks for input on whether that should be broadened to allow the choice of a representative based upon any “accepted common practice” of who can give consent for medical treatment.

HHS said that the current rule interferes with research in states that do not have specific laws on the subject. Vermont is one such state.

Ed Paquin, Executive Director of Disability Rights Vermont, said his agency will be submitting comments to express concern about the possibility of the definition being broadened.

Allowing a greater range of persons to provide surrogate consent without adding patient protections would go against recommendations made by the Secretary's Advisory Committee on Human

Research Participants in 2008. That committee noted that a surrogate can never be “ethically equivalent” to a person's own consent, even if considered legally equivalent.

Although the public comment period was scheduled to close on January 6, such comment periods

for proposed rules are sometimes extended. If the comment period is still open, Internet access is via <http://www.regulations.gov>. Enter docket ID number HHS-OPHS-2015-0008. On the next Web page, click on “Submit a Comment” action and follow the instructions. AD

SSI Recipients Lose Suit, Benefits Cut Begins

ESSEX JUNCTION — Families on Reach Up with a member receiving Supplemental Security Income benefits saw those benefits cut by \$125 a month beginning in December, according to state officials. A lawsuit by Legal Aid to block the reduction was unsuccessful. SSI is a federal program for persons who are aged, blind, or disabled and have little or no income.

The cut was ordered by the legislature in the state's budget starting this past July. It was on hold while Legal Aid appealed the decision based on grounds of disability discrimination. Hal Cohen, Secretary for the Agency of Human Services, said the state will not seek to take back what he called “overpayments” made from July through November. The legislature said that the reduction to Reach Up reflected the additional

household income from SSI. Advocates had argued that SSI was a federal entitlement that could not be applied in determining household need, but a court rejected that argument this fall. AD

Providers Say Group Therapy Rate Cuts Will Hurt Care

MONTPELIER — Advocates are warning the state that its decision to slash Medicaid reimbursement for group therapy by nearly 50 percent will reduce access for patients seeking help. The new rates will make it unaffordable for many providers to offer group therapy at all, according to a letter from the Vermont Psychiatric Association. The administration said that the change was necessary to follow Medicaid regulations. AD



ALYSSUM'S OPEN HOUSE to celebrate four years as Vermont's peer-run alternative respite house included the warmth of a bonfire for the raw October day and an array of food inside. (Counterpoint Photos: Anne Donahue)

At 4-Year Anniversary, Guest Reflects on Alyssum

ROCHESTER — More than 200 guests have experienced the support of Alyssum, an alternative crisis respite house, in the four years since it opened. It was “a life-changing place to be,” reflected one of those past guests as she joined others at an open house to celebrate its anniversary in late October.

Linda, who asked that her last name not be used, said that in a life of struggling with diagnoses of bipolar and seasonal affective disorders, it was “the first opportunity ever to be able to come to a place where I could work on issues”

from a traumatic childhood. Alyssum was a place where she was “able to feel safe and [yet] not be hospitalized.”

It offered her the chance to learn the skills to address anxiety and conflict resolution, for example, she said, instead of just addressing symptoms, “so it really stuck with me.”

When she began to feel anxious, the staff asked, “What do you want to do?” and “talked me through it” in ways she has been able to continue to use. “The peer support piece is really important,” she said, because she knew she was

being supported by people who had also experienced what she was going through.

Her biggest regret is that so few people are aware of Alyssum, and that there are not more such programs around the state. For many people, the drive to this small central Vermont community is too far, and for others, the waiting list for the two-bed program is too long, she said.

Linda experienced two family deaths a year ago, and after Christmas was put on the list for Alyssum. “By the time I came here [in February] I was really needing support,” she said. AD

COMMENTARY

I Am Not a Peer

by MALAIKA PUFFER

Nearly every day I hear people use the word “peer” to describe people with psychiatric labels. I’d like to see this trend stop and request that others join me in making this happen. I’m only the addressing issue of people being called peers, not the use of the word in terms like “peer support.” In the latter case, “peer” is used as an adjective to describe the type of support and the nature of the relationship rather than as a static label for the people participating in the support. It’s the static label that I take issue with.

Here is why:

It’s semantically incorrect.

The word “peer” is a relative term that cannot stand on its own. It means someone of a similar rank or social group. We are all peers to some people in some way but none of us can simply be called “a peer” without some other point of reference. “Is she a peer?” does not make sense as a yes or no question. (The correct response to that question is, “A peer to whom?”)

It’s unclear.

I honestly don’t understand what people mean when they call someone “a peer.” While it is defined in mental health statute (bizarrely), it is in practice used to mean so many things! It could

mean someone who receives services, someone who has been hospitalized, someone who has been diagnosed, someone who does peer support for work, someone who hears voices but never received services, someone who has emotions, etc. The word does not provide useful or accurate information. Think about all the different ways you could interpret this sentence: “We have some staff who are peers.”

It’s lazy.

A one-word label for “those people” is understandably desirable for its convenience but it’s not acceptable. It’s okay if we struggle with our language a little and maybe even use a few extra words in order to describe the people we are referencing accurately and respectfully. Seventy-five percent of the time that I suggest we not use “peer” as a label people ask me, “Well, what term do you suggest that we use then?” That question is part of the problem. Let’s practice actually describing what it is that we mean.

It’s oppressive.

