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

vermont psychiatric survivors

Counterpoint

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Legislature: Psychiatric Survivors 'Not More Likely To Be Violent'

A FORMAL FAREWELL — Graveside services for Phil Grenon were held at the Ethan Allen Cemetery in Colchester with military honors on June 7. His daughter, Niki Carpenter, is at far left; in the center are her six children, Grenon's grandchildren. Some 50 relatives, friends and public officials attended. Counterpoint Photo: Anne Donahue)

Daughter of Man Killed by Police Grateful for Advocacy Results

MONTPELIER — The daughter of a man killed by police last spring has expressed her "heartfelt thank you" to those who advocated for creation of a commission that will review interactions between police and persons with mental health symptoms that end in serious injury or death. Legislation to create the commission was signed into law on May 23.

"I am grateful that something good could come from my father's tragic death, and that a light was shined on this issue and its much needed reform and attention," Niki Grenon Carpenter wrote by email from Arizona. "Although I was not a hands-on part of this process, I was with you in spirit."

Carpenter's father, Ralph "Phil" Grenon, 76, was killed by police after a 5-hour standoff in Burlington. He was hiding in a shower in his apartment with two knives. Grenon was reported to have dealt with mental health issues for years.

Last fall, a former friend and retired State Senator, Jim Leddy, convened a group of concerned persons to discuss how future deaths could be avoided. Vermont Psychiatric Survivors was a participant in the coalition, which later named itself the "Grenon Response Advocacy Group."

The group identified three priorities: establishment of a commission to review such deaths or injuries and make recommendations in response, improved funding for mental health crisis response, and an assessment of police training being used in the state.

Members of the coalition — which also included State and Burlington Police, the Police Training Academy, NAMI-VT, and private citizens, including a retired judge and former University of Vermont Medical Center psychiatrist — met with legislators to press for the commission, which is intended to do in-depth reviews to identify what occurred and what can be learned to prevent future deaths.

Carpenter had raised the hope for change last May at the press conference announcing that no charges would be brought against the officer who shot her father, "so that situations like this are able to end peacefully in the future and not in the way they did with my dad.... That's what I think my father's hopes would be as well."

A Loving Father

Carpenter spoke with *Counterpoint* about her relationship with her father, who as a stay-at-home dad raised her because his diagnosed bipolar illness began to interfere with his ability to work in 1979. Her parents decided that her mother, a nurse, could support the family while he cared for Niki, then 2.

She described a unique childhood with a father

(Continued on page 4)

Bill Was Bright Spot Despite Other Discrimination

MONTPELIER — A first-ever official legislative finding that "(T)he overwhelming majority of people diagnosed with mental illness are not more likely to be violent than any other person" was a bright spot among actions this year by Vermont lawmakers.

"I think this is pretty historic for a legislature to make an explicit finding about the absence of a link between mental illness and violence," said Wilda White, Executive Director of Vermont Psychiatric Survivors. The finding was listed in a bill that overturned a state Supreme Court decision that imposed new obligations on mental health providers to warn others about "violent propensities" of clients.

That bill — a version developed by a coalition of stakeholders that included Vermont Psychiatric Survivors — was adopted by the House after a debate in the Senate that often focused on claims of the risks presented by persons diagnosed with mental illnesses.

The original Senate version had perpetuated the "false link" with violence and would have "operated almost as a license" for discrimination, White testified to a House committee.

In discussion on other bills before the legislature this year, discrimination and biases were also reflected in comments by many lawmakers:

- A bill passed to address long delays in emergency rooms included a requirement to re-evaluate forced psychiatric services and drugging, with a requirement to "examine the interplay between staff and patients' rights."

- Another bill passed by the Senate claimed that the state had to address "the pressing facility needs" for "individuals who are not willing or able to engage in voluntary community treatment but do not require hospitalization." That directive was later removed.

- A bill for parity in recognizing workers' compensation claims for mental injuries was vigorously opposed by some representatives on the House floor, before the bill eventually passed.

By the end of the legislative session in May, the bill to address the shortage of services for mental health resulted in more than $8 million to support salaries for designated agency staff and added $200,000 for the Vermont Support Line.

(See legislative roundup articles, pages 6-9.)

Peer Leadership and Advocacy

Meeting Dates and Membership Information for Boards, Committees and Conferences

Peer Organizations

Vermont Psychiatric Survivors

A membership organization providing peer support, outreach, advocacy and education. Must be able to attend meetings monthly. Experience with boards preferred, but not necessary. For information call (802) 775-6834 or email info@vermontpsychiatricsurvivors.org.

Counterpoint *Editorial Board*

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

Currently Recruiting New Members

Alyssum Peer crisis respite. To serve on board, contact Gloria at 802-767-6000 or info@alyssum.org.

Disability Rights Vermont PAIMI Council
Protection and Advocacy for Individuals with Mental Illness. Call 1-800-834-7890 x 101.

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 Patient Advocacy and Consumer Affairs 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.

Save the Dates!

2017 Alternatives Conference

The National Empowerment Center (NEC) will organize and host the 2017 Alternatives Conference at the Boston Park Plaza from Friday, August 18, through Monday, August 21. Further information is at www.power2u.org.

Hearing Voices Conference

The Ninth Annual World Hearing Voices Congress will be held at Boston University August 16-18. The Hearing Voices Movement will be celebrating its 30th Anniversary. The Hearing Voices Movement consists of over 30 national networks from around the world joined by shared goals and values, including a fundamental belief that...hearing voices is not, in itself, an indication of illness.More information at http://www.hearingvoicesusa.org.

NARPA 2017 Rights Conference

NARPA's 2017 Annual Rights Conference will be at the Holiday Inn by the Bay, Portland, Maine, September 6 - 9. For more than 30 years, NARPA has provided an educational conference with inspiring keynoters and outstanding workshops. We learn from each other and come together as a community committed to social justice for people with psychiatric labels & developmental disabilities.Conference begins with Wednesday evening reception and ends Saturday noon. Check NARPA's website at for details: www.narpa.org/

State Committees

Adult Program Standing Committee

Advises the Commissioner of Mental Health on the adult mental health system. The committee is the official body for review of and recommendations for redesignation of community mental health programs (designated agencies) and monitors other aspects of the system. Members are persons with lived mental health experience, family members, and professionals. Meets monthly on 2nd Monday at the Department of Mental Health, 280 State Drive NOB 2 North, Waterbury, noon-3 p.m. To apply for membership, contact Melinda Murtaugh (melinda.murtaugh@vermont. gov), Clare Munat (claremunat@ msn.com), or Marla Simpson, M.A. (marla.simpson@ymail.com) for further information.

Local Program Standing Committees

Advisory groups required for every community mental health center. Contact your local agency for information about meetings and membership.

Facebook and Web Sites

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."

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 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.

Vermont Federation of Families for Children's Mental Health
Statewide support for families of children, youth or young adults in transition who are experiencing or at risk to experience emotional, behavioral or mental health challenges. 800-639-6071, 802-876-7021

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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 our families and friends.

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Send It to *Counterpoint!*

Your peer newspaper

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***Counterpoint* Deadlines**

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How to Reach
The Department of Mental Health:
802-241-0090

http://mentalhealth.vermont.gov/

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

New Address: 280 State Drive NOB 2 North
Waterbury, VT 05671-2010

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VERMONT MAD PRIDE

The Right to BE FREE • The Right to BE ME 2017

Vermont Mad Pride is a March and celebration organized by psychiatric survivors, consumers, mad people, and folks the world has labeled "mentally ill." Mad Pride is about challenging discrimination, advocating for rights, affirming mad identities, remembering and participating in mad history, and having fun. Our lives and contributions are valuable and need celebration!

DATE: **July 14, 2017**

TIME: **2 p.m.**

ROUTE: **Meet at Another Way, 125 Barre Street, Montpelier, VT, March to State Capitol Steps**

Catered dinner following Mad Pride March
Another Way
125 Barre Street, Montpelier, VT

SPONSORS:

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Daughter of Man Killed by Police Grateful for Advocacy

Ralph "Phil" Grenon, 2016

(Continued from page 1)

who was such an "avid, avid reader" that some of her earliest memories are of being with him at the library. "We went to the library all the time," and he read her Shakespeare, not nursery rhymes; when she played dress-up, she acted out King Lear. She played chess at an early age.

"His favorite thing was being a dad," Carpenter said. "My dad was always there for me. He was involved in everything I did."

When she got engaged to a man she met in Utah, he came out to give her away at her wedding. He also travelled to Arizona for the birth of two of her children.

The youngest of her six children, now 2, has Down's Syndrome, and Carpenter said it was her father who helped her to cope with the news.

"He loved Levi right from the beginning," she said, and "he loved being a grandfather." He called every Sunday to talk with them.

Grenon was born in Barre as one of seven children from what Carpenter said was a very dysfunctional family, and from the time he was seven he lived at St. Joseph's Orphanage in Burlington. He graduated from Rice High School, served in the Air Force, got his degree in philosophy and history at the University of Vermont, and then his Master's in sociology and philosophy at St. Michael's College.

He went on to teach at Claremont College in New Hampshire and was married in 1971. The couple were not able to have biological children, Carpenter said, and they adopted her in 1977.

Grenon was a man who "broke the cycle of abuse" from his childhood with his own wife and child, and was a gentle man with "a fantastic sense of humor," she said. He "never judged" anyone.

For most of his life after his first breakdown in 1971, he was able to stay stable with the help of medication and therapy, Carpenter said. "I didn't even know he had a mental illness, growing up," she said.

Major life events, however, sometimes triggered relapses; it happened with his divorce in 1998, and again in 2007, that time leading to an involuntary commitment. He was healthy again until seven or eight months before his death, until the departure of a longtime caseworker created an emotional crisis, and he stopped treatment, she said.

The man who, his Burlington neighbors said, was threatening and verbally abusive to the point of being served with an eviction notice and drawing a police response to his apartment last March, "really wasn't who my dad was," Carpenter said.

Carpenter and her family came from Arizona this June for a delayed funeral service for her father. She was waiting for his headstone from the Veterans' Administration. Grenon's interment with military honors was at the Ethan Allen Cemetery in Colchester.

Grenon Bill

The Grenon bill was an effort to find better ways to address circumstances like his, when a person's actions related to a possible mental health crisis brings police intervention, with sometimes fatal results.

Leddy said that "more than simply establishing an 'after-the-fact review,' [the bill] is a commitment to improved training for police and mental health crisis workers, as well as functional police and mental health partnerships throughout the state."

Leddy said that "the passage of H. 145, now known as the Grenon law, is a prompt and positive response" to the tragic death.

Through the work of the coalition, "what could have been a contentious and adversarial legislative process turned out to be anything but." He added that as the bill progressed through the House and Senate, "it became compellingly clear that the community mental health system is woefully underfunded and has generally lacked the resources to provide mobile outreach services in response to crises and to work in partnership with the police in responding to these crises."

The increased funding for community mental health services in this year's budget "was an unexpected but welcome outcome," he said. *(See budget report, page 8.)*

Police in Vermont have killed five people who showed symptoms of a mental crisis since 2001, three of them between 2012 and 2017.

There are no statewide records for injuries but, under the new law, police will be required to report any event that results in death or serious bodily injury to the Attorney General's Office, if it involved "a person acting in a manner that created reason to believe a mental health crisis was occurring."

The new Mental Health Crisis Response Commission will also have the option to review situations "not resulting in death or serious bodily injury" or "interactions with positive outcomes that could serve to provide guidance on effective strategies."

The purposes of the Commission identified in the law include to "identify where increased or alternative supports or strategic investments within law enforcement, designated agencies, or other community service systems could improve outcomes"; "to recommend policies, practices, and services that will encourage collaboration and increase successful interventions;" and "to recommend training strategies for public safety, emergency, or other crisis response personnel."

It will be coordinated by the Attorney General's Office and includes 11 members, including a person with lived experience of a mental condition or psychiatric disability, a family member, Disability Rights Vermont, and mental health and law enforcement representatives.

The first meeting is to be held by September 30.

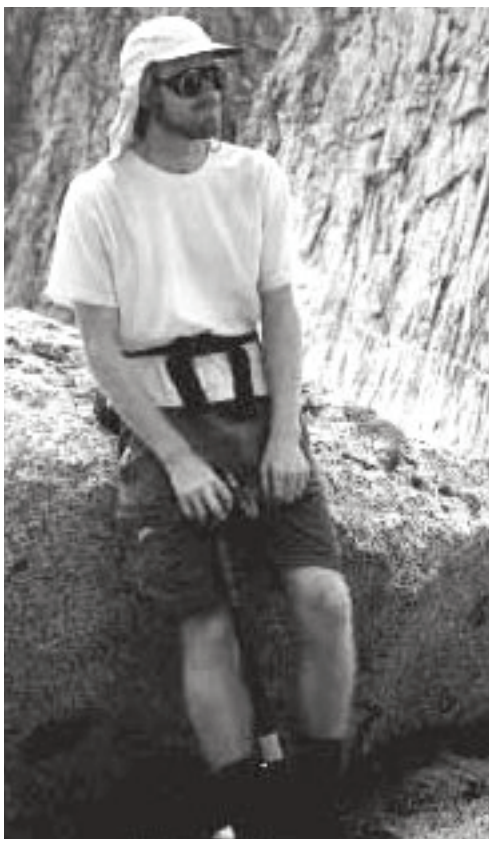
Deaths from police shootings of persons who appeared to be in a mental health crisis between 2001 and 2016 have included:

In 2001, Robert Woodward, 37, was reported to be showing signs of a psychotic episode when he interrupted a church service in West Brattleboro, holding a knife and threatening to kill himself. *(Woodward's death led to the creation of a statewide introductory course for police in interactions with persons with a mental illness, which became mandatory for all law enforcement officers in 2014.)*

In 2006, Joseph Fortunati, 40, who had a diagnosis of paranoid schizophrenia, had gone off into the woods in Corinth; his relatives reported he threatened them at gunpoint and they asked for help for him.

In 2012, Macadam Lee Mason, 39, called the Dartmouth-Hitchcock Medical Center and told a staffer there that he felt like killing himself. He was reported to be agitated but unarmed when he was fatally shocked by a Taser. *(Mason's death led to a state law in 2014 requiring police training in stun gun devices, and a mandate for basic training on mental health for all police.)*

In 2013, Wayne Brunette, 49, was coming at police with a shovel after his mother, saying he was agitated and destroying property, called for help. His parents reported they had told officers that their son "had mental health issues."



Robert "Woody" Woodward, 2001

Joseph Fortunati, 2006

Macadam Lee Mason, 2012

Wayne Brunette, 2013

Peer Crisis Bed Staff Testify on How Their Work Prevents Unnecessary Emergency Room Use

by ANNE DONAHUE
Counterpoint

MONTPELIER — Crocker Stickney took a job last winter as a support worker at Maple House, a peer-run crisis bed. It came with an unexpected bonus: the opportunity to be a voice for survivors at the state legislature.