When people label me as “a peer,” a line is drawn between *us* and *them*. If I’m labeled this way by people who identify as peers then I feel involuntarily lumped into a category that I don’t really buy into (“us”). If I’m labeled as a peer by

someone who does not identify as a peer, I feel painfully pathologized and othered (“them”).

In Title 18 “peer” is defined as “an individual who has a personal experience of living with a mental health condition or psychiatric disability.” While there was clearly an attempt to use euphemistic and less nasty language here, what is implied is mental illness.

Mental illness is a powerful social construct. It is so penetrating because it calls some of the most personal and existential parts of us — our thoughts, feelings, and behaviors — *sick*. It’s a label that, more than any other, comes with the threat of coercion and loss of civil liberties.

Using the peer label gives credence to a violent idea: the idea that there is a fundamental difference between those of us who get psychiatric labels and those who evade them; the idea that the psychiatrically labeled belong to our own rank or social group; the idea that only some of us are peers.

Malaika Puffer is a psychiatric survivor and subversive innovator. Malaika is part of The Hive Mutual Support Network in Brattleboro and manages peer support services for Health Care and Rehabilitation Services of Southeastern Vermont (HCRS).

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

Editorial

Without Us

Lots of us don't agree on various topics. We can't even agree who the “we” are: peers? survivors? consumers? persons with a lived experience of a mental health diagnosis?

And if we are confused, think about the rest of the world, trying to figure out what label to use to identify our voice.

But whatever name we use, one thing should be clear. If decisions are being made that impact our community and our friends, we need to be at the table.

We need to be included in the conversation, with all of our assorted viewpoints.

For a while it seemed as though at least in Vermont, that message was pretty clear: Nothing about us, without us. Unfortunately, every right worth fighting for requires sustaining the battle. In the past several years, we seem to be backsliding.

Look at the recent list:

A new Commissioner of Mental Health was appointed without any input from the State Program Standing Committee for Adult Mental Health.

New “holding rooms” in emergency departments were built at several hospitals. No local consumer groups were asked for input on a design for safe but trauma-sensitive space.

The Vermont Psychiatric Care Hospital established committees to work on the federal “Six Core Strategies” process for reducing restraint and seclusion. Despite the fact that peer involvement is one of the core strategies, none of the committees include perspectives from a patient or past patient.

The process for selecting annual grants for peer-directed programs came with new “strings attached” to what the peer advisory group was allowed to recommend.

We could blame the various organizations involved for failure to reach out to us... or we could be asking ourselves, have we become less visible? More complacent? Too polite?

Frederick Douglass said — and it is memorialized on every Counterpoint editorial page — “Power concedes nothing without a demand. It never has and it never will.”

If it is the squeaky wheel that gets the grease, it seems that we are not squeaking enough.

An old expression reminds us, “If you are not at the table, you are probably on the menu.”

It's time to start speaking up again.

PUBLISHER'S COMMENTARY

DMH Anti-Smoking Campaign Needs More Sensitivity and Honesty

by WILDA L. WHITE

Earlier this fall, I received an invitation from Vermont's Department of Mental Health (DMH) to attend a daylong conference to learn how DMH is “implementing new innovations to support individuals in need of mental health support and treatment.” According to the invitation, Dr. John Hughes, Professor of Psychiatry and Psychological Science at the University of Vermont and one of the 10 most-cited tobacco researchers in the world, was scheduled to deliver the afternoon keynote entitled “Motivating and Helping Smokers with Psychiatric or Alcohol/Drug Problems to Stop Smoking.”

However, rather than motivating and helping smokers, Dr. Hughes elected to objectify, label, dehumanize, and mislead. Dr. Hughes titled his talk “Why People with Mental Health Conditions Smoke So Much and What to Do About It.”

During his talk, he casually referred to his patients as “bipolars” and “borderlines.” And, he never got around to answering the question in his inflammatory title, perhaps because people with mental health diagnoses do not as individuals smoke so much.

The fact of the matter is that the overwhelming majority of people with mental health diagnoses do not smoke at all. According to the Center for Disease Control and Prevention, in the period 2009 to 2011, 36.1 percent of people with any mental health diagnosis were smokers. This means that more than six in 10 people with a mental health diagnosis do not smoke.¹

In titling his lecture, Dr. Hughes, who takes money from pharmaceuticals that sell tobacco cessation products, chose to strip of individuality those of us who have been psychiatrically labeled to advance his own purposes. That's called dehumanization and it is inexcusable coming from a psychiatrist at a conference sponsored by DMH.

Dr. Hughes's sensational title is particularly offensive when you consider the role played by psychiatrists and tobacco companies in encouraging and supporting psychiatric patients to smoke, a role that Dr. Hughes chose to hide.

The tobacco industry specifically marketed cigarettes to patients with mental health diagnoses and worked successfully to exempt psychiatric hospitals from smoking bans. The tobacco industry promoted research that has since been discredited that attempted to prove that patients with a diagnosis of schizophrenia were less susceptible to lung cancer. Tobacco companies also funded research to support the idea that people with a diagnosis of schizophrenia needed to smoke as a form of self-medication — an idea that is unsupported by any evidence.²

On behalf of the American Tobacco Company, a psychiatrist provided expert commentary to the Food and Drug Administration Drug Abuse Advisory Committee arguing that nicotine is nonaddictive.³ Psychiatric hospitals have historically rewarded patients with cigarettes or outdoor smoke breaks for good behavior or medication compliance⁴ and requested and accepted free or cheap cigarettes from tobacco companies.⁵

While statistics do suggest that people with mental health diagnoses, as a group, smoke at a greater rate than the general population (36.1 per-

cent versus 21.4 percent, according to the CDC between 2009 -2011¹), there are a multitude of reasons for the difference and it was misleading of Dr. Hughes to focus only on a person's mental health diagnosis. Smoking rates vary greatly across demographics.

Men smoke more than women. Whites smoke more than blacks. People with GEDs smoke more than people with high school diplomas, and more than people with less than a high school education. Younger people smoke more than older people. Poor people smoke more than rich people. Gay people smoke more than heterosexuals. Those living in the South smoke more than those living in the West or Northeast. Veterans smoke more than non-Veterans.¹ Psychiatrists smoke more than other medical specialists.⁶

I wonder how Dr. Hughes would feel to be subjected to a presentation entitled “Why Do Psychiatrists Smoke So Much and What to Do About It.”

If DMH is sincerely interested in reducing smoking, and I don't doubt its sincerity, it must approach the endeavor with much more sensitivity and honesty. People with mental health diagnoses face an inordinate amount of societal discrimination and scapegoating. We do not need yet more blame under the guise of DMH's anti-smoking campaign.

DMH representatives told me that before Dr. Hughes delivered his lecture, they asked him to change some of his language. DMH's request betrays a misunderstanding about the source of derogatory language. Language is a symptom of a problem, not the problem itself. Language is how we express our values, assumptions, and beliefs. Dr. Hughes's presentation revealed his backwards beliefs. However, he can't be expected to change his language without changing his beliefs.

DMH knew beforehand that Dr. Hughes would use offensive language and it nevertheless allowed him to speak. For me, that's the greater offense.

Wilda L. White is Executive Director of Vermont Psychiatric Survivors and the publisher of Counterpoint.

¹ CDC. Vital Signs: Current Cigarette Smoking Among Adults Aged ≥18 Years with Mental Illness — United States, 2009–2011. *MMWR* 2013; 62(05); 81–87.

² Prochaska, Judith J., Sharon M. Hall, and Lisa A. Bero. “Tobacco Use Among Individuals With Schizophrenia: What Role Has the Tobacco Industry Played?” *Schizophrenia Bulletin* 34.3 (2008): 555–567. *PMC*. Web. 29 Nov. 2015.

³ Cloninger CR. The State of Texas vs. the American Tobacco Company, et al. Videotaped Oral Deposition of C. Robert Cloninger.

⁴ Hall SM, Prochaska JJ. Treatment of smokers with co-occurring disorders: emphasis on integration in mental health and addiction treatment settings. *Annu Rev Clin Psychol* 2009;5:409–31.

⁵ Torry EF. Cigarette donation request for long-term psychiatric patients <https://industrydocuments.library.ucsf.edu/tobacco/docs/qxxw0083>

⁶ Frank E, Boswell L, Dickstein L, Chapman D. Characteristics of female psychiatrists. *Am J Psychiatry*. 2001 Feb; 158(2):205–12.

Agency Worker Was Abusive, Insulting

To the Editor:

I am overwhelmed by anger and frustration, and those feelings are driving me to take action.

At 25, I am a veteran of the mental health system, and currently I am gravely disappointed. I have had many positive experiences, but I have also had many negative experiences, especially recently.

It seems that nobody wants to listen when something goes wrong within the mental health system. I am expected to shut up and pretend that nothing has happened. But that would be a lie. If people/agencies don't want to be held responsible for their actions, then they should be very careful about how they treat people.

I am ashamed of our society for discouraging

individuals from speaking out about mistreatment, bullying, and poor care. A society that shames the victim is not a society that I want to be part of.

For the past 4 to 5 months, a staff member from the Counseling Service of Addison County (CSAC) has been verbally harassing me. She works at their residential program, where I am currently staying until I find housing.

She screams at me, laughs at me when I get upset, provokes me, manipulates me, and insults me on a regular basis. She gets away with it because she always shifts the blame back to me. Also, she is friends with the director of the program.

But the fact is, she is staff and I am a client, and no matter what I do or say, it is never okay for a staff member to treat a client the way she has been treating me. I am being bullied by CSAC staff while staying at a crisis bed and nobody cares. That saddens, angers, and disgusts me. There need to be consequences.

I talked to the director of the program, but the abuse continued. I wrote letters, but nothing happened. It wasn't until I wrote to the Department of Mental Health and mentioned the words "lawyer" and "lawsuit" that somebody actually listened.

Is that truly what it takes in this country for people to do the right thing?

Maybe CSAC sees me as a mental patient and thinks they can get away with treating me like dirt, but I won't tolerate it. I am smart and I have a strong sense of right and wrong. I might be homeless and have depression, but that doesn't make me any less deserving of respect or compassion.

I am writing this letter to raise awareness and advocate for myself and for all the inspiring people I have met on my journey to wellness who have received less than adequate care. I also write it with the future clients of CSAC in mind, because they deserve better than what I have received. The system tries to keep us quiet when things go wrong, but please speak out.

I enjoy advocating for what is right, so if CSAC wants a battle, bring it on.

MOLLY SAUNDERS
Middlebury

Community Services of Addison County was given an opportunity to reply to this letter, and opted not to.

Higher Suicide Vulnerability Is Caused by Inpatient Trauma

To the Editor:

I saw an article in the fall 2015 *Counterpoint* in which people made all kinds of excuses for why people are the most vulnerable to suicide right after release from a psychiatric inpatient setting.