He and Zack Hughes were at the State House for a Washington County Mental Health Services "meet-and-greet" legislators day when they were asked to testify about the crisis in the mental health system that was leading to long waits in hospital emergency rooms.

"To be honest, I was a little nervous testifying in front of the Health Care Committee, because that was the first time I had stepped foot in the State House," Stickney said later. He wants to get more involved in advocacy because of the peer work he is now doing, he said.

"It has been a long, hard road to recovery, so I feel that supporting peer advocacy is the least I can do for other clients as well as for the people that have helped me along the way."

While Hughes had been doing peer work for more than a decade, it was new to Stickney when he applied for the job at Maple House in December.

They told the legislative committee that the work they do makes a difference in helping to get people out of the emergency room when they don't need to be there.

Although most clients are currently referred by a case manager or by the crisis screeners at Washington County Mental Health Services, a person in crisis "can call us directly," Stickney said.

The chair of the committee, Rep. Bill Lippert, asked Stickney what made it different to have peers running the crisis bed.

Clients "are able to relate a little better" when they know they are talking with another person who has been diagnosed with a mental illness, Stickney explained.

The peer staff are "able to share some of their personal stories, their failures, their successes."

The crisis bed "is an important piece," Hughes said, and "we've really been reaching out to the crisis folks and case managers" over the question of "whether a person really needs to be up in the ER or is just sitting there waiting for a bed."

Hughes said that in the emergency room"we can get to the bottom of what's really happening, which is really important."

Some individuals simply go there "because it's what they know," that "when things get out of hand… you go to the ER."

One example, he told the committee, is a person who might say, "Actually, the reason I have to be here is because I said I was going to jump off a building, when I really didn't mean it," or someone who simply says they are there because their case manager said they should be.

"We really strive to catch them before they go into that emergency room," Hughes said, "before we get the call for them to be transferred from the ER."

Among other things, he said, it saves money.

"We say, wow, they went into the ER and just used all that resource, and now they're coming to us."

Committee member Rep. Doug Gage said that, in his own experience of being in the emergency room in Rutland, where the average wait is five hours for any condition, "I find my mental health being escalated as far as my tolerance for what's going on as I'm waiting."

"I see the ER as inappropriate for mental health situations for that reason alone."

Lippert asked whether the one bed was adequate to meet the need.

"No," Stickney responded — a second bed definitely "would be used" if available.

Hughes said, "Crisis managers are begging us to get permission to use the second bed" that exists at Maple House. That bed is reserved for clients who are homeless and are referred for temporary support by a case manager.

The crisis bed currently is also available only to CRT clients. Clients usually stay only a few days, although sometimes it can be a week or more.

"We recognize certain people need to be in the ER," Hughes told the legislators. But this is "a viable option to the backup in the ER."

The program currently runs with five staff, who are on call for when there is a referral, but there is a current effort to hire additions to the pool to "reduce some of the strain" of recent months, Stickney said.

"I really appreciate you coming in and talking with us this morning," Lippert told Stickney and Hughes. "It really helps enrich our sense of some of the alternatives there already are."

In a separate interview with *Counterpoint,* Stickney, who is 28, said that "being able to work has been one of the greatest parts of my recovery."

Stickney said that he has been "in and out of the hospital several times," most recently two years ago. It was an involuntary hospitalization and lasted six months.

He found a job as a dishwasher, and "I was tired of grinding away working at a restaurant."

"Being able to go to work and have a really serious responsibility" at Maple House "helps me have a different focus… being focused outside of myself helps me with my recovery and helps me with my symptoms."

He does worry about having to deal with hospitalization again. "Last time around was pretty difficult for me," he said. He is maintaining medication but still has symptoms recur.

"I hear it now and again," he said of the voices that landed him in the hospital. "It's sporadic; some days are easier than others."

Hughes, who is 39, was already active with the peer warmline and independent hospital outreach when he got together with peers to brainstorm about a crisis bed in 2012. Maple House opened in 2013.

There have been rough times for him, and at one point "every day was a struggle to get up."

"What's really cool" about peer work "is the job provides an insulator… a reason to go to work"in part so that he does not leave Crocker alone. "We rely on each other," he said.

Although his hospitalizations have never been involuntary, and the last one was in 2010, "I've come close."

"It's a scary place to be on the edge" of being unable to make decisions, he said.

Hughes is quick to defend the fact that Maple House is a true peer program, even though it is within Washington County Mental Health Services.

He's sometimes told by other psychiatric survivors, "You're working with the enemy" — but it is "good to collaborate" and "sometimes it's good to have the agency right there."

Even though it operates within a designated agency, there is still "a little bit of separation." That's necessary, Hughes said. Without it, "then our guests are not going to be willing to talk to me."

TEAMMATES — Crocker Stickney (left) and Zack Hughes, pictured outside the Statehouse in Montpelier, help staff the peer-run crisis bed at Maple House. They testified there to the House Health Care Committee about the value of peer-run services and crisis beds to divert individuals who go to the emergency rooms. Maple House is run by Washington County Mental Health Services. (Counterpoint Photo: Anne Donahue)

Legislature Directs Analysis,

MONTPELIER – The legislature has directed an analysis and action plan on components of mental health services in Vermont, saying that the emergency room crisis is "a symptom of larger systematic shortcomings in the provision of mental health services statewide." The bill — S. 133 — was awaiting signature by the governor as of the *Counterpoint* press date.

The bill requires that a first draft of an action plan be completed by September 1, stating that current emergency room delays was causing "some individuals [to] experience trauma and worsening symptoms while waiting for an appropriate level of care."

One component of the analysis includes re-evaluating the use of non-emergency forced drugs and a determination as to "the role that involuntary treatment and psychiatric medication play in inpatient emergency department wait times."

The bill identified a need to balance urgency — noting the "suffering under existing circumstances" — with good data and analysis. The goal is access to "appropriate, high-quality, and recovery- and resiliency-oriented services in the least restrictive and most integrated settings for each stage of an individual's recovery."

Some of that analysis was already started by work groups established by the Secretary of the Agency of Human Services in February, as the legislature also developed its directives.

The bill also requires that by January of 2019, "specific steps" be identified to develop "a common long-term statewide vision regarding how integrated, recovery- and resiliency-oriented services will emerge as part of a comprehensive and holistic health care system."

Understaffing in community services was identified as a key driver of the shortage of services, and the state's budget later added more than $8 million in funds to bring salaries at community mental health agencies ("designated agencies") to more competitive salary levels. An additional $200,000 was added to expand hours for the Vermont Support Line to assist in hospital diversion. The support line was intended as a 24/7 service in legislation in 2012, but was never fully funded. The new money will increase hours of daily operation from eight to 14.

In addressing the emergency room crisis, the bill identified research showing the connections between how long individuals wait and factors such as homelessness, reliance on public insurance, alcohol and substance use, and the use of restraint or "sitters" in the ER.

It directs data collection to "help pinpoint solutions," including "causes underlying increased referrals and self-referrals to emergency departments" and to "determine the availability, regional accessibility, and gaps in services."

The legislation also notes that individuals involved with the criminal justice system are often "held in correctional facilities after being referred for inpatient care due to the lack of access to inpatient beds," and that persons in Corrections "do not have access to appropriate crisis or routine mental health supports or to inpatient care when needed."

The bill was first drafted in the Senate, but underwent a series of revisions in the House after testimony from Wilda White, Executive Director of Vermont Psychiatric Survivors, in the House Health Care Committee. She objected to the Senate's emphasis on developing a "system that fosters the movement of individuals." White said that in talking to other psychiatric survivors, "None of them would say, 'I'm trying to optimize my flow through the system.'"

"They want to feel better," she said. "They want to flourish; they want to live full lives."

The language in the bill "makes it seem like we're talking about people being on a conveyer belt" and looks to efficiency "without regard to whether they're better off."

The House version of S. 133, which was the version that passed the legislature, rewrote the underlying language of the findings and the different parts of the study to place a focus on individuals' need.

It also removed discussion of a separate "mental health system of care" referring instead to "the delivery of mental health services within a sustainable, holistic health care system."

Components of the immediate analysis and action plan, which is due to the legislature by December 15 with recommendations for funding and legislation, include:

Care Management

The plan must "address the potential benefits and costs of developing regional navigation and resource centers" that would "foster improved access" to care "at levels of support that are least restrictive and most integrated for individuals with mental health conditions, substance use disorders, or co-occurring conditions."

Other models for care coordination are to be reviewed, including ones that "address the goal of an integrated health system."

Parity of Access

The plan is required to "evaluate opportunities for and remove barriers to implementing parity in the manner that individuals presenting at hospitals are received, regardless of whether for a psychiatric or other health care condition."

Emergency Room Diversion

The agency must evaluate potential expansion of diversion beds and potential new models, including a 23-hour bed model intended to "prevent or divert individuals from the need to access an emergency department" through observation and stabilization.

The Senate bill focused only on the 23-hour bed model, while the House's final version expanded the review after White's testimony that questioned that model.

White said that a similar model in California

(Continued on page 7)

Staff Salary Increase Mandated Even If Service Cuts Are a Result

MONTPELIER — The longstanding debate over state budget support for services at designated agencies and whether salaries are adequate to maintain those services has resulted in a mandate for increased wages in the state budget this year, but also the possibility of reductions in services. "Designated agency" is the state's term for community mental health centers.

The budget has been vetoed by the governor, but not related to mental health budget items.

Nearly $7 million was added to the budget to increase staff salaries at designated agencies. The new mental health money was directly tied to another bill, S. 133, that directs a major study of mental health services in the state and of the causes of crisis levels of delays in emergency rooms.

The budget language directs that the money be used to ensure that all staff receive a minimum of $14 per hour in salaries, and that crisis services staff salaries are "competitive" with similar jobs in other health care or school settings.

If the $6.9 million is not enough to meet that purpose, then the agencies are directed to "reduce services or other operations" in order to meet the increased wages. Crisis services "shall remain a priority" and would not be permitted to be cut, if other reductions are needed. The mandatory salary levels will apply to all designated agency staff, including those working with developmental disability programs, so the full budget increase for the agencies is $8.3 million,

In future years, under S. 133, rates paid by the state to the designated agencies will have to be based on amounts that are "reasonable and adequate" to meet costs to deliver the services the state expects.

For next year in particular, in its budget directions, the legislature said the state's Agency of Human Services must develop a budget that will increase hourly wages to $15 per hour, and increase salaries of "clinical employees" in general to be competitive with other similar jobs in other settings.

That budget will have to identify the "required outcomes" expected of the designated agencies within a budget that enables them to meet their mandatory responsibilities and meet the required salary increases. As part of the S. 133 action plan, emergency services funding has to be specifically analyzed for any gaps that prevent services from being "available to all individuals within a specific designated or specialized service agency's catchment area." Emergency services are defined to mean both crisis response teams and crisis bed programs. According to Rep. Kitty Toll, Chair of the House Appropriations Committee, all of the funding for increased designated agency salaries comes from the transfer of funding for hospitals.

Hospitals receive special federal and state money as a partial make-up for the unpaid services they provide to individuals without adequate insurance. This year, the state budget cuts those funds by 27 percent for a total savings of $10 million. The budget also assumes that hospitals will save $1.5 million in lower emergency room costs as a result of the increase in staff at the community designated agencies.

Testimony during the legislative session about long waits in emergency rooms identified low salaries as a reason that many agency staff positions are vacant, resulting in shortages in coverage for crisis support services to divert patients from hospitals. The total of $11.5 million cut from the hospital budgets was used for the $8.3 million designated agency increase, plus an increase in rates for primary care doctors.

Action Plan on ER Crisis

(Continued from page 6)

"just relocated the patients [from emergency rooms] where no one can see it," leaving individuals housed "on yoga mats" on the floor of one large room. "If you want to build another facility" for emergency room diversion, she urged, then increase the number of peer respite programs. "They're much cheaper," and "they're effective."

White supported the need for greater diversion capacity, saying that many persons who end up in an emergency room "don't really need to be there."

"I'm not saying they're not in distress," she said — but there are other ways to address it if they are made available. Vermont Psychiatric Survivors is developing a survey for people who are left waiting, to identify the reasons they came to the emergency room.

She also noted that when someone is discharged, the standard instructions are to "return to the ED" if they have any problems.

"We are really telling people that?" she asked, incredulously, rather than even including a peer support line number.

One committee member, Rep. Betsy Dunn, asked why such an issue could not be resolved immediately by hospitals.

The bill directed AHS to report in its September update "any immediate action steps that the Agency was able to take to address the emergency department crisis that did not require additional resources or legislation."

New Facilities

The law calls on the Agency to review whether there are existing facilities that the State could use, or whether new ones are needed, for a geriatric skilled nursing or forensic psychiatric facility, an additional intensive residential recovery facility, an expanded secure residential recovery facility, or supportive housing.

Each of those areas — older patients who need nursing home care, patients with criminal law interactions, persons who are homeless, and persons who require a secure residence prior to being able to live in the community — were identified as causes of delayed discharges from hospital units.

The state budget proposed by the House included added funding for supportive housing for that purpose, but that was rejected by the Senate, which designated the money to expand the Vermont Support Line instead.

Involuntary Drugs

The law also directs a new review to assess court-ordered hospitalization and drugs, including looking at "gaps and shortcomings in the mental health system, including the adequacy of housing and community resources available to divert patients from involuntary hospitalization; treatment modalities, including involuntary medication and non-medication alternatives available to address the needs of patients in psychiatric crises; and other characteristics of the mental health system that contribute to prolonged stays in hospital emergency departments and inpatient psychiatric units."

It goes on to say that the analysis "shall also examine the interplay between the rights of staff and patients' rights" related to the use of involuntary treatment and medication.

It includes consideration, for the first time, of the effects of court-mandated intervention, by directing the agency's Department of Mental Health to issue "a request for information for a longitudinal study comparing the outcomes of patients who received court-ordered medications while hospitalized with those of patients who did not receive court-order[ed] medication while hospitalized, including both patients who voluntarily received medication and those who received no medication, for a period from 1998 to the present."

A request for information means soliciting proposals for a study, but not actually funding such a study. Such a review about evidence of outcomes has been a long-time request of advocates.

"There's pluses and minuses" to the bill as a whole, Disability Rights Vermont executive director Ed Paquin said. "The plus is, they're taking a serious look at the mental health system — they're taking a decent look at the resources that would be needed…

"The part that is somewhat troubling," he said, is that it is "looking to 'study' speeding up the involuntary medication process, which they do every couple of years."

"We acknowledge that there may be circumstances where it may be necessary to treat someone against their will, but we really believe that solid due process is needed to protect people's rights."

Shortage of Professionals

The law's findings also note "a shortage of psychiatric care professionals both nationally and statewide" and "challenges in meeting the demand for services at current funding levels."

The bill creates a "Mental Health, Developmental Disabilities, and Substance Use Disorder Workforce Study Committee" that is "to examine best practices for training, recruiting, and retaining health care providers in Vermont."

Representation on the committee will cover a broad range of stakeholders, including peers and families of peers. That plan is also due to the legislature by December 15. The bill also directs the action plan to "identify the levels of resources necessary to attract and retain qualified staff."