Let's face the obvious — a large share of the time, it's because the experience of being a psychiatric inpatient is a very negative and traumatic experience; the inpatient experience leaves the patient in a very bad emotional state.

I think what mental health professionals need to face is that inpatient "care" is usually harmful and counterproductive except for possibly a few silver linings when there are staff or fellow patients who the patient connects with.

Even with "good" inpatient care, there are some basic dynamics to it that are counterproductive and tend to lead people to become suicidal. Let's look at the obvious reality and stop making excuses to dance around it.

People tend to feel the most intense feelings after a high-stress experience is over, more so than while the high-stress experience is happening.

One time when I was walking on Main St in Keene, N.H., a car accident happened right in front of me.

I was first on the scene and did the first aid until the ambulance arrived. I did a very good job, functioned very well.

After the ambulance arrived, I left, and then I got really upset and scared, and freaked out, and could not even remember where I had been walking to. A friend of mine who did similar good samaritan first aid, described a very similar experience.

This is typically what happens with high-

stress situations. People function as well as they possibly can to handle it, and this usually involves focusing on what to do, and not focusing on distractions, including feelings. After it is done, the feelings come rushing in.

When people are in a mental hospital, in order to get out, they have to behave in such a way that the staff will release them. Their attention is on functioning, not on healing, and certainly not on their feelings.

They must keep their attention on acting the right way and not on their feelings, in order to be released. If they are having too many feelings, it is seen as symptoms of mental illness or otherwise a sign that they are not ready to be released.

All psychiatric inpatient situations are involuntary as soon as the patient walks through the door, because the hospital has power over whether the patient can leave, and can even change it to involuntary if they want.

So people tend to earn their release by acting — by functioning — and by not paying attention to their feelings. Then the situation is over — they are released — and the feelings all come flooding in.

These are very intense feelings. It is just a normal response to what the situation is. If you want patients to have a different response, you would need to change the dynamics of the situation.

In addition, the stuff that goes on in inpatient care is usually very dehumanizing and even traumatic, adding to this effect and causing patients to feel suicidal.

Remember: psychiatric inpatients are human beings. They are intelligent and have feelings. Coercive methods don't honor that.

HEIDI HENKEL
Putney

What About Housing?

To the Editor:

Where in the course of recovery does homelessness fit? Too many people are held on psychiatric units when they are ready to leave. Why? Nowhere to go. Is this part of the continuum of care we, as a state, are providing?

Many inmates (often those living with mental illness) are kept incarcerated after they have served their minimum sentence because there is no safe housing available. Why is this not a violation of their civil liberties?

The severe lack of housing takes a human toll on all these individuals plus the substantial tax burden for the state to carry.

This letter is meant to be an invitation to all readers. Please share your story. With enough voices, we can make housing a priority.

CLARE MUNAT, Brattleboro
cmunat@yahoo.com

Share Your Thoughts Here!

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.

That's What the Opinions Pages Are For!

Louise Wahl Creative Writing Contest

RUNNERS UP — PROSE

The Words That I Could Have Said

by JILL TUTTLE

I can still feel the hallway floor vibrate under my heavy footsteps as I bolted out of our front door. A 22 shotgun slung over my left shoulder.

“Jill, where are you going?!” yelled my mother, who was close behind. Dad just stood there. This was no lifetime movie! I was 17, in the spring of 1975, and I wasn’t even close to understanding my emotions!

Oh, there had been incidents, as early as 13. My first boyfriend dumping me at our bus stop for another girl, who in my view was a Partridge Family look-alike. Ironically, his old neighbor was Susan Dey of the television show! Looking back, was it all worth it?

After all, I was deeply in love with a classmate, of all things, it was a she. Back in the ‘70’s, people called girls like myself queer or lezis! I’m so glad that I didn’t kill myself over Kenny!

On this day I sat shaking on the front seat of my old Pontiac. The cops would have had no problem finding me, because the car was creamsicle orange and white, and fast! It had a 350 engine and often when I drove it fast I felt as though I was flying.

Hours had passed. Afraid to go home, I drove straight to my grandmother’s house. She met me at her front door. “Jill, you’ve scared us all to death!”

I had just spent an afternoon terrorizing my family and I know now that I was never really intending to kill myself. It just felt so good to scare the hell out of my parents.

I was in a battle with myself, you see. People like me weren’t accepted and I didn’t accept me either! I hated the world and I truly believe that I was a misunderstood kid who helped myself to being so

much more misunderstood. I became what my family thought that I was. I don’t blame myself entirely, but a wise friend once told me that sometimes when we’re feeling badly the best thing is to do nothing when we have the urge to do just anything!

I really wanted the pain to stop! The pain of knowing that a person whom I cared about so very deeply would never care back. The pain of hiding the truth about the sexual abuse done to me by the neighbors and worst of all, by my own mother!

From the simple to the very complicated, it was all there choking and squeezing my insides. I had to find a way to relieve this pain!

Tomorrow is my 57th birthday. I was so certain that I would not live past 25 and to be honest, I almost didn’t.

As I sit here, I’m rewinding that movie reel. Instead of grabbing for the 22, I count to ten! I put my hands into an ice bucket, snap rubber bands on my wrists and take my place at the kitchen table.

I call for them both and this time, I’m holding them hostage too, but it’s in sort of a positive way! Who knows? I may even get some good results? So much missed opportunity to just communicate back then, right up to their deaths.

I want to tell them that I accept who they were as my parents, flawed but mine. I’d tell them that I love them and in my own messed up way, I loved them back then, too!

I can tell them that they were wrong about their assumptions about their only daughter. I was never going to join Reverend Moon’s cult, I didn’t like pot, only drinking and that I just wanted them to pay attention to me instead of one another, so often.

My Mom wasn’t always a brilliant mind. She

did things like decorating the kitchen with fake rocks through the years, and nearly knocked us out a few times. And the time she melted that big Sears microwave! Now, I still can’t figure it out. And my father, making the stupid choice to take on girlfriends and leaving me alone, with a resentful woman who felt entitled to take it all out on me.

Thankfully, grandma lived for a few years beyond my parents’ early deaths. I know that she saved my life in so many ways. She was the one bit of unconditional love that I had to my name. If I have learned anything, it’s to try to say the things that I didn’t know how to say back then. It’s so much easier now to write, sing, even text it! To communicate one’s feelings no matter what the outcome, if safe to do so without putting oneself or someone else in danger. There are kind and clever ways to speak our minds. You never know what the outcome will be.

I still struggle with my disappointments, losses, and failures. I have my very good days and very bad ones. On some days I really want to give up but then I think: I like living my life so far. It’s been hard and throughout the years, I had to insert myself into a lot of therapy and support groups.

If I had accomplished what I had set out to do so many years ago, I would have never gotten the chance to love the people and beings that I love, or to get on Facebook or dine out on delicious pizzas at the Athens Pizza Place.

I’ve experienced life and I have earned my suit of armor. I’m in charge! This journey’s now mine to make! And I’m all ready to wake up tomorrow and start it all over again.

Jill Tuttle is from Putney.

Stone Walls and Bridges

ANONYMOUS

I have with my own hands rolled, hauled, lifted and flipped rocks. I have made many stone walls, walls which hold back the waves of time as the earth beneath shifts and moves. Some of my stone walls will last a lifetime or more, others, it is only a matter of time before they shift and move creating a scattering of rock.

My stone walls are a metaphor for the internal walls I have made to keep myself safe, to keep others out. I am a soul being rebuilt, one who has been used and abused not once or twice but over a number of years. I have worked ever so hard to become more open and doing my best to remove my inner walls.

With each stone wall I create the building of the wall becomes a cathartic experience and something inside me shifts and another stone that surrounds my heart falls and turns to sand. The inner walls are coming down. I was very frightened at first.

I didn’t want to have to take down my inner walls but if I didn’t do that then I would not have the deeper connections with people that I now have. I had to build a wall of decent, kind, loving people around me to begin healing properly. I have put myself in a situation that lends itself to the process of healing and becoming whole.

I no longer seek out people or situations that are potentially hurtful to myself. Though I sometimes still put myself in situations that I am not able to cope with well, I do it less than I once did. I have found that instead of walls I should build bridges. Bridges to the new life of joy I have long sought.

I am almost there. I am happier than ever I have been. I continue the journey by making bridges and

taking down stone walls and the walls I make now are only ones that decorate my world. Never again will I cut myself off to the world, the world that I have made into a beautiful place with the help of beautiful people, people who are loving, patient, kind, and compassionate.

If I can imagine (imagine and create) my future, shape it into the world I want in which I now stand, then anyone can.

That means you can too. Imagine with me, let us co-create a meaningful and delightful life, filled with adventure and blossoms. Let us allow ourselves to blossom each petal opening until we flower reach-

ing the very pinnacle of our being in the moment of joy that we have made for ourselves. It never happens all at once, but, as with the flower, one petal at a time. Should we fall before we get there we can always get back up again and keep moving forward, never allowing the setbacks to keep us down. Let nothing stand in your way.

I go under, around, over, or change direction but I don’t let anything get in the way of what is truly important to me. You shouldn’t, either; in an infinite universe there is room for infinite joy for everyone. It begins with the thought and the very first step, even a small step and then... keep going.

Louise Wahl Memorial Writing Contest

Named for a former Vermont activist to encourage creative writing by psychiatric survivors, mental health consumers and peers. Entries are judged by an independent panel. 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.

Next Contest Deadline: *March 15, 2016*

2015 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
Runners-Up, Poetry: *The Hidden Face*, by Jan Abbott; *Daddy*, by Nikisha Davis

■ COMMENTARY

The Challenges of Social Contacts, Reaching Others

by GEOFFREY MCLAM

People have worked hard to talk to me and make me feel valid and comfortable: asking me about relatives mostly and my community supports inquire about my poems and play writing, to further have me swim in validity. Indeed, I am thankful for that. You can't say some people haven't been gracious.

However, in instances where people won't talk to me, why do I have to be the olive branch?

Are those folks just innately stubborn? Is their moral compass foggy? Will Batman overcome the Penguin's wacky voice?

It just seems the mood isn't savory for me to take that first step. I tend to look at visual characteristics of the face as a cue to talk or not to talk. Sadly, the latter is true for me. It is close to chronic, my inability to be the first to talk in an encounter with someone.

There are some people that are very interesting and important to me, yet I won't budge verbally and they, nine times out of ten, won't meet me halfway conversationally.

Am I the stubborn one? It's ok for the moment hypothetically that I am, I just don't easily flex my decision-making muscle often enough.