Long-Term Vision

The long-term vision that the Agency must begin to develop is directed to include:

(1) whether the current structure is succeeding in serving Vermonters with mental health needs and meeting the goals of access, quality, and integration of services;

(2) whether quality and access to mental health services are equitable throughout Vermont;

(3) whether the current structure advances the long-term vision of an integrated, holistic health care system;

(4) how the designated and specialized service agency structure contributes to the realization of that long-term vision;

(5) how mental health care is being fully integrated into health care payment reform; and

(6) any recommendations for structural changes to the mental health system that would assist in achieving the vision of an integrated, holistic health care system.

New Patient Representative Begins

RUTLAND — Kate DeWolfe of Brattleboro, a professional artist and art activist, has been hired as a new Southern Vermont Patient Representative, Vermont Psychiatric Survivors has announced

"I am highly interested in the way oppressive power structures in society affect mental health," DeWolfe said. That has led to her interest in advocating for systemic change in psychiatric settings.

"I want to help people in need of psychiatric care to be treated with respect and dignity. Patients should feel safe and have positive outcomes from their treatment."

DeWolfe received a B.S. in Cinema and Photography and a B.A in Art in 2009 from Ithaca College.

She later did post-graduate work at the University of Maine at Machias for her teaching certification in Art, prek-12 and Social Studies, 7-12. She has worked as a VISTA project coordinator, an art educator, and a children's Behavioral Health Professional, all in Maine.

Patient Representatives are mandated in Vermont law to be available to involuntary patients being served in hospitals, intensive residential recovery facilities, and the state's secure residential recovery facility.

Their purpose, according to statute, is to"advocate for patients and... foster communication between patients and health care providers."

DeWolfe will be covering the Brattleboro Retreat, the Windham Center, Meadowview, and Hilltop. She can be reached at (800) 603-0144. AD

Kate DeWolfe

Human Rights Commission Rules Service Dogs Don't Require Vests

MONTPELIER — A local business illegally discriminated against a man with a service animal because the dog was not wearing a vest, according to a ruling of the Human Rights Commission. The man, Jeff Nolan, had the support dog to assist with symptoms from a traumatic brain injury and PTSD, the Commission's investigator reported.

A business is permitted to ask only two questions when it is not obvious that an animal is a service animal, the report said. The person can be asked "whether the animal is required because of a disability," and "what work or task the animal has been trained to perform."

"The owner/operator is not allowed to make any inquiries into the 'nature or extent' of the person's disability, or to request documentation or proof of training. The regulations also make it clear that lack of a vest, badge or other equipment is not a permissible basis for assuming that the animal is not a service animal," the report said.

The Human Rights Commission found on a 4-1 vote that there were "reasonable grounds to believe" that Capital Deli discriminated against Nolan. AD.

Legislative Round Up

Money Added For DA Staff And Warm Line

MONTPELIER — The state legislature passed the most bills related to mental health in one session in recent history this spring, including adding almost $7 million to increase salaries for mental health staff at designated agencies.

The state budget also added $200,000 to the budget of Pathways Vermont to increase the number of hours of operation of the Vermont Support Line. A support line was directed in law in 2012 to "be staffed at all times to ensure that individuals with a mental health condition have access to peer support," but was only funded to allow for eight hours per day.

The current budget for the line is $297,000, and the additional funding will allow another six hours per day of coverage, according to Hilary Melton, Executive Director of Pathways.

Although the governor has vetoed the budget, the mental health funding has not been seen as at risk. If the veto is upheld at a special session in June, a new budget will need to be passed.

The money for designated agencies was targeted at being able to recruit and retain staff, in particular for emergency screeners and crisis diversion beds in response to the backlog in emergency rooms.*(See budget details, page 6.)*

Testimony in the legislature suggested that staff vacancies were a significant contributor to inadequate coverage by emergency services and for crisis diversion bed programs.

At the same time another bill, S. 133, was passed requiring a major evaluation of the services available for mental health in Vermont, stating that the emergency room crisis "is a symptom of larger systematic shortcomings in the provision of mental health services statewide." *(See bill report on pages 6-7.)*

Other mental health issues were addressed in the following bills:

Police Crisis Response: Establishes a review commission for interactions resulting in death or serious injury. *(See page 1.)*

Consent by Minors to Treatment: Permits minors to provide consent for outpatient mental health counselling.

Duty To Warn: Overturns a Vermont Supreme Court decision requiring mental health staff to tell "caregivers" about patient dangerousness.

Mental Health in Corrections: Orders faster response for inmates with mental health issues.

Secure Residence: Directs the state to purchase land to build a 15-bed secure residence to replace Middlesex temporary facility.

Workers' Compensation Parity: Requires workers' compensation to cover mental injuries.

Suicide Prevention: Directs study into causes of increased suicide deaths in Vermont.

Telemedicine: Expands reimbursement for counselling that is provide electronically.

Childhood Trauma: Recognizes the impact of childhood trauma in later life, and directs a plan to be developed for prevention of adverse childhood experiences.

Shackling: Bars contracts with sherriffs' departments that do not comply with Department of Mental Health policies on shackling during hospital transports.

Details on each of these bills follow:

Consent by Minors

As of July 2018, Vermonters under the age of 18 will be able to seek outpatient mental health care without the consent of a parent. The change came through legislation passed by the House that applied only to counselling regarding sexual orientation and gender identity.

The Senate amended the bill to give any minor the right to seek outpatient counselling.

Both versions were controversial, based on objections to violation of the rights of parents to make decisions about health care for their children, but the Senate amendment brought stronger objections.

Sen. Joe Benning explained his vote against the bill on the Senate floor by saying, "Our courts have held time and again that parents have a constitutional right to parent their children, which includes assisting them with their mental health needs."

Benning said the House version recognized that "youth struggling with sexual orientation and gender identity issues might forgo mental health treatment because parental consent was required," which balanced parents' rights with "the need to protect struggling youth with this particularly difficult concern."

In the Senate version, "parents can be prevented from knowing about any mental health issue, can be blocked from participating in the conversation, cannot object to treatment even if they become convinced it is having negative effects, and yet ironically leaves them financially responsible for the cost..."

"I also believe the cure we have created may have the unintended consequence of being far worse than the disease, when it comes to family dynamics," he said.

The original sponsor of the bill, Rep. Gabrielle Lucke, said that "for some of us, our parents can be our greatest advocates, and sadly, for some of us, our parents can be our greatest adversaries,"

In response to Benning's criticism about responsibility for payment, she said, "I'd rather be able to pay a bill and be able to have my kid to hug at night" even if she wasn't otherwise involved in the care.

A mother of two and a mental health professional in her private life, she said she had a mental list "of young kids who are not on this earth because they made a permanent choice about a temporary problem... For me, [the bill was] suicide prevention legislation."

Duty To Warn

Vermont lawmakers have overturned a 2016 state Supreme Court decision that had required mental health providers to decide when a patient might have a "propensity for violence," and give caregivers "reasonable information… [about] steps he or she can take to mitigate the risks."

In reversing the court, the legislature found that "the overwhelming majority of people diagnosed with mental illness are not more likely to be violent than any other person."

The law now restores the standard to what it was prior to the *Kuligoski v. Brattleboro Retreat* court case, and matches what is permitted under federal law. It clarifies that "a mental health professional's duty to warn is triggered when there is an imminent risk of serious danger to an identifiable victim, but does not require a mental health professional to otherwise train or advise caregivers or to take other precautions to protect an unidentifiable victim or victims or property from a client's or patient's behavior."

Wilda White, Executive Director of Vermont Psychiatric Survivors, testified before the House Human Services Committee on behalf of a stakeholder group "from sometimes really diverse points of view [who] have come together to address a decision that affects us all in some similar and some dissimilar ways." The group included mental health advocates and providers, and helped draft a different version of legislation from what had passed in the Senate.

White said that the court's decision set standards based on unclear terms, resulting in providers feeling they had to "err on the side of depriving people of their rights."

She noted that the decision affected 10 percent of all Vermonters — the 62,000 who seek mental health care each year — who differed widely but who "all suffer from discrimination" that "affects us in the same basic ways."

She pointed to housing and employment, and said that the Senate version of the bill created a statement by the legislature that such individuals "are so dangerous" they must be "single[d] out in a way we don't treat anyone else." Such a statement "operates almost as a license" for discrimination, she said.

White testified that such attitudes are "driven by the misconception that there's a link between mental illness and violence" based upon being "bombarded with these images in the media."

She asked the committee "not to perpetuate that false link."

The new version of the bill passed the House unanimously, was accepted by the Senate, and was signed by the governor on May 30.

The Kuligoski decision concerned a severe assault by a Vermont man who had been released months before from the Brattleboro Retreat, and was receiving services from Northeast Kingdom Human Services. He was living at home, but was not in the custody of his parents, though the court referred to them as caregivers.

Corrections

A bill directing the Department of Corrections to plan and open a forensic mental health center by July of 2019 was passed this session.

The center "shall be available to provide comprehensive assessment, evaluation, and treatment for detainees and inmates with mental illness, while preventing inappropriate segregation," the legislation says. The bill had not yet been signed by the governor when *Counterpoint* went to press.

The plan for the center must be developed in collaboration with the Department of Mental Health (DMH) and the community designated agencies, and presented to the legislature in January, 2018. It is envisioned, according to legislators, as a 4-to-6 bed facility within Corrections.

The bill also requires an agreement for greater collaboration with DMH, directing that when Corrections identifies an inmate "requiring a level of care that cannot be adequately provided," the two departments must determine how to work

(Continued on page 9)

Legislative Coverage by C.B. Hall

Legislative Round Up

(Continued from page 8)
together to augment the inmate's existing treatment plan. They must also formally outline the role of DMH in placing inmates coming into involuntary mental health custody or voluntarily seeking hospitalization and meeting inpatient criteria while in Corrections..

By 2019, when the new center is operational, every inmate who is identified as a result of screening as requiring inpatient evaluation, treatment, or services is required to be provided treatment "in a setting appropriate to the clinical needs of the inmate" within 48 hours; until then, they must be "referred" to such care within 24 hours.

In addition, the bill requires Corrections to study "approaches to substance abuse recovery services in-State and out-of-state correctional facilities for inmates who are in need of substance abuse recovery in order to provide a holistic approach to their recovery."

The current secure residence in Middlesex, built in 2012 after Tropical Storm Irene destroyed the Vermont State Hospital in Waterbury, was intended to be used only for a few years. It was constructed from two modular homes.

Secure Residence

The state's two-year construction spending budget has authorized the purchase of land for a permanent, secure residential facility to replace the temporary one built in Middlesex out of two modular homes after Tropical Storm Irene in 2012.

The language directs that the land be appropriate to the Department of Mental Health study last year that identified the need for a 15-bed program to replace the current 7-bed facility.

The bill directs a review of how to address "pressing facility needs" for both secure residential patients and "elders with significant psychiatric needs" who either do, or do not, meet criteria for skilled nursing facilities.

The review must evaluate whether constructing new facilities would better serve current or anticipated future populations. A preliminary report is due to the legislature in September, with a final report next January.

Workers' Compensation

Among the bills generating controversy was a bill aimed at achieving mental health parity for workers' compensation and establishing the high risk of post-traumatic stress disorder (PTSD) for emergency first responders.

The legislation establishes that workers' compensation benefits can be awarded for a mental injury sustained at work, even if it was a known risk in that profession. Previously, mental health claims were only allowed for a stress that was unusual for the job category.

In addition, the legislation establishes a presumption that first responders suffering from post-traumatic stress disorder (PTSD) acquired the condition on the job.

The law makes Vermont the only state in the country to establish such a legal presumption, and it makes Vermont one of only three states that give mental illnesses full parity within workers' compensation, according to Bradley Reed, a lobbyist for professional firefighters.

The legislation faced debate and angry exchanges on the floor of the House.

Rep. Cynthia Browning offered five amendments to limit the effect of the parity provision. Her proposal on the House floor to potentially require separate state funds for the workers' compensation bill, instead of the usual employer contributions, received the most support, but was defeated, 45-85. Browning said that the new mental health coverage could bring new claims that would create a backlog and delay for those who needed care.

She denied she was seeking to discriminate against mental injury, but that she was trying to "protect property taxpayers from the possible costs of yet another unfunded state mandate" because of costs to towns. The Vermont League of Cities and Towns had testified that the bill would have a "high potential cost to municipalities, which will be reflected in property taxes," and "potential high costs to the state."

Rep. Sarah Copeland-Hanzas, who had introduced the bill, told colleagues in response, "To carve out and require the state to reimburse for a mental injury, as if those are somehow less valid, less debilitating, less tragic for the injured worker and her family is a violation of the goal that we have expressed as a body here: injury is injury."

The bill not not yet been signed by the governor when *Counterpoint* went to press.

Suicide Reporting

The Legislature has instructed the Agency of Human Services to prepare a series of reports on suicide in Vermont and the risk factors that lead Vermonters to take their own lives. The new law is aimed at supporting suicide prevention activities and overcoming "gaps in systemic responses, and barriers to safety and well-being for individuals at risk for suicide."

The agency's mandate includes analyses and reports bearing on its participation in the federal Centers for Disease Control and Prevention's National Violent Death Reporting System, which operates on a grant that will expire in two years. The agency will ultimately have to present both plans for how data relevant to suicide will be collected after the grant runs out and recommendations based on data collected through the national system.

Telemedicine

Gov. Phil Scott has signed legislation that will oblige insurers to cover telemedicine services, defined as those provided by live, interactive audio and video. The bill originated to include mental health services with the primary care physicians who are currently covered.

It was expanded during the legislative process to include any health practitioner. Psychologists, psychiatrists, and drug and substance-abuse counselors are included.

The purpose was described as enhancing access to care, especially for rural areas.

Legislators expressed concern about differences between direct, in-person treatment and remote treatment, and added an informed consent provision.

Childhood Trauma

The Agency of Human Services has been directed to develop a plan by 2019 that will address the prevention of childhood trauma and the "case detection and care of individuals affected by adverse childhood experiences."

The bill includes numerous findings and principles about trauma in childhood and the importance of, and strategies for, prevention.

The overall focus of the plan and a workgroup designated to help develop it is on prevention. However, it also notes "people who have experienced adverse childhood experiences can build resilience and can succeed in leading happy, healthy lives."

Shackling

More than 10 years after first setting standards to require that restraints for transports be restricted to "least restrictive means," the legislature passed a directive that Sheriffs' Departments that do not comply will not be permitted to have state contracts for providing services.

The language in the state's budget specifies that the Agency of Human Services "shall only enter into contracts... [to transport mental health patients and children] if, by entering into the contract, the designated professionals or law enforcement officers affirmatively agree to comply with the Agency's policies on the use of restraints.

Legislators expressed concern over data that show that although the majority of departments use few or no restraints, or only "soft,"medical restraints, a few continue to routinely use metal shacklings when bringing patients to the hospital. Sheriffs' Departments with the worst records in 2016 were Franklin, Caledonia and Chittenden, while those with the best records were Rutland, Lamoille and Bennington.