Oh, I'm good at phone calls and texting, yet the gift of the gab has escaped me and left me making sometimes morbid and personally activist feelings and stances toward people.

I think Bruce Springsteen said in a song of his, "I just can't stand myself!" which I might feel when facing my fear of talking to others. If someone writes a book on ice-breakers, I'd be first in line for that.

I've got to get with it. Hurry my impulses and gut instinct and just go with it.

Stephen Hawkins encourages talking and said that separates us from the animals. When it comes to talking publicly, I'm a primate verbally hibernating.

Geoffrey Mclam is from St. Albans.

Some Agencies Rude, Don't Provide Help

To the Editor:

Three times I have been to an area agency, only to be very rudely and brashly told that there was nothing that they could do to assist me with a rather difficult and challenging situation.

I truly feel that they are insensitive and simply do not care, except to fill their hours and collect a paycheck. Practically worthless in my hour of need. On my last visit, I was verbally abused. No way will I ever go back there.

I sometimes wonder if I am being discriminated against, because I am severely and persistently mentally ill.

I have no choice but to tough it out and continue to get ongoing support from my mental health agency. They are the only one ever willing to help. Without them, I'd be out in the cold and helpless.

RICHARD WILLIAMS
Bennington

Arts

Poetry and Drawing



Sketch by Pamela Spiro Wagner, Brattleboro

Journey, Interrupted

For Kim

One by one
They are leaving me
Walking soundlessly
Like frightened leopards
Friends that are chopped off
From the framework
Of life

At night I see them
As falling stars
Eyes get used to Darkness
But the heart remains
In the desert

That summer in Santa Cruz
I worked as a waitress
I wanted to be a poet
But I often
Lost my words

At night
I would sneak into your garden
To smell the roses
Sometimes I saw tears in the petals
Sometimes I saw fairies

You lived
On the other side of the garden
With your daughter and wife
Always working
Always smiling
Always trusting life
Where are you going
My generation
Driving the highways to Heaven
Slow down, roll down the windows
It's not yet the time
To give up Illusions
After all those years
After all those memories
I still don't have a life
I only exist
Between sunset and sunrise
Writing poems
Collecting seashells
Still reckless, still mutinous,
Still believing
in my American dream

by VESNADYE. Burlington

*The Color of Vowels*

by Sarah Robinson

Artist Shares at Alyssum

ROCHESTER — Artist Sarah Robinson shared her recovery and her art during the open house celebrating the fourth anniversary of Alyssum, the peer-run alternative respite home.

Her artist's statement explained that "The Color of Vowels" is "a pencil drawing that is both a self-portrait and an autobiography of my recovery process post-acquired brain injury on the left side in 2013."

The recognition and comprehension "of letters, numbers and things as well as special relationships, colors, shapes and perspectives" have taken thousands of hours of "focus and repetition" to recover, she said.

"I no longer think my work is about beauty," she explained in her statement. "Rather it is about what is thought as much as what is art. There is an aesthetic to be found in the intersection of these two processes in all art. My striving has been to focus on empathy and understanding rather than loss and anger and grief for the sources of my awe in my artistic inspiration."

Survival

You know I'm overwhelmed spiritually for I sometimes
 feel, here I am so scared, so alone, why can't I find
 my safety zone? Not feel where I belong? (Fit in...)
 Find a home (a big four-letter word) that I can call my own?
 I don't want to feel this heartache any more
 Feel the wind and the rain
 Hold onto your life, I survived
 I survived, and I'm so glad that I survived
 Hurt and pain were sometimes my only company
 Separated from love, So many nights I cry myself to sleep
 For my heart keeps wondering
 Hold me please, for I'm suffering
 I survived, I survived, I'm so glad that I
 survived, hold onto your life
 Oh, I know the night is long, hold on, for your life
 For the road I'm on, Might be too long
 Yet I encourage you to go on
 You'll be alright, yes, I'll be alright, I survived
 I survived, I'm so glad I survived
 I'm alive and I'll be alright.

by JESSICA FAIRWEATHER, Rutland

Meaninglessness

Meaninglessness
 is only a trick
 of the mind of a person
 who's tired and sick,
 only a function of the mind
 of one out of touch
 with the Just and the Kind.
 He has breathed into
 existence and life
 the Purpose all Beings follow.
 And does He not care,
 and is not this the Reason
 He brought us to life
 and taught us to share?
 Where's meaninglessness when
 one still speaks to, and listens
 to Infinite Wisdom?
 Just when we forget
 or in pain turn away,
 denying our God,
 thus incurring disaster,
 when we follow after
 the dreams that are empty and hollow,
 that's when meaning departs
 and our shriveling hearts,
 so starved and deprived,
 lead us to question
 not only our lives,
 but the lives of those others
 whom He also loves.
 Where's meaning?
 Seek it only in Him,
 the Fount of our Being,
 the One who is
 Infinite Love.

by ELEANOR NEWTON, Burlington

#8

i am new
 the we didn't recognize me
 until now
 it pulls the gut tighter
 breathing is difficult
 who am i
 the writer, the lover, the thinker
 or the fool for not hearing
 the silence for not screaming
 the feelings trying to explode
 where was the awareness?
 we say welcome to the surface
 now what needs to be done?
 releasing the energy ensnared
 for decades amongst twisted webs
 and now the voice is seeking freedom
 from holding multiple secrets
 of love, of sexual arousal,
 of creating the inside into the outside

by m. a. wakeman
 north bennington

Feb Up



It is well that they make it the shortest month
 For winter gets pretty dreary
 And those of us birds who can't fly south
 Get a bit Febru-weary.

by RICHARD A. WILLIAMS
 Bennington

Youth Unaging

I look up at the star-swarmed heavens
 And see the freckled face of God.

Changeless youth is He,
 The flower forever on the stalk,
 The lightning never vanishing.

I see Him with a fish-pole on His back,
 Going to the quiet river,
 Whistling barefoot in the grass,
 His face a bright grin, His eyes alive.

No wrinkled Patriarch,
 But vital and boy-like, never to grow old.

Feel the tug of a million stars
 Wavering the liquid of the night?
 Hear His youngish laughter by the
 banks
 Of eternity, flowing by the mesas of
 time?

I'll see my friends grow old,
 I'll watch my youngsters age,
 But never He,
 Ever-blissful child of eternity.

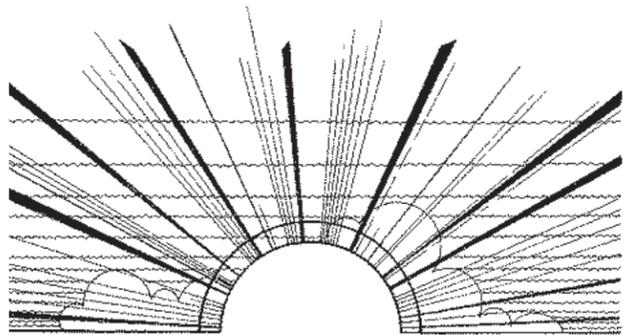
by PATRICK WILLIAM BRADLEY, Sr.
 St. Albans

Share Your Art!

Express Yourself in Drawing,
 Prose and Poetry...

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

Art Show!

The Howard Center Arts Collective in Burlington is in its third year of putting on group shows of work by artists who give and receive services through Howard. Its newest show is now open at the VCAM (Vermont Community Access Media) Gallery at 208 Flynn Avenue in Burlington and running until the beginning of February.



DISABILITY RIGHTS VERMONT ANNOUNCES FY 2016 PRIORITIES

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

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

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

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

DRVT and Vermont Legal Aid continue to work with Adult Protective Services to monitor how they institute new policies and to insure that they continue making progress in improving their response to the abuse, neglect, and exploitation of "vulnerable adults" – mainly elders and people with disabilities. The monitoring directly linked to our lawsuit is ending and we are working on new mechanisms to review their activities.

We have continued our work with DLP monitoring Special Education services for youth detained at Woodside Juvenile facility. DRVT staff is also monitoring and providing quality assurance regarding uses of force against youth detained at Woodside. We are reviewing new regulations as Woodside continues its transition from the status of detention facility to its current position as a treatment program.

DRVT has also been using legal advocacy to assure that prisoners with serious functional impairments (SFI) do not suffer delayed reintegration because of their disabilities. We are working to reduce the use of segregation of prisoners with mental health issues and are advocating for services to help people from entering the criminal justice process in the first place.

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

DRVT has registered voters and given information on voting rights in all of our outreach settings around the state. DRVT staff continues to survey polling places for accessibility, providing the results and recommendations to provide access to local officials.

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

DRVT has also worked to provide victims of crime who have disabilities with accommodated assistance as they deal with the criminal justice system. Our work in assisting victims with disabilities sometimes involves assistance beyond legal assistance and helps victims with access to safety and to social services they might need.

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

DRVT is publishing our formal Fiscal Year 2016 (10/1/15 - 9/30/16) priorities for the Protection & Advocacy for Individuals with Mental Illness (PAIMI) program on the adjoining page. These priorities serve to focus the work of the agency and are developed by our Board and our advisory council, who get input from the community and staff. **Your input is appreciated!** We strive to do as much as we can with the resources we have and we can do that best when folks in the community let us know their greatest advocacy needs!

We need volunteers, too!

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

Each applicant must identify with one of the following categories:

You are a psychiatric survivor

You are or have been a recipient of mental health services

You are a mental health professional

You are a mental health service provider

You are the parent of a minor child who has received or is receiving mental health services.

You are a family member of an individual who is or has been a recipient of mental health services

You are a lawyer

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

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

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



DISABILITY RIGHTS VERMONT **FY'16 PAIMI PRIORITIES**

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

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

Measure of Success:

- A. Work on a minimum of 100 cases of abuse, neglect, or serious rights violations of people with mental health issues. Among closed cases, at least 75% of those not withdrawn by client or found to be without merit by DRVT staff should be resolved favorably.
- B. In at least 2 opened cases, DRVT will advocate for adequate discharge of involuntary patients in the spirit of the community integration mandate of the Americans with Disabilities Act.
- C. DRVT will assist at least five clients to assure they receive appropriate medication, with informed consent and without coercion, and/or alternative treatment if that is their preference.
- D. Note whether the individual describes the issue as having occurred during a first contact with the mental health system because of the potential for coercion and trauma.