A Letter To My Neighbor: The Police Response to My Son

I am the mother of a young adolescent boy with several mental health diagnoses, who also happens to be on the autism spectrum. Most of the adversity our family faces is not a result of any of his diagnoses, though. The source of our struggle is primarily due to the gap between what our family needs and the community's ability to provide it.

Here is an email I recently sent my neighbor:

Dear Neighbor,

A week ago you walked by me on the sidewalk in front of my house while I was engaged in a discussion with police. I wanted to let you know a couple of things:

1. I'm okay. Everyone's okay.

2. I'm thinking that you didn't stop or check in with me later out of concern for our privacy. No need to worry about this. We lost the luxury of privacy years ago. Our lives are out there for all to see!

3. To outsiders, the involvement of police indicates that someone is breaking the law. This was not the case Monday morning. At that time my son was experiencing an emotional crisis. This, for him, often means that he is distressed about something to the extent that we can no longer contain his anxiety safely on our own.

4. Calling the police is not what we would prefer to do. What our son needs in moments like these is a mobile crisis unit staffed with mental health professionals. When you see the police here, it is almost always because support from our designated mental health agency is not available.

That particular day I called the crisis line at 7:34 and did not get a call back until 10:20. A lot can happen in three hours. So we called the police. Luckily they had a street outreach worker who is great with kids. But it's a package deal: We get the outreach worker, but he comes with police, on site, armed and in full uniform.

5. The use of law enforcement, first responders, and the ER has not only been straining our public resources, they have created further trauma for the children they are trying to help. Long after the incident is over my children have to face their neighbors, who have sometimes watched the events play out in the middle of our street.

They may have seen my child in handcuffs, or standing in the snow in his bare feet. They may hear him screaming as he is put into an ambulance under five-point restraint. And yet we hear from no one.

Contrast that to the response on another occasion which involved an ambulance on our street — when Mr. (name withheld) had a heart attack. I'm not wishing that people would bring us casseroles. I just think it's interesting that when the cause of the emergency involves a child's behavior, there's a distance that people keep.

6. I know when you come upon a scene like the one you witnessed the other day, it's hard to know what to do. I trust that you haven't said anything out of respect for our privacy, but I wanted to let you know that it's okay to make eye contact and give a smile of support, stop and ask if you can do anything, or email to check in. Most families who are in crisis are also socially isolated. So chances are, your concern would be very much appreciated.

7. Finally, if you don't want to do any of those things I won't hold it against you. I just wanted you to feel like you had the option. Please know that if you choose not to respond in the ways I suggested, I won't hold it against you. I feel better already knowing that you understand. Thanks for taking some time to have me fill you in, and I'll see you around the 'hood.

******

A few days later I received a heartfelt email from my neighbor, and we met in person a few days after that. She told me that she has a friend whose young daughter is struggling with mental health issues, but she has been on a waiting list for a psychiatrist for several months now. I let her know that this story is all too common.

When are we going to see the day that the public sees police responding to a child in distress and doesn't see it as a signal that there is something wrong with the child, but rather a signal that there is something wrong with our system of care?

When are we going to see the day when the agencies designated to provide care to children with complex needs start to measure their success not by the number of calls their crisis lines receive, but by the decrease in that number from year to year? Better care would mean fewer ambulances, fewer police, and fewer emergency room admissions.

If parents voicing their concern were all that was needed, the problem would be solved. I don't believe things will change until a sizable number of allies stands up to say that we can do better. I hope my email inched us a bit closer to that day

NAME WITHHELD
[To protect the privacy of her son.]

No Duty To Refer for Assisted Suicide

BURLINGTON — The state has settled with a group of doctors who said their rights were being violated by being required to inform all patients with a terminal illness about the "Death with Dignity" law, Act 39, even if the patient was not requesting such information.

A "consent agreement" was approved by the United States District Court. In it, the state agreed to revise its websites to be clear that the Patient's Bill of Rights for Palliative Care law does not create a duty to counsel or refer patients for assisted suicide.

The court had found that there was no such duty in its ruling in *Vermont Alliance for Ethical Healthcare v. Hoser.* The state Board of Medical Practice had taken the position after Act 39 first passed that because the Patient Bill of Rights requires doctors to counsel and refer for "all options" for palliative care, the new "option" of assisted suicide needed to be included.

Disability rights groups fought the assisted suicide legislation in 2013 on the basis that persons with disabilities, already subjected to discrimination, could be placed at greater risk under such laws.

They also said that such laws labelled living with a disability as being less than dignified. AD

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Jim Tomlinson (holding hypodermic) in a photo in the *Toronto Star* of a protest at the American Psychiatric Association's annual convention in 1982 in Toronto during the 10th Annual Conference on Human Rights and Psychiatric Oppression.

A Sparkle in His Eye

I met Jim Tomlinson, and the peer group he led, while reaching out for comment on our agency's priorities [Disability Rights Vermont]. I didn't anticipate meeting a man with an open heart, a sparkle in his eye, a healthy suspicion of authority, and a beautifully non-judgmental way of interacting with people who were going through hard times. Getting to know Jim over time and in other settings, all those aspects were revealed. He was a prince, an "old hippie" in the best sense that could be taken, and I just feel like we are worse off for the loss of the man. Ed Paquin, Montpelier

He Insisted on Loving

I met Jim while both of us were serving on the Board of Vermont Psychiatric Survivors. We had minority opinions that were difficult to voice. Jim supported me to speak from the heart and made me feel like what I was saying was valuable instead of crazy.

The first time we got together outside of VPS business we ended up talking for eight hours in a Denny's in Burlington. Jim had brought a number of items he wanted me to see. He was a bard in need of a kindred clan. Each story wove together until he had about 12 of them going at the same time, threads being picked up chapter and verse like some magnificent tapestry of Vermont, national, local, political, musical, and cultural history all interconnecting and inextricably intertwined.

He was a follower of the Tao, and recited wisdom like poetry. He was always 'crawling on his belly naked over broken glass trying to get back to the garden.'

He refused to be discouraged by ignorance or cruelty, and insisted on loving 'not until it hurts, but until it stops hurting.' I called him up one time when I was sick and afraid of dying. He read to me from Lao Tzu and reminded me we all are living on borrowed breaths — lent to us at birth and returned with our passing.

Much love to you my brother. May we meet again soon. Sarah Knutson, Barre

James Hollis Tomlinson
1945 - 2017

Jim Tomlinson

BURLINGTON — The Reverend James Hollis Tomlinson, 71, of St. Albans, passed away March 19, 2017, at the University of Vermont Medical Center.

Jim Tomlinson was an early member of the Vermont Liberation Organization, a human rights and psychiatric survivor movement, and went on to serve countless terms on the Board of Directors of the organization that succeeded the VLO, Vermont Psychiatric Survivors (VPS). He was a long-term member of the consumer advisory council of Northwestern Counseling and Support Services. He founded the VPS peer support group in St. Albans, which is the longest-running support group by and for mental health peers in the state of Vermont.

He was born July 13, 1945, in Burlington, the second son of Wayne and Catherine Tomlinson. He is survived by his two sons, Maitreya and Devin, and his granddaughter, Lily Catherine.

Unconditional Love

My father loved his children unconditionally. He also loved his friends and provided a refuge for those in need. We all miss him dearly. Rest In Peace, Papa.

Maitreya Tomlinson

One of Jim's Favorite Quotes

To let go isn't to forget, not to think about, or ignore. It doesn't leave feelings of anger, jealousy, or regret. Letting go isn't winning, and it isn't losing. It's not about pride, and it's not about how you appear, and it's not obsessing or dwelling on the past. Letting go isn't blocking memories or thinking sad thoughts, and doesn't leave emptiness, hurt, or sadness. It's not giving in or giving up. Letting go isn't about loss and it's not defeat. To let go is to cherish memories, and overcome and move on. It's having an open mind and confidence in the future. Letting go is accepting. It's learning and experiencing and growing. To let go is to be thankful for the experiences that made you laugh, made you cry, and made you grow. It's about all that you have, all that you had, and all that you will have soon again.

Letting go is having the courage to accept change, and the strength to keep moving. Letting go is growing up. It's realizing that the heart can sometimes be the most potent remedy. To let go is to open a door, and to clear a path, and to set you free…

Unattributed

A Mark on Our Hearts

I first met Jim at an Intentional Peer Support (IPS) group which met in Burlington. He had a bard-like presence, and spoke poetically about both the joy and pain of living.

Jim came to an Intentional Peer Support training I ran in part, because he was providing transport for his friend Deb Hill-McGourty. She offered to pay for him to attend in return for a ride — symbolic of a mutual spirit of generosity. In many respects their relationship represented the sort of mutuality we talk about in IPS. Neither of them were in positions where their attendance was being paid for, so the effort they both made to attend and contribute was truly humbling (and we returned their checks!)

Jim shared a love of an eclectic range of music that many others find intolerable and bizarre with me. He had for many years paid annually for a Flynn membership, and so was able to access many concerts for free or a nominal charge. He would occasionally text me and ask if I wanted to attend a concert that night — either with him, or with someone else if he couldn't make it. The times we went together he was wonderful company — proving an extraordinary and unstoppable wealth of knowledge, wisdom and insight on the wildest range of music and musicians!

Jim Tomlinson has left his mark on many of our hearts and lives. I feel honored to have known him — albeit for a brief bite of his colorful life.

Chris Hansen, Burlington

Honorable About Being Human

When I think about Jim, I think about suspenders, a button up shirt, light colored slacks and his peaky sneaky smile. Remembering he is now gone is easier to grasp having sat in the Tuesday Night St Albans Vermont Psychiatric Survivors Support Group with about 25 of his peers from around the state, sharing stories not too long ago.

Thinking of when I last saw Jim, I think about a night where four of his local peers came together for a visit when he was unable to speak just two days before he moved on. It's hard to know what to say or do when visiting a friend who is present but not able to emit his usual radiating energy. So, we all spoke to him and held his gripping hand. Jim pet my service dog Winston and looked at me and smiled and we looked at recently posted pictures on Jim's Facebook page.

Seeing Jim that night reminded me of the last time I saw our mutual friend Linda Corey. I left that night with an uncertainty. I met Jim and Linda probably around the same time. They both were similarly encouraging and at that time of getting to know Jim I was team leading a peer project, nervous as heck. He only had good things to say, commenting on my colorful personal touch of adding in graphics and photos to the quarterly report. His words helped me to know it was okay to be me in the realm of the peer world, somewhat of a fatherly feeling of it's okay to let yourself shine.

What I liked most about Jim Tomlinson was that he let his emotions be shown when they surfaced. He was honorable about being human in the experience of being human. I have missed Jim's informative emails. I am grateful for Sarah Knutson for her shoutings out to what was happening with Jim. It is far too often people in our community pass without awareness of their hard turns.

Melanie Jannery, Burlington

A Force of Nature

I always thought of him as a force of nature that would live forever and it's hard to imagine him passed on. To say the least he was a caring person and militantly protective of peers. A vociferous person that was not afraid to be outspoken.

Michael Sabourin,, Marshfield

Filled with Life

I will miss Jim. He was someone who connected people, who could change the direction of a conversation. He said things in our peer group that stayed with you, he was filled with life always. I say this not only for myself but will speak for those in the group as well. We will miss him.

Keith Martell, St. Albans

We Changed the World

Hey, Jim, lucky you moving on to a better life. I suppose I will be joining you at some point in the next few years, You know now what a truly amazing and great thing we did. At the time it seemed like there were a lot of us but in the grand scheme of things we were only a few, but you know what we did. We changed the world. It will never be the same. It may take a couple more years or even a couple more generations to realize it, but what we did changed the world.

Think of it. The crazy people spoke out and told the world what we were thinking and what we thought of them and what our lives were like and you know what? We didn't sound so crazy after all. We got to know each other and we had each other so we weren't alone and we weren't crazy anymore.

I always felt that you gave me your state. I was an interloper here but you knew I meant well and you were ok with me being here. That meant a lot to me. I always thought you idolized me a bit too much. I am just a visitor and a guest. Your great state and your great people made it happen.

Paul Engels, Burlington

Jim Tomlinson during an interview with *Counterpoint* in 2008 at the newly opened Bayview House crisis bed program in St. Albans. Jim was a peer advisor in the development of the program.

Child Services Expert and Crisis Clinician Take Over the Department of Mental Health

Commissioner Melissa Bailey and Deputy Commissioner Mourning Fox

WATERBURY — Melissa Bailey and Mourning Fox see many mental health issues in the same light, which should not come as a surprise, given that Bailey selected Fox as Deputy Commissioner shortly after becoming Commissioner of the Department of Mental Health this January.

They shared their different backgrounds, and their common goals of a system that addresses people's needs before they become crises, in a joint interview with *Counterpoint* in May. A new governor — in this case, Governor Phil Scott — appoints department commissioners, so the new leadership at DMH was expected.

Although the focus in the state legislature this spring was on delays for persons in emergency rooms and the pressures causing those multi-day waits, Bailey said she wants to be looking further. She wants to know, "Why are they [patients] going there in the first place?" She said she wants to look at what gets people to where they are, all the way back to the beginning of the continuum of care.

Both Bailey and Fox come from a place of wanting to implement "more of what's actually working" in meeting people's needs, Fox said.

Bailey said she is concerned that "society is struggling" with more of the pressures that create chronic stresses and contribute to "anxiety and depression all the way to more severe mental illness." She wants to see more emphasis on housing and job skills; if a family can't put food on the table, it can't address other issues.

The system has "tipped away from direct clinical work," she said.

She also believes there is an increasing environment of "cultural issues of [not] understanding and supporting people's differences."

Fox pointed to the impacts of a broader community that has biases and fears about people with differences.

"People have the right to be loud; people have the right to paint eccentric paintings on their wall," and the general population needs to learn how "to be supportive."

It is "less than helpful" when professionals who are seen as leaders in the community "are not necessarily aware of their own biases" in themselves, Fox said, pointing to one physician who talked publically about patients in mental health crisis being "dumped in my emergency room," and "obstructing" care for cardiac patients.

Background

Although they share goals — "We think the same way about where things should go," Fox said — the Commissioner and her Deputy come from very different backgrounds in the mental health system.

Bailey's work has almost exclusively been with children and families, while Fox did most of his early work in adult crisis services and corrections mental health. Bailey said she is having a "huge crash course in the adult world" since becoming Commissioner.

She first became interested in the field when she was in high school, heavily influenced by a teacher in a course on sociology and psychology. A grandfather who was a Baptist minister and had a Master's degree in psychology was also an influence, she said.

Despite that, based on that same teacher's background, after graduation she went to fashion school instead. But she never lost her desire to work in psychology, and later took the opportunity to get her Master's degree in psychology.

That led to work at the Howard Center's school-based children's program in Burlington, and then to the Department of Mental Health in 2001. She was director of Integrating Children's Services before becoming Deputy Commissioner at DMH in the fall of 2015.

Fox said his interest in mental health issues also began early, when he was "the person in high school that people would come to talk to."

He started his college education in pre-med, then shifted to a Peace and Global Studies major. After a stint teaching in high school special education, however, he returned to school to get his Master's in psychology.

Like Bailey, his career got started at the Howard Center; there he worked in crisis services and at Assist, the crisis bed program.

From there, Fox became involved in correctional settings in Indiana and Massachusetts, returning to Vermont in 2012 to work at Lamoille County Mental Health Services, and then to the Department of Mental Health to become Director of Care Management.

In the Legislature

Bailey acknowledges that the Legislature has placed a major task in her hands with S. 133, a bill that requires major study of what is driving the crisis in the system, and what needs to happen to address it.

"We really need to take a step back" and identify what people need, she said. Much of that work was already underway, she said. She has also already identified major themes that have repeated over time by reading almost two decades of past studies of the system.

The mandates in S. 133 are broad enough to help the Department get there, Fox added, because it identifies things they already realize they need to know. "We want to make informed decisions," he said. On the other hand, "We cannot be frozen in inaction by fear of not having the perfect plan."

Money for DAs

The Legislature made a decision to put resources into staff salaries at the 14 designated agencies — the state's community mental health centers. Was that the best investment in addressing the current crisis?

"One of my mantras" has been that the hardest jobs are in the front lines at the designated agencies, Bailey said, and those staff "should have the right to make a livable wage." The Department's job is to hold the agencies to quality outcomes, though, and Fox wants to continue to pursue actions based on information that shows results.

The question about wages, he said, is "is it going to yield the retention [of staff] that we want?"

Involuntary Treatment

When it comes to involuntary treatment, and in particular, involuntary medication, "we want to ensure that it is the smallest subset of the population," Fox said.

Noting that requests for court medication orders have increased, he said the Department needs to find out why. "Is it coming from the doctors? Is it severity, or acuity [of illness] in hospitals?"

Bailey sees a part of it as what can happen with "a system that can't do what it should do" if staff do not have the necessary skill set. She pointed to the work of Sandy Steingard, the Howard Center's medical director, in reducing over-reliance on medication.

Secure Residence

This year's legislature also directed the purchase of property for replacement — and expansion — of the current seven-bed secure residence in Middlesex, building on a plan for a 14-bed facility that was developed by the previous administration.

Is expansion of a coercive setting the right direction? Bailey said there is definitely a need to replace the temporary building in Middlesex, but "where we get stuck" is in the size and the type of needs to be served, which range from a very small number of persons that need a "really long-term" place, and others who are working towards returning to their community.

Fox said there were individuals who no longer need inpatient care but who "struggle to manage safely in the community in a less restrictive setting." However, because they range widely in clinical needs, there was a question about whether anywhere from 10 to 25 beds were appropriate for mixing individuals in such different situations.

Discussion of 14 beds is really just creates perception "of a release valve" for patients currently stuck in inpatient settings, Fox said, but is not necessarily the right solution.

Future Vision

S. 133 also requires the Department to develop a long-term future vision for mental health services as a part of an overall health care system in

(Continued on page 13)

New State Leadership

A Restaurant Owner Now Runs The Agency of Human Services

Secretary Al Gobeille

WATERBURY –Al Gobeille is clear about his ideas of how to get things done.

The new Secretary of the Agency of Human Services, appointed in December by incoming Governor Phil Scott, says he believes the first step is to admit that you don't know the answer, and then bring people together to help.

Despite that, the restaurant owner and health care reformer can't stop himself from jumping into ideas he has when he is confronting a tough problem.

One of the biggest he is facing in his new job is how to address mental health services in Vermont.

As he sits in a meeting room in the former office of the Superintendent of the Vermont State Hospital, he recounts how he looked at a chart showing the population at the hospital when it housed more than 2,000 patients. Today, the new Vermont Psychiatric Care Hospital in Berlin has 25.

"We de-institutionalized," he said. "We never came up with a Plan B."

"Where did everybody go?"

"Who's [now] showing up at the emergency rooms, and why?"

"It may not be about mental health facilities," he continued. "It may be about housing."

Animated, Gobeille presses on: "We have a housing issue that exposes itself in mental health."

"Anyone want to admit they're connected? Plan B, it might be housing. It might be periodic intervention."

Finally, he shook his head.

"The economic disparities of the last 20 years and the opiod crisis… this is a cocktail for bad outcomes."

Gobeille wants to come back to the legislature next January with the "Plan B" that never happened: with data on what works, the vision, and the resources to do it. "I don't have a vision yet, but I know the mission," he said.

He sees the consensus around the need for new responses as an opportunity that doesn't come often. "We now have the moral authority to plan, Plan B."

That means bringing people together, and in Vermont, "I've never opened the door and invited them [people] in and had them not come in," he said.

He has evidence of that already from the work groups that he assembled this past winter to begin digging into the mental health issues that have led to lengthy waits in emergency rooms for persons in psychiatric crises.

Has he done enough to reach out to the people most affected, the psychiatric survivors and consumers?

"That would be a good criticism," Gobeille answered. "You can't possibly do what I'm talking about without reaching out."

The Secretary said he's been getting out around the state — "I've been to Middlesex [the secure residence] and talked to the people there" along with several of the hospitals — but recognizes it isn't enough and knows that just understanding a mental health issue is "not the same as going through it."

"We're going to have to actively pursue it. We're going to go to them," he pledged.

But Gobeille is also a man of great optimism who sees Vermont as a place that is "hyper-critical" of itself, and therefore quickly demoralized when things go wrong.

"In Vermont, we don't say the glass is half full. We don't say the glass is half empty. In Vermont, we don't even acknowledge there is a glass," he said — despite having top rankings in the country for health care and even for mental health.

Where there are weaknesses, "you're not going to fix any of that if you're down [on yourself]."

Gobeille said he has found a "great bunch of people" working at the Agency, and thinks he can serve well if he can help develop "a culture of appreciation for each other."

He accepted the job running the largest part of state government because, as chair of the state's health care oversight board, he saw the Agency of Human Services "from sitting outside" and interacting with it, and felt it needed help if it was to serve Vermonters better.

It needed "change from within, with everybody rowing," and Governor Scott "liked the way I included people in decision-making," he said.

Gobeille came to the incoming governor to help give him background on ongoing health care reform in the state, and in particular, on the All Payer Model that is an experiment in payment reform. He said Scott asked him if he would help him by accepting a leadership position in the administration.

That brought a new leader who has no direct experience in human services.

Gobeille and his wife started a restaurant in Burlington, the Shanty on the Shore, 20 years ago, and that grew into the purchase of two other restaurants. He didn't have a background in that, either, other than washing dishes from the time he was 14 through college to earn money.

As a graduate of Norwich University, however — a school that is "all about service — the importance of getting involved in community service was never far from his mind, and in 2007, he joined the Shelburne Select Board.

"Most of what I learned" from that experience was "how much I didn't know about stuff."

Former Governor Peter Shumlin then asked him to serve on a health care payment reform committee, and he began to delve into the issues of health care.

When the Green Mountain Care Board was established by the legislature in 2011, one of the five members was supposed to reflect the concerns of the business community.

Applying to serve on the independent Board was "a whole story of naivete," he said. He pictured it as another part-time volunteer board position. When he learned more, he had to come to a decision with his wife. She would have to take on more of their restaurant business if he was going to join the Board.

Then Shumlin asked him to take over as Chair. He said he told Shumlin he wasn't qualified, and the response was, "That's not for you to decide."

Leaving that position to move into state government meant a pay cut and a whole new level of responsibility.

The morning before his interview with *Counterpoint*, Gobeille received a call at 7:30 that a man was driving up from Brattleboro to see him — distraught and angry that he couldn't get help for his 10-year-old daughter, who was suicidal.

He met with the father and connected him to the people in the Agency who could intervene.

"We are so much stronger together" as an "agency of one" rather than separate departments, and he wants to continue to build relationships that way, using as an example the relationship between housing and mental health, areas under the responsibility of different departments.

Although his new boss, Governor Scott, has been "very clear in his values" about being more effective with state resources while "protecting the most vulnerable," Gobeille rejects the term "most vulnerable" as a description of those served by the Agency.

That term is used for whichever group is the focus of the moment — the elderly, those with mental illness, children in foster care, children who are being abused — and "most vulnerable" is "a competition that no one [should] want to win."

The mission of the Agency of Human Services is not about "creating more vulnerability," its new leader said.

"We want to prevent vulnerability." AD

Bailey, Fox

(Continued from page 14)

Vermont. "It gives us the opportunity" to compare "what's needed to sustain the system we have" to being engaged in health care reform in an integrated way, Bailey said. The Department needs to "take a lead in shifting what that [a reformed system] looks like."

She said she was concerned if new Accountable Care Organizations were too ready to say, "We take care of all this [the medical side], and you take care of that [mental health]." Building a vision requires "inserting ourselves" into the conversation, and soliciting input.

Bailey wants to have people in groups such as the Statewide Standing Committee for Adult Mental Health "be more engaged in the future" and what it might look like, "rather than the status quo."

"Running the mental health system itself is a full-time job," Bailey observed, so the effort to also "move this conversation forward" on a future vision is a major challenge. AD

Commentary

Five Reasons To Question Your Diagnosis

(First in a two-part series.)

by MALAIKA PUFFER

1. The Descriptions of Psychiatric Diagnoses Are Very Subjective

In order to receive a psych diagnosis, someone will first hear about or observe your thoughts, feelings, and behavior. Then that person needs to compare their impressions of you to some lists in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* and decide whether you fit any of these descriptions.

These lists include some very subjective words, such as "inappropriate," "excessive," "significant," "understandable," "intense," "unstable," "normal," "deceptive," "exaggerated," "delusional," etc. This explains why it is possible for someone to see multiple clinicians and get a different diagnosis from each one.

What is considered "normal," "understandable," or "healthy" varies by culture, time period, religion, and from person to person.

You may be from a background where concerns about curses or demonic intervention is completely reasonable, but the person diagnosing you may see that as "delusional."

Loud demonstrations of anger are normal in some families yet your school counselor or group home therapist may consider this part of "oppositional defiance disorder" or "borderline personality disorder."

Receiving a diagnosis for certain thoughts, feelings, and behaviors, then, may reveal more about the beliefs and values of the system or people *giving* the diagnosis than it does about the person receiving it.

2. It May Not Be a Very Useful Summary of Who You Are or What You Need

The most common defense of psychiatric diagnoses is that professionals need a way to communicate with each other about their clients, and researchers need a way to categorize groups of people.

For most diagnoses in the DSM, you only need to fit some of the possible criteria listed. For many diagnoses, you may need to meet something like five out of nine possible criteria in order to be diagnosed.

This means that it's possible for two people with the same diagnosis to have only one of those criteria in common!

The categories in the DSM are so unscientific that the National Institute of Mental Health, the lead federal agency for research on "mental disorders," decided in 2013 to stop using DSM diagnoses to guide research.

According to Thomas Insel, the director of NIMH at the time, "DSM diagnoses are based on…not any objective laboratory measure" and "patients…deserve better."

These labels, particularly if people see them as a biological disease, may increase other people's mistrust, fearfulness, and lack of empathy towards you. [1]

Diagnoses also don't take into consideration your life circumstances. You may be having a hard time because of things that have happened in the past or continue to happen to you but a diagnosis will probably not reflect this. Instead, diagnoses locate the problem *within* you rather than in what has happened to you.

3. There Is No Clear Biological Cause for "Mental Illness"

Ask a random sampling of people in the US what causes mental illness and you are very likely to hear responses like, "chemical imbalance" or "genetics." Who taught us this?

More than anything else, we are likely to have heard it from pharmaceutical commercials. We may have also been told this directly by doctors or teachers.

The theory of chemical imbalance actually didn't come about until after psychiatric drugs had been in use for years. When a study seemed to support this theory, it was widely reported on in the media and made headline news.

Drug companies benefitted because this meant they would continue selling more of their drugs, and psychiatry benefitted because it improved their poor reputation.

However, closer examination of these studies — which turned out to be very faulty — and the completion of many more, revealed that "there is no scientific explanation whatsoever that clinical depression is due to any kind of biological deficit state."[2]

Unfortunately, neither psychiatry nor the drug companies came forward to tell the public this and set the record straight.

Dr. Ronald Pies, a well-known psychiatrist and editor of *Psychiatric Times,* has said, "In truth, the 'chemical imbalance' notion was always a kind of urban legend — never a theory seriously propounded by well-informed psychiatrists."

4. Drug Companies and Psychiatry Want You To Keep Believing in Your Diagnosis

As the public has slowly become more aware that the chemical imbalance theory is untrue, psychiatrists and pharmaceutical companies have had to explain why they promoted the theory long after it had been disproven.

"It's a useful metaphor to encourage medication compliance," has been one answer. If you do not believe that your struggles are due to a biomedical problem in your body, you are probably less likely to take psychiatric drugs, which means a loss for the drug companies.

There have been many "anti-stigma" campaigns, some sponsored by drug companies, that aim to "raise awareness" that "mental illness" is a biological disease. These have largely served to keep people believing in psychiatric diagnoses and, consequently, consuming psychiatric drugs. During the years 1988-1994, about 1.8 percent of Americans were taking an antidepressant while during 2005-2008 that number had increased to 12.7 percent.[3]

Inventing more illnesses is another strategy to expand the "market." A few years ago, a new version of the DSM was created, with more diagnoses than ever before. More than two-thirds of the 170 people working on creating the new DSM had financial ties to drug companies.[4]

5. There Are Other Options

There are many ways to understand experiences like hearing voices, being paralyzed by sadness, having incredible amounts of energy, and other phenomena that some see as "symptoms" of "mental illness."

In certain cultures, people with some of these experiences are believed to have something unique and valuable to offer the community and therefore are revered and cherished.

Malaika Puffer

Another framework made popular by The Icarus Project is the idea of dangerous gifts, similar to super powers. A very sensitive person may see their sensitivity as a gift rather than a burden and learn ways to use it to their advantage.

A person who fluctuates between the poles of extreme highs and extreme lows may use their productive time to maximize their positive impact on the world while using the low times to recuperate, all the while learning together with others having similar experiences to make these extreme states less tumultuous and jarring.

Another way of understanding emotional distress is that people are simply responding in diverse ways to hard things in the world, and that the solution is to make the world a better, safer place for all people.

For others, their distress is about a spiritual emergency or existential crisis as they grow into a new, stronger, wiser person.

Many of these alternative theories (and there are so many more than can be mentioned here) do not see experiences like voices, extreme emotions, or unusual beliefs as inherently problematic.

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Malaika Puffer lives in Brattleboro and advocates for the rights of people with psychiatric labels.

Soteria Works To Live Up to Promise

by ANNE DONAHUE
Counterpoint

BURLINGTON — Soteria is a place that "picks you up and rebuilds you."

That's the way it feels to "Irish" — his preferred nickname — who came to the alternative residence here after months in two different hospitals, and found a new start. *(Irish asked to use his nickname for this article so that he could be fully open about his personal history and experiences.)*

Soteria opened in the spring of 2015, and the 5-bed residence has had 24 individuals find their way here to a "program" that has no program except for what guests want for themselves.

"It was like walking into a hug."

"They were able to make me feel at home" in his first meeting with staff, Irish said. "They treated me like a person, like a human being."

"It was like walking into a hug." All of a sudden, "there was hope."

His story reflects the goals and ideals of the Soteria model, which was founded in California in 1971. It lost funding there after less than 10 years, but not before establishing a reputation for success in treating first episodes of psychosis with little or no reliance on medication.

Recreating its vision was a goal for Vermont psychiatric survivors for years, and it finally received approval and funding when the state was looking for new program options after the loss of the old state hospital in Waterbury to Tropical Storm Irene's flood waters.

The focus is on "being with" a person, instead of "doing for" them, staff say. "We'll sit here as long as we need to sit here; sometimes there's talking and sometimes there's not."

Irish's analogy is that it is "like you were broken, being held up until you healed."

"They literally just stand by you."

The vision included being a place where people can go when they are experiencing a first-time psychotic break instead of going to a hospital.

That goal has not yet been realized, according to staff; it has started out instead primarily helping people who are being discharged from a hospital but need help rebuilding their lives

"It's out of our hands" in terms of criteria for a referral, staff said, because if a person has been assessed as being in need of inpatient care, they cannot be admitted to Soteria. However people who just finished a hospital stay are "still in a very fragile state."

For Irish, who is 34, it was exactly what he needed. He was scared about where he would be going when he left the hospital after "pretty traumatic stuff" there.

Irish believes he was experiencing bipolar disorder for many years without realizing it, and that the hospital diagnosis and initial medication were important.

"My brain was just overloading. My brain just shut down," he said. "It was like being stuck on a really bad trip. I thought certain people were evil. My brain was telling me the most messed-up things."

He ended up being taken to the Brattleboro Retreat for several weeks, which was not helpful, he said, and a few days after being discharged he "went back to right where I started."

A Montpelier police officer "saw me just lost on the street" and "I guess he just cared... and brought me to the hospital." The experience at Central Vermont Medical Center "helped me way more," but a hospital is not an environment for healing, he said. Problems that other people were having meant "they would be lashing out" at others and it would "freak me out." People are "feeding off each other."

"You can't really grow from it." He said he developed new problems there as a result, including night terrors.

As he neared discharge, "I was doing OK," but "I was pretty scared" about what would happen next. It was a staff person at Central Vermont who identified him as a candidate for Soteria. "They really set me on the right foot."

His very first night at the residence in the Old North End, he experienced night terrors, and found support through a warm staff person who "calmed me down" and "made me cookies."

Irish believes his challenges are a combination of a "really severe chemical imbalance in my brain" and "a lot of stuff from my childhood that I wasn't aware about," and medications helped. However "they did overdo it" at the hospital, and he felt "like a zombie." Soteria helped him to taper off medications, and he is now stable with just one, at a lower dose.

Irish went through several rehabilitation programs when he was younger. "You have to do their program, and when you finished, you're out. People didn't want to be there."

In contrast to the hospital, at Soteria there is so much space that even if others are having difficulties, a person can find a different space to be in. "You can go to a room. You can go for a walk" with a staff person.

"There was more room to grow" there, compared to a hospital, where "you feel you're in a jail."

"People don't talk behind your back," he said, and it is easier to talk with staff "knowing that they've been through it" themselves, as peers.

"The best part," Irish said, was that "the people loved what they're doing" and it showed.

Irish says he is now home, has a good support network, and is looking into job opportunities — though he's being careful to start slowly so that he doesn't overdo it.

At Soteria, staff helped him find a job, and being around people again made him feel that "I don't have the fear of it, of getting a job now."

Without the seven months he spent there, "I probably wouldn't have made it," Irish said.

"I think I would [still] be lost."

Although he found his hospital stay detrimental, he said he does believe that a brief hospital assessment is probably needed before a person might be referred to Soteria.

Irish connected with exactly the supports that the staff at Soteria say they are trying to provide. In a freewheeling discussion at a meeting with *Counterpoint*, staff shared what they have experienced in working in such a different environment.

"Hospitals don't try to heal people," one staff member said, while the goal at Soteria is to "break the cycle of hospitalization" by helping persons to heal.

"We start with the assumption that people are strong and resilient and able to find their own solutions," another said. "It's really cool to be in a position to not judge [a person's actions] versus [asking] 'what does that look like for you?'"

"When people find their own answers, it's much more meaningful," one person noted. "Being there" for someone means "not jumping into problem solving; being a respectful listener."

Counterpoint asked what have staff found unexpected in working at Soteria compared to other residential support programs.

A staff member replied that, "My first night" a resident asked about lived experience, and it "broke away from traditional 'staff are the sane ones and the residents are the crazy ones.'" It was "an ice breaker for them" and a "powerful, moving experience for me."

Another staff member said that Soteria is "not distracted by a lot of the dynamics" that are negative when there is a lot of discussion about why someone has to be there. There is "a lot of coercion" around medication compliance at other programs and "a lot of friction" as a result. Soteria staff are "freed from all that."

Irish looks out over the yard of his home.

Another commented, "We can really be there as partners. We're all equals in the house."

"We share," one staff member said. "It normalizes it, it breaks down a lot of barriers; allows people to explore things and be vulnerable"

Counterpoint asked staff how Soteria is seen by other programs.

There are some who are "shocked at what we're doing," one person said, which may be rooted in the fear of not being in control.

There is questioning: "What do you do there? Reinforce their delusions?"

Another added that providers often themselves think that "it's what they do" that helps people, instead of helping by "cultivat[ing] people's internal strengths."

"It's not about what we're doing," the staff member said. "We're just supporting them — that's difficult [to accept] for people who have taken on the role of the helper."

Soteria Data Points

- 24 total residents since opening
- 19 past and 5 current
- Average of five-and-one-half month stay
- 62.5 percent staying less than six months
- The longest stay was for 11 months

Editorial Page

Opinions

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

Editorial

Our Best Behavior?

What's in a word?

A lot of hurt, sometimes.

It is becoming more and more popular to refer to services for mental health and substance use as "behavioral health care."

What exactly does behavioral health mean?

If it means health that has to do with our behaviors, then that would mean... let's see... eating right? Stopping smoking? Exercising every day? Avoiding stress? Finding relaxing activities?

Those all have to do with actions we choose — our behavior.

The consequences if you don't choose those behaviors show up in all sorts of health problems: heart disease, diabetes, cancer, and yes, mental health issues. But obviously, not solely mental health issues!

Yet most people don't say "behavioral health" and mean the things we all do (or fail to do) that can put our health at risk. Instead, they mean health that shows up as a "behavior" that we are failing to control: moping around, acting out, being threatening; you are lazy, you are weak.

All of a sudden, "behavioral health" is used as another term for *mis*behavior. It perpetuates the same labels and discrimination that has applied to mental illnesses through the ages. It is a new term for an old game of blame.

We are all both body and spirit. New research has proven what many of us have known for years: that childhood trauma leads to adult labels of mental illness, because our body's stress protection mechanisms go into overdrive, and we cannot escape the trauma.

People who are depressed are more likely to die of heart disease, and people with heart disease are more likely to get depressed.

Changing our behavior can change our biology. Exercise can reduce stress as well as strengthen muscles as well as burn off calories. Mind and body are deeply interrelated.

But calling mental health, behavioral health, is ignoring the interconnection. It ignores the biology of the brain that sends out the stress signals, and it ignores the unhealthy choices that cause physical damage to our bodies.

The behavioral health label is a barrier to the kind of holistic health care that considers all aspects of our health and what makes us tick. It is also a barrier for people who want to get mental health support, because it perpetuates the stigma against those labelled with a mental illness.

Behavioral health seems to be presented as a gentler sort of label -- but those are the most dangerous kind of labels, because they are not even recognized for what they are.

We who wear those labels do not choose to be depressed, or to be traumatized, or to hear voices. It is wrong to discard us as "behavioral problems."

Do you agree with this editorial? Disagree? Call in and vote on the Counterpoint *telephone poll. See opposite page for the phone number.*

PUBLISHER'S COMMENTARY

On Being Called 'In Recovery'

by WILDA L. WHITE

Word came in the spring that Vermont's Governor had re-appointed me to the State's Mental Health Block Grant Planning Council. The federal government provides money in the form of block grants to each State to help support community mental health services. In return, each State must establish a Planning Council. The Council's role is threefold: (1) to review the State's Mental Health Block Grant application, contribute to its development, and make recommendations regarding the state's community mental health plan; (2) to advocate for adults with "serious mental illness, children with severe emotional disturbance, and other individuals with mental health issues"; and (3) to monitor, review, and evaluate the allocation and adequacy of mental health services in Vermont, at least annually."

By federal law, the Planning Council must be comprised of residents of the State, including representatives of (1) the principal State agencies responsible for mental health, education, vocational rehabilitation, criminal justice, housing, and social services; (2) public and private entities concerned with mental health services; (3) "adults with serious mental illnesses who are receiving (or have received) mental health services"; and (4) "the families of such adults or families of children with emotional disturbance." At least 50 percent of the members of the Planning Council must be individuals who are not state employees or providers of mental health services.

When I arrived at the first meeting at the end of April, I was greeted at the door by a Department of Mental Health (DMH) staffer who handed me a preprinted, tent card with my name. Printed beneath my name were the words "Individuals in Recovery." I felt like I had been punched in the stomach. I could actually feel myself struggling to breathe. I glanced around the room. On the tent cards of other planning council members were words such as "Parent," "Family," "DMH," and "Advocate."

When the meeting began, each member of the planning council was asked to introduce him, her or their selves. I was distracted both by my anger, and by the fact that I did not understand why I was so angry. Was I embarrassed or ashamed of being labeled a person with a mental illness? Was it the use of the plural "individuals" rather than "individual"? Was I offended by the presumption that I was "in recovery," rather than "recovered"? Did it make me feel unequal to other planning council members? While other members were designated by the work they do or a role they assumed, for example, DMH, parent, family or advocate, the label given to me seemed to describe who someone thought I was.

When it came time to introduce myself, all I could do was to say that I was angered by the "Individuals in Recovery" label, that I didn't consider myself an "Individuals in Recovery," and if that was the role that I was to play on the Planning Council, then I was probably not an appropriate Planning Council member.

A DMH staffer explained that she had created the labels so that attendees could see the categories that were represented on the Council. While the explanation addressed why she chose to use labels, it didn't address why she chose the particular words "Individuals in Recovery" to describe me. Her explanation did, however, reveal that she was using the term "Individuals in Recovery" as synonymous with "adults with serious mental illnesses who are receiving or have received mental health services," which struck me as a perfect example of the cooptation of the Recovery Movement. The Recovery Movement emphasizes the idea that people can recover from mental illnesses. The DMH staffer somehow interpreted this to mean that anyone who has been diagnosed with a serious mental illness is "in recovery," which essentially renders the phase meaningless.

Wilda White

The use of the phrase "Individuals in Recovery" also struck me as a perfect example of pitfalls of focusing our advocacy efforts on changing the language that people use to describe mental illness rather than focusing our efforts on confronting the underlying ideology that results in language that we find offensive. I do believe the DMH staffer had the best intentions when she elected to label me an "Individuals in Recovery." I'm sure she thought it was kinder and gentler than "adults with serious mental illnesses who are receiving or have received mental health services." However, the term "Individuals in Recovery" includes a set of ideologically-rooted beliefs about mental illness and social policy that are just as problematic to me as describing me as an adult with a serious mental illness who is or has received mental health services. At least the latter is, by definition, accurate. That is, I am a person who has been diagnosed with a serious mental illness for which I received mental health services. On the other hand, I do not consider myself "in recovery" or even "recovered." To me, recovery denotes a return or a regaining of something that once was. I will never regain what I lost during the psychotic manic episode I endured. I do however feel transformed by the experience and what I have managed to make of it. I actually feel that I've become more fully human through working through the experience of mania and psychosis.

And that helps me understand why I was so angered by the label "Individuals in Recovery." First, it's a label. As a person marginalized and oppressed in this society based on my race, sex, sexual orientation, and psychiatric history, I don't wish to be labeled by the dominant culture based on that marginalization and oppression. I think I would have been similarly angry had the name card referred to my sex, race or sexual orientation. Second, the label purports to describe me in a way that is inconsistent with how I view myself. It was presumptuous on the part of the DMH staffer to label me as "in recovery." She knows nothing about where I am in my personal journey. Third, the phrase is objectifying. While my lived experience with mania and psychosis qualifies me to sit on the Council, I'm a whole person with a myriad of skills and experiences, all of which I draw on in the advocacy work that I do. The "Individuals in Recovery" label made me feel as small and insignificant as a speck of dust.

I ultimately decided to resign from the Planning Council. It felt like a necessary act of self-love and political action.

Op-Ed Page

Letters

Medical Records Can Label and Discriminate

To the Editor:

I had a chance today to dive into the article on confidentiality [of medical records] in the winter *Counterpoint*. I am so glad that I did.

This is so important to me. My brother died of an undiagnosed brain tumor because his condition was overlooked as merely psychological ("not real") symptoms of his mental health condition, excruciating migraines inducing vomiting and blurred vision and stumbling — all of which got passed over by his primary care for whatever the reason... we have never found out.

He had been self-treating for a bipolar disorder for years. But he succumbed, undiagnosed, to a physical condition for many of the same reasons that are highlighted in this article: The stigma, the ambiguity, the lack of communication, the fear of incrimination, backlash, etc., and the lack of understanding around shared information.

I really appreciate the light that you are helping to shine on this.

NAME WITHHELD

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To the Editor:

Who else dislikes electronic medical records? From my experience, it is not information-sharing so much as it is discriminatory.

When I went to the emergency room for a bad case of the flu, they did nothing for me, nada. I think people who want so badly to "label" everyone ought to watch out that those same labels don't get stuck to them. But I have been against electronic medical records from the very beginning. When I work with clients, it is with a tabula rasa, blank slate... I relate that the person is the expert on themselves, and I don't even get into diagnostics, even though I know them.

Electronic Medical Records (EMR's) color the picture of treatment against the client/patient, especially if that client has a diagnostic record of mental health conditions.

For example, if the patient had previously been involuntary, or restrained or secluded, that would be in the EMR. If that is the case, the patient is ten times more likely to be involuntarily hospitalized again.

Another issue with EMRs is that the information may not necessarily be true; it may be open to interpretation, or simply a wrong diagnosis. They can be a hazard to people with mental health histories.

I had an acquaintance who went to the hospital for a hip issue and then, against his will, became involuntarily hospitalized in a psychiatric unit. This was absolutely terrifying for him. This man ended up killing himself, very tragically. He had been a well-known mental health advocate, and graduate of Middlebury College, like me. So situations like the former are scary for me as well.

Recently I went to the hospital for flu symptoms. In my heart I was terrified that they would keep me there for psych reasons, even though I had zero psych symptoms at the time. But because of the EMR, it would be very easy for medical staff to say, "Ah well, this patient has a history of involuntary hospitalizations and the use of restraints."

Needless to say, I did not receive any treatment whatsoever for my flu. Was this bias against me because of a history with hospitals? Hopefully you see my point.

Heidi Henkel has great suggestions for how clients and the medical community could deal with the situation of information-sharing:

"People should be able to create their own on-hand emergency records to be referred to in the event of an emergency, for example, getting hit by a truck and being close to bleeding to death and being unconscious.

"There are some things I would want medical staff to know, such as that I had a deep vein thrombosis in the past and had an allergic reaction to penicillin in the past. I think this should be able to be done with an add-on to the advance directive and then put into a computer system for anyone to pull up anywhere, along with the advance directive.

"That would be a way to bypass EMRs in favor of what the patient wants doctors to know in an emergency. Perhaps primary care doctors could help patients decide what to prioritize to put on it."

MARLA SIMPSON, M.A.
Randolph

Simpson credits Heidi Henkel for contributing to this letter.

Poll Supports Greater Degree of Confidentiality

RUTLAND — Twelve people responded to the winter *Counterpoint* phone poll, and all 12 answered "yes" to the question, "Do mental health records need more privacy than other medical records?"

Five added comments about their concerns.

"You're going to have people who may or may not have a diagnosis or have had a psychiatric incident, whenever they go to the hospital, be treated as if their problems are all in their head, or they're drug seeking, or whatever [as a] knee jerk reaction," one caller said. "Until you can get rid of stigma and there's fair treatment of everybody all the time," mental health records need a greater level of confidentiality.

She gave the example of a person's trauma history, saying that "the electronic health record is challenging in that somebody's trauma history may end up in the hands of somebody that they don't want to share that with."

The poll related to an article in *Counterpoint* discussing the push within the health care field to treat medical records in the same way, whether or not they include a mental health history.The new poll for this edition, below, asks about whether the term "behavioral health" is offensive for persons with mental health or substance use diagnoses.

Counterpoint Telephone Poll

New Issue: Labels Used About Us

Question: Do You Object to Use of the Term Behavioral Health?

Vote by calling 888-507-0721 (Toll Free call)

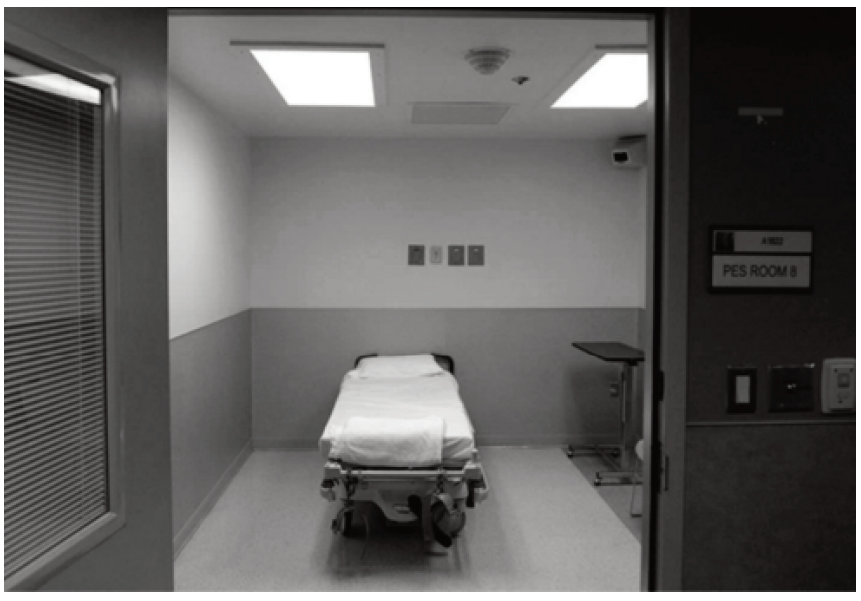
To vote "Yes"
Dial Extension 12

To Vote "No"
Dial Extension 13

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

Commentary

The Helping Room



by Steven Morgan

Every culture has its share of individuals who break down in bewilderment. People who hallucinate, behave beyond norms, seek to die, think in strange ways. Called many things — witches, patients, healers — we are met with as many responses, each reflecting how our culture understands help. The photograph above was taken in a Denver psychiatric hospital in 2016.

Look closely: this is what help in the U.S. looks like today.

On a surface level, a clinical level, I see a rollaway bed with leather belts dangling. Belts that strap people down to be hauled without contest. I see an impenetrable camera lurking in the corner. Instead of first and last names, I see numbers and acronyms coding the room's function. Fluorescent light drops evenly so nothing hides in shadow; I see brown and beige and dark grey cooling an empty box. Order reigns.

What I notice most, however, is not the presence of severe state technology — a scene akin to capital punishment — but the absence of the most essential ingredient for anyone's sanity: love. It is impossible to love in this room.

By love, I do not mean an *everything goes love* that lacks discernment, nor do I mean a mutated *tough love* that absolves punishment. I mean a deliberate effort to be vulnerable with another person in an attempt to deeply bond.

Of course, love is not all we need, but the culturally-ordained, legalized intention of this room — to help people in high distress — is unachievable without it. Love is necessary for helping minds. Remove a chimpanzee from her tribe and lock her in a cage, a week later she's self-injuring (a trait never seen in the wild). We can forcibly tranquilize her until she's too sedated to do anything but obey, or we can bring her back to the tribe.

But entering a psychiatric hospital I am no longer part of an ecology. I am stripped of clothes and context, my stories reduced to sputters from a broken sprinkler. Lit and watched in perpetual spotlight, I am objectified, examined. The gulf between myself and the mental health workers trained to hold a distance — to oppose love, flames the searing disconnection that caused my crazy.

And for my bewilderment, I am not only exclusively liable, but punished, in this room where violence is state-sanctioned — a violence the United Nations Human Rights Council calls *torture*.

The most likely time anyone completes suicide is within two weeks of departing a psychiatric hospital.

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Look closely at the psychiatric nurse's note, to the right, about me: this is the language of help.

Blaming, scouring even, no mention here of the evaluator, just a collection of acrimonious terms illustrating my malfunction:

Guarded — Labile — Psychomotor Retarded — Guilty — Ideas of Reference — words to affirm expertise of mind and behavior. Evaluative rather than relational, this language of help creates a distance necessary for arguing my reality as sickening. No one wakes up and says to their friend, *I am feeling oppositional, grandiose, and intrusive today, with a self-deprecative and tangential thought process*. We could talk together about fear, hope, pain, joy, confusion, excitement: concepts that include me in the tribe, even connect. But the first step to abusing someone is otherizing them. Thank God I was *pushing limits* that day.

Steven Morgan

I have worked in places with helping rooms. I have been locked up next to them (though privileged to have never been in one). I am not Pollyannaish to the difficulty of loving strangers who flip out or present danger, so in our culture's vacuum of support, I can understand how this morally indefensible room intended for the least controllable of us makes logical sense.

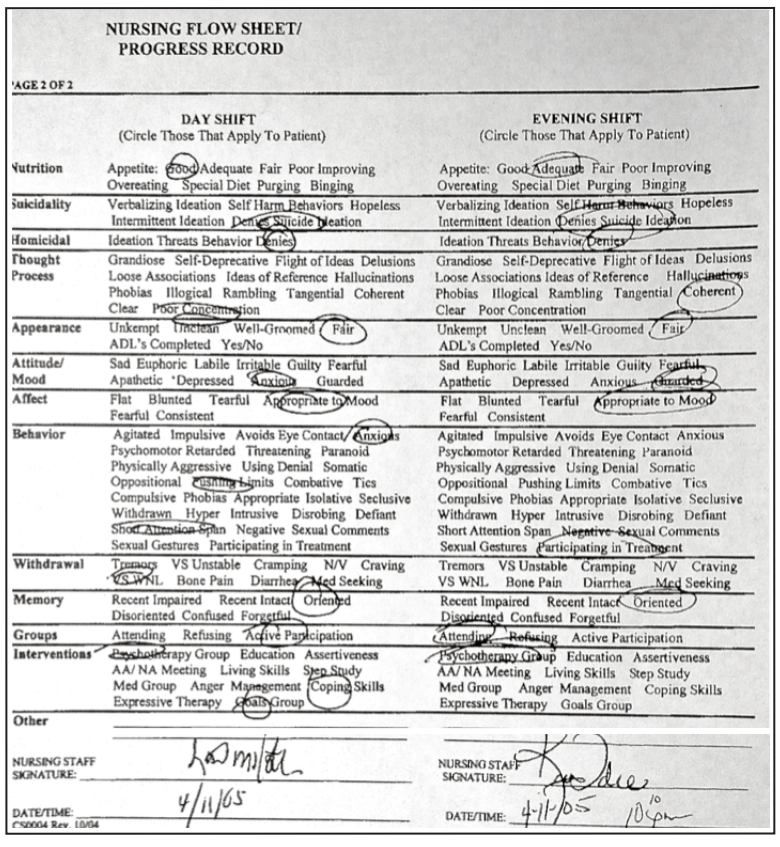
In the last hundred years, so did cramming ice picks in our eye sockets — which won its auteur a Nobel Prize, so did sterilizing us, so did institutionalizing us forever, so did electrocuting our brains against our will. All of these treatments were widespread, legal, celebrated, and considered modern scientific advances furiously defended by people with the highest education. They were committed in the spirit of *our own good*, and as such were unassailable by individuals who felt themselves harmed. Only when Life Magazine showed giant photos of these horrors to the American public did our culture begin to question whether it was helpful.

Today, many U.S. citizens do not see that same monstrosity in this room. For decades, pharmaceutical companies and their colluding psychiatrists have crammed megaphones with unsubstantiated messages that *mental illness is a brain disease* — and nothing else. As such, help now means manipulating the brain, the organ of ultimate prestige; a legitimizer for psychiatry, and the most profitable. And they've won.

Witness Abilify, a drug originally developed for psychosis, last year outselling every other medicine of any class in the United States. That's a lot of power, and it's increasing. Never mind that trauma you likely experienced before breaking down; a brain isn't manipulated on a couch but in a hospital, where doctors work, and who still, as always, know best.

So the Denver Post editorial board is not outraged to see this room — in fact, their op-ed (from which the first photo is taken) is titled *Congress is Painfully Close to Passing Mental Health Reform* — nor is the American public. Because a brain doesn't need love, it needs control.

And controllers. To be clear: helping rooms are the problem, not necessarily their employees. I have sat at tables where hospital workers and psychiatric survivors alike acknowledge them as traumatizing, sometimes for both sides. Many psychiatric hospital workers find their work miserable and exhausting, in part because they must act in unnatural, professional (code for *distant*), and sometimes violent ways towards people. But insofar as staff hold all the power in these rooms, we need them to revolt.



NURSING FLOW SHEET/
PROGRESS RECORD

PAGE 2 OF 2

	DAY SHIFT (Circle Those That Apply To Patient)	EVENING SHIFT (Circle Those That Apply To Patient)
Nutrition	Appetite: Good Adequate Fair Poor Improving Overeating Special Diet Purging Binging	Appetite: Good Adequate Fair Poor Improving Overeating Special Diet Purging Binging
Suicidality	Verbalizing Ideation Self Harm Behaviors Hopeless Intermittent Ideation Denies Suicide Ideation	Verbalizing Ideation Self Harm Behaviors Hopeless Intermittent Ideation Denies Suicide Ideation
Homicidal	Ideation Threats Behavior Denies	Ideation Threats Behavior Denies
Thought Process	Grandiose Self-Deprecative Flight of Ideas Delusions Loose Associations Ideas of Reference Hallucinations Phobias Illogical Rambling Tangential Coherent Clear Poor Concentration	Grandiose Self-Deprecative Flight of Ideas Delusions Loose Associations Ideas of Reference Hallucinations Phobias Illogical Rambling Tangential Coherent Clear Poor Concentration
Appearance	Unkempt Unclean Well-Groomed Fair ADL's Completed Yes/No	Unkempt Unclean Well-Groomed Fair ADL's Completed Yes/No
Attitude/ Mood	Sad Euphoric Labile Irritable Guilty Fearful Apathetic Depressed Anxious Guarded	Sad Euphoric Labile Irritable Guilty Fearful Apathetic Depressed Anxious Guarded
Affect	Flat Blunted Tearful Appropriate to Mood Fearful Consistent	Flat Blunted Tearful Appropriate to Mood Fearful Consistent
Behavior	Agitated Impulsive Avoids Eye Contact Anxious Psychomotor Retarded Threatening Paranoid Physically Aggressive Using Denial Somatic Oppositional Pushing Limits Combative Tics Compulsive Phobias Appropriate Isolative Seclusive Withdrawn Hyper Intrusive Disrobing Defiant Short Attention Span Negative Sexual Comments Sexual Gestures Participating in Treatment	Agitated Impulsive Avoids Eye Contact Anxious Psychomotor Retarded Threatening Paranoid Physically Aggressive Using Denial Somatic Oppositional Pushing Limits Combative Tics Compulsive Phobias Appropriate Isolative Seclusive Withdrawn Hyper Intrusive Disrobing Defiant Short Attention Span Negative Sexual Comments Sexual Gestures Participating in Treatment
Withdrawal	Tremors VS Unstable Cramping N/V Craving VS WNL Bone Pain Diarrhea Med Seeking	Tremors VS Unstable Cramping N/V Craving VS WNL Bone Pain Diarrhea Med Seeking
Memory	Recent Impaired Recent Intact Oriented Disoriented Confused Forgetful	Recent Impaired Recent Intact Oriented Disoriented Confused Forgetful
Groups	Attending Refusing Active Participation	Attending Refusing Active Participation
Interventions	Psychotherapy Group Education Assertiveness AA/ NA Meeting Living Skills Step Study Med Group Anger Management Coping Skills Expressive Therapy Goals Group	Psychotherapy Group Education Assertiveness AA/ NA Meeting Living Skills Step Study Med Group Anger Management Coping Skills Expressive Therapy Goals Group
Other		
NURSING STAFF SIGNATURE:		NURSING STAFF SIGNATURE:
DATE/TIME: 4/11/05		DATE/TIME: 4-11-05 10pm

CS0004 Rev. 10/04

Arguments for using state-sanctioned, legalized violence in this room often get tangled in details: *What other option did we have for this person at this moment?*

Which illustrates the question's redundancy. When you operate under a one-size-fits-all medical model funded with almost every dollar by the National Institute of Mental Health, there are no alternative routes in the mainstream to illustrate a better way (though they do exist outside the mainstream).

We said the same thing about lobotomy: *What other option?* Answers cost something. Money follows public outrage.

So while I do not believe critics of this room and creators of new ways can outrun the psychiatric and pharmaceutical mammoth controlling the narrative, cash flow, and legislation for our culture's understand-

(Continued on page 19)

Commentary

A World without Hospitals

by Calvin Moen

Since the state hospital in Waterbury closed in 2011 following Tropical Storm Irene, I'm told, the state has been in a crisis. Even with the new state hospital in Berlin with its 25 beds, I keep meeting people who have been held in emergency departments for days and weeks awaiting a bed on an inpatient unit.

Sometimes they give up waiting and ask to leave the emergency department, and sometimes they try to leave on their own. That's when emergency room doctors put them on "emergency evaluation" status, meaning they're now stuck in the ER, often with nothing to do and no one to talk to, sitting on a bed day after day with a security guard or police officer outside their door. ER staff don't have the training or capacity to offer the kind of care or attention they need, and whatever state they were in when they arrived continues to escalate and unravel.

I'm feeling all right today. But subject me to a strip search, put me in a mostly bare room where the lights are always on, and have someone in a uniform watch me while I sit there for days? Subject me to chemical and physical restraint if I get upset or try to go outside for fresh air? You wouldn't recognize me.

One answer to this debacle, I'm told, is to increase the number of psychiatric hospital beds. This would mean speedier transfers and shorter ER waits. It does sound like a simple solution, and it does address that immediate crisis.

The thing about a hospital bed is, once you build it you've got to fill it. You've now put your precious resources into expanding a system that provides short-term relief for some, compounded trauma for others, and then spits people back out into the same communities with the same lack of resources that existed before. Visiting the Brattleboro Retreat for the past two-and-a-half years, I have seen many of the same faces in and out that revolving door.

I see a similar pattern in this country with the prison system. Here in the US, we have the largest prison population in the world and the second-highest per-capita incarceration rate. About half of those released from prison will be re-incarcerated within three years.

Many are willing to assume the worst about repeat psychiatric patients and chronically incarcerated people: that some people are just ill, that some people are just criminals. That the best we can do is to keep "those people" hidden away from the rest of "us" and keep order and create safety. I'm trusting readers of this publication to know better.

Prison abolitionists invite us to imagine a world without prisons and pose the question, "What would we need in our communities to make prisons obsolete?" What if everyone's basic need for shelter, food, clothing, and connection were met? What if we had the skills and the space to address harmful behavior within communities, looking at the context for that behavior and restoring safety without torturing people by locking them in cages?

I propose that we look at the psychiatric system through that same lens, that we take a step back from this bed shortage crisis to look at the circumstances that lead to hospitalization, the supports that keep us out of hospitals.

And I'm in good company doing so.

For World Health Day in April of this year, a statement was released by Dainius Pūras, United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (quite a title). In this statement, Pūras critiqued traditional medical approaches to distress and suffering as ineffective, contrary to human rights, and contrary to evidence.

Pūras called for "a shift in investments in mental health, from focusing on 'chemical imbalances' to focusing on 'power imbalances' and inequalities" such as poverty, violence, and gender inequality. He advocates for psychosocial supports addressing education and poverty reduction and strengthening communities. In doing so, he draws on a large body of evidence that stable housing is a clear determinant of both physical and mental health and that unemployment and lack of affordable housing are correlated with psychiatric hospitalization.

In the Intentional Peer Support framework developed by Shery Mead, she talks about "crisis as opportunity." Faced with a crisis — a moment at which we realize that things can no longer remain as they are — we can choose any number of paths. Some of them might lead us to growth and possibility, and others might shut down autonomy and connection.

Over the past six months, I have gone in and out of a kind of personal crisis. Some days I was in so much emotional distress, I was desperate to feel different. A few times I considered the traditional mental health options available to me. I thought about asking my doctor to put me back on psych drugs. I wondered if I could bring myself to an emergency room, knowing what kind of experiences so many have had there.

But because I am part of a supportive, caring community, I knew I had other options. I organized a meeting of my closest friends, letting them know what was going on and what kinds of support I was looking for. They took turns spending time with me when I couldn't bear to be alone. And because I have a supportive employer and paid time off, I was able to take a couple of weeks away from work to attend to my self-care. And because I have a supportive primary care physician, I was encouraged to try natural supplements and alternative therapies that don't have the side effects or withdrawal symptoms of pharmaceuticals (and pretty similar success rates).

Calvin Moen

Not everybody has all these things. I want to live in a state — a world — where everybody who wants them has all these things and more: peer support, a living wage, secure housing, plenty of good food, health care with dignity, freedom from violence and coercion, and everything else we need to thrive — regardless of our (actual or perceived) gender, race, ability, sexuality, or belief systems.

When I was in my early 20s, I did go to the emergency room during a period of emotional and mental distress. I went at the urging of my primary care doctor, who believed my crisis required immediate medical intervention. I just wanted a safe place where I would be cared for until I could understand what was happening to me. I certainly did get meds, but I didn't get anything that felt like care or a framework for making sense of my pain.

Somehow we've gotten to a place where the mainstream response to mental health crisis is so narrow that anything else sounds radical. So, too, with this supposed psych bed shortage. The shortsighted response is to increase the capacity of a system that is failing to respond to our most basic needs. But we have an opportunity as a state to invest instead in community supports that build up our resiliency and connection to each other.

To those of you who have benefited from an inpatient stay, for whom psych hospitals have been life-saving and medication absolutely essential: I'm not trying to take away what you need and value. I am calling for a wider range of options and resources. I am inviting us all to imagine what it would take to co-create a world where we seldom, if ever, need to rely on locked doors and sealed windows, restraint and seclusion, and removal from our homes and communities to keep us safe.

Calvin Moen is the southern outreach worker and patient representative for Vermont Psychiatric Survivors and does grassroots organizing with the Hive Mutual Support Network in Brattleboro.

The Helping Room

(Continued from page 18)

ing of help, I do believe we are building a critical culture of resistance.

One ready to steer new ships should the public tide turn. And from that culture, my Hail Mary is another Life magazine exposé. A meme, a movie, a hashtag, an image that evokes the barbarism of this room to citizens who never know the bruise of leather straps with no reason to investigate psychiatric corruption.

Something so potent and outrageous that the American public does not care anymore about *What other option did we have for this person at this moment?*

They just see the horror and press Eject.

No More.

Like lobotomy, they say, *To hell with your Nobel Prize, this cannot stand* — and instead vote for love.

Steven Morgan is Operations Manager and a trainer for Intentional Peer Support. Over the past decade, he's worked various peer support roles in both traditional service agencies and peer-run settings. In Vermont, he was director of a peer-run community center, helped launch a peer-run respite house, and was project developer for Soteria-Vermont. He currently resides in Colorado. This article first appeared in Mad in America.

A PEER PRESENTATION

Hot Topix: Addiction

Greetings! My name is Greg, and this is but one of the presentations I've prepared for my peer-for-peer mental health education group 'Hot Topix'.

I sit on the CRT Advisory Board as a peer member, along with about seven or so other peers. Part of the duties of this position is producing and evaluating the yearly consumer satisfaction survey.

While going through this year's survey, I noticed that in the suggestions there were many requests for some type of mental health education group. This is where the idea for the group grabbed me.

Greg Burda

It didn't take me very long to get permission to get the group up and running, which utilizes the topics coming from those that attend, since it's a peer-for-peer group. The topic rules are simple; it needs to be related to mental health.

Topics include, but are not limited to, info about disorders, medications, alternative treatments, and/or something as valuable as what questions to ask your doc.

We meet in Bennington, at the CRT kitchen, on 316 Dewey St., Tuesdays from 1:30-2:30, although we usually run a little late. The reason for this is because of the in-depth healing conversations we have, that are brought up by the topic itself or by a comment from one of the members, or just something a member needs to vent about. If you're ever able to make our group, all are welcome, as well as friends, family, and caregivers.

When in the process of researching and composing a presentation, there are interesting tidbits of info I find. While we go around and read, that's when I reveal that info for clarification and so the members can take notes if desired. I find this leads to a more interesting and involved group.

For purposes of this article, I put some of that info at the bottom of this piece.The word "addiction" is derived from a Latin term for "enslaved by" or "bound to." Anyone who has struggled to overcome an addiction, or has tried to help someone else to do so understands why.

The 10 most common addictions are alcohol, tobacco, drugs, gambling, shopping, sex, food, video games, the internet and work.

Addiction is a condition that results when a person ingests a substance or engages in an activity that can be pleasurable, but the continued use/act becomes compulsive and interferes with ordinary life responsibilities, such as work, relationships, or health. Users may not be aware that their behavior is out of control and causing problems for themselves and others. This is a state of being enslaved to a habit or practice or to something that is psychologically or physically habit-forming, to the point where stopping said practice causes severe trauma or withdrawal.

Addiction exerts a long and powerful influence on the brain that manifests in three distinct ways: craving for the object of addiction, loss of control over its use, and continuing involvement with it despite adverse consequences.

Today we recognize addiction as a chronic disease that changes both brain structure and function. Just as cardiovascular disease damages the heart and diabetes impairs the pancreas, addiction hijacks the brain. This happens as the brain goes through a series of changes, beginning with recognition of pleasure and ending with a drive toward compulsive behavior.

The brain registers all pleasures in the same way, whether they originate with a psychoactive drug, a monetary reward, a sexual encounter, or a satisfying meal. In the brain, pleasure has a distinct signature: the release of the neurotransmitter dopamine. Dopamine release is so consistently tied with pleasure that neuroscientists refer to the nucleus accumbens region as the brain's pleasure center.

All drugs of abuse, from nicotine to heroin, cause a particularly powerful surge of dopamine. The likelihood that the use of a drug or participation in a rewarding activity will lead to addiction is directly linked to the speed with which it promotes Dopamine release, the intensity of that release, and the reliability of that release.

When it comes to alcohol and drugs, the individual will usually develop both a ***physical*** and a ***psychological*** addiction. The way this usually happens is that the person develops a psychological dependence first of all, and this drives them to keep using the drugs until they become physically addicted as well.

Other compulsive behaviors, like those related to gambling, food and sex for example, may also be expressions of addiction. Some research suggests that these types of "***behavioral*** addictions" involve similar changes in the brain and common risk factors and behaviors. They also show common responses to certain types of treatment. These findings suggest the possibility that addiction may be one disease with different forms or expressions.

Behavioral addiction is a form of addiction that involves a compulsion to perform a rewarding non-drug-related behavior repeatedly, sometimes called a natural reward, despite any negative consequences to the person's physical, mental, social, and/or financial well-being.

Scientists once believed that the experience of pleasure alone was enough to prompt people to continue seeking an addictive substance or activity. But more recent research suggests that the situation is more complicated. Dopamine not only contributes to the experience of pleasure, but also plays a role in learning and memory, two key elements in the transition from liking something to becoming addicted to it.

Addictive drugs provide a shortcut to the brain's reward system by flooding the nucleus accumbens with dopamine. The hippocampus lays down memories of this rapid sense of satisfaction, and the amygdala creates a conditioned response [trigger] to certain stimuli. This system has an important role in sustaining life because it links activities needed for human survival, such as eating and sex, with pleasure and reward.

If skipping your normal morning cup of coffee leaves you with a throbbing headache, you're likely familiar with the effects of withdrawal, the body's response when a frequently used drug is suddenly removed from the system. While unpleasant, such a headache is a result of the adjustments your body has made to compensate for caffeine's presence in your daily life.

The body makes these adjustments in an attempt to maintain stable internal conditions. Maintaining this stability, called homeostasis, is a bit like keeping a seesaw balanced when weights are constantly being added and removed.

Whether it's alcohol, opiates, or caffeine, all recreational drugs trigger the release of dopamine, which is what makes them so addictive. This is like adding extra weight on one side of the seesaw.

With long-term drug use, brain reward systems will slow down, returning the seesaw to its level position. However, when a drug user chooses an abrupt break from drug use instead of gradually decreasing consumption, the drug's stimulatory effects on the reward system are no longer present. As a result, the seesaw tips in the other direction, and activity in the brain's reward systems drops, resulting in an anti-drug low, which can include symptoms like depression and irritability.

It is not just the reward systems in the brain that are affected by drug withdrawal. For example, if heavily dependent alcohol drinkers stop drinking, they often face a range of cognitive and physical symptoms. Alcohol is a sedative drug that slows brain function. To compensate, many brain circuits increase the normal level of activity. Without alcohol present, these circuits become hyperactive, resulting in anxiety, hallucinations, seizures, and even death.

My Strange Addiction is an American documentary television series that focuses on people with unusual compulsive behaviors. These range from eating specific non-food items to ritualistic daily activities to bizarre personal fixations or beliefs.

Despite the title of the show, few of the show's subjects have what would medically be classified as true addiction, neither conventional (substance-related) nor behavioral. Rather, the cause of their behavior varies and may include a variety of psychiatric diagnoses.

Examples of disorders on the show are: obsessive-compulsive disorder, pica, schizophrenia, psychosis, Alzheimer's disease, exercise bulimia, trichotillomania, body dysmorphic disorder, dermatillomania, and object sexuality. Many of these addictions could be considered harmful. Video games can kill. People have been murdered because of the on-line games that many play against each other. There's been instances when one player wins or captures another's favorite weapon or such, rage can/does ensue, which leads to violence, and yes, even murder.

The psycho-scientists don't like the word 'withdrawal' used with psych meds, because withdrawal denotes addiction, and psych meds aren't supposed to be addictive. They prefer 'Discontinuation Symptoms' instead.. HUH, WTF??? Beware!! If it weren't for the Rubber Band, Lobsters would rule the world...

Greg Burda is from Bennington, and is a member of the Vermont Psychiatric Survivors Board of Directors.

Commentary

Food and Wellness: How I Made It Onto the Web

by SANDY SNYDER

WESTFIELD — A journey that began with writing an article for *Counterpoint* has led to having a bio of me posted on the website of Food Solutions New England.

In it, I talk about wanting to call attention to the need for real, whole food for human wellness, especially around the issue of autism. So much money is spent just sustaining people, rather than moving towards healing people!

It has been very rewarding for me to get peer support for my current approach to nutrition in this way, and I proudly call your attention to the site: http://foodsolutionsne.org/get-involved/stories-inspiration.

My involvement with the power of healthy and nutritious foods in healing people might never have happened except for *Counterpoint.*

I pick the paper up at a local coop, and about five years ago I noticed the editor, Anne Donahue, was looking for writers.

"Just my speed," I thought as the newspaper is published once every few months, which would let me have plenty of time to research my subject. Anne not only gave me an assignment, she sent me an excellent writer's guide that had been written by her father, a newspaper editor.

My assignment was to write about Alyssum, a new mental health facility in Rochester.

The state's mental health hospital in Waterbury had recently been flooded by Tropical Storm Irene and was now permanently closed. I just assumed my assignment was to write about a new state lock-up facility and I called to talk to the director, Gloria van den Berg, to get an interview, hopefully in person, at the new facility.

She was gracious and to my delight gave me the names of multiple people who had been at the facility and said they would be willing to talk to me. Several interviews would be in Rochester and two would take place in Burlington.

I was surprised when I reached Alyssum to discover a two-bedroom house that did not dispense drugs and used alternative approaches to the issues people were dealing with, such as suicide attempts, drug reactions, and depression.

The program had been years in the planning, with consistent leadership coming from Linda