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

Measures of Success:

- A. Work with at least two institutions to create respectful, trauma-informed, violence free and coercion free mental health treatment environments.
- B. Conduct systemic advocacy in the legislature, and with the administration, to preserve or enhance the right of Vermonters to be free from coercion in their mental health treatment. Monitor whether the State adheres to due process required for involuntary treatment and to timelines within the Emergency Evaluation process.
- C. Work in at least one community to improve the system-wide response to mental health-related emergencies to prevent unnecessary use of force, involuntary treatment and incarceration.
- D. Monitor the implementation of standards for the use of Tasers (Act 180 of 2014) including the requirement for statistics on their use.
- E. Continue to monitor implementation of the settlement in our litigation regarding Adult Protective Services.
- F. DRVT will continue to offer Disability Etiquette trainings to volunteers or other personnel or organizations which deliver emergency services, resources permitting.

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

Measures of Success:

- A. Outreach and monitoring is conducted at a minimum of 10 community care settings, including but not limited to residential care homes, therapeutic community residences or licensed residential childcare facilities.
- B. Outreach is conducted, at a minimum, to the four state prisons housing the most PAIMI eligible prisoners.
- C. Outreach is conducted at all designated facilities, including intensive recovery residences and any state run facility.
- D. DRVT literature is distributed to all of the community mental health agencies, prisons, and designated hospitals, including their emergency departments, to intensive rehabilitation residences, and to specific homeless shelters, "club houses" and peer-run services.
- E. Outreach will be conducted to individuals labeled with a disability who are victims of crime or domestic abuse.
- F. DRVT PAIMI Staff will receive training on bias and its effect on diverse communities and non-dominant cultures.

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

Measure of Success:

- A. Four self-advocacy and/or advance directive trainings for 40 individuals.
- B. Assist at least 5 individuals across the State of Vermont with their preparation of Advanced Directives.
- C. Work with the administration, other advocacy groups and individuals to monitor the implementation of Act 79.
- D. Encourage the development and expansion of peer run and alternative services in Vermont's mental health system reform and educate peers on access to these service.
- E. DRVT will participate in systemic efforts to improve state services for individuals in or at risk of incarceration to speed successful reintegration.
- F. Participate in efforts to insure that state and local emergency planning efforts include the needs of people with mental health issues.
- G. Participate in coalition efforts to address transportation infrastructure needs of low-income people with mental health issues.
- H. Support the Vermont Communications Support Project in order to ensure that people with communications disorders related to their mental health can participate in the judicial and administrative systems.
- I. DRVT Staff will receive training in awareness of alternative treatment modalities available for individuals with psychiatric disabilities.

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

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

How can you make your voice heard?

Contact DRVT at: 141 Main Street, Suite 7, Montpelier, VT 05602

Or by phone: 1-800-834-7890 or, locally, at (802) 229-1355

By email at: info@disabilityrightsvt.org

Please visit our website at www.disabilityrightsvt.org

Resources Directory

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

Contact us if your organization's information changes:
counterpoint@vermontpsychiatricsurvivors.org

Vermont Psychiatric Survivors Peer Support Groups

Brattleboro:

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

Bennington/UCS

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

Northwestern

St. Paul's United Methodist Church, 11 Church Street, St. Albans; 1st and 3rd Tuesday, 4:30-6:30 p.m. Leave message for Keith at 802-782-1387

Rutland

- Wellness Group, VPS Office, 606 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; 128 Merchants Row, Suite 606, Rutland, VT 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, Derby; 334-6744; 800-696-4979

2225 Portland St., St. Johnsbury; 748-3181;

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; 229-6328

Windham and Windsor Counties: Health Care and

Rehabilitation Services of Southeastern Vermont,

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

51 Fairview St., Brattleboro, 05301, 254-6028;

49 School St., 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

Warm 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: 802-229-8015; 7 days/wk, 6-11 p.m.

Mutual Support Network

The Hive: info@hivemutualsupport.net
www.hivemutualsupport.net
 802-43-BUZZ-3 (802-432-8993)

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.

GLBTQ Youth Crisis Hotline:

The Trevor Lifeline now at 866-488-7386. TrevorText - 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.

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

Peer 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.

NAMI Connections

Peer Mental Health Recovery Support Groups

Bennington: Every Tuesday 1-2:30 pm; United Counseling Service, 316 Dewey Street, CRT Center

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

Rutland: Every Sunday 4:30-6 pm; Wellness Center (Rutland Mental Health) 78 South Main St. (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 connection@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. Montpelier currently organizing. Call or watch for future announcements.

Brain Injury Association

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

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, 39 Elm St.; 257-5600; tpwc.1@hotmail.com

Burlington, Turning Point Center of Chittenden County, 191 Bank St, 2nd floor; 861-3150; GaryD@turningpointcentervt.org or <http://www.turningpointcentervt.org>

Middlebury, Turning Point Center of Addison County, 228 Maple St, Space 31B; 388-4249; tcacvt@yahoo.com

Morrisville, North Central Vermont Recovery Center, 275 Brooklyn St., 851-8120; recovery@ncvrc.com

Rutland, Turning Point Center, 141 State St; 773-6010 turningpointcenterrutland@yahoo.com

Springfield, Turning Point Recovery Center of Springfield, 7 Morgan St., 885-4668; spfldturningpoint@gmail.com

St. Albans, Turning Point of Franklin County, 182 Lake St; 782-8454; tpfdirection@gmail.com

St. Johnsbury, Kingdom Recovery Center, 297 Summer St; 751-8520; c.boyd@stjkr.org; j.keough@stjkr.org; www.kingdomrecoverycenter.com

White River Junction, Upper Valley Turning Point, 200 Olcott Dr; 295-5206; mhelijas@secondwindfound.net; <http://secondwindfound.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.vtvetvet.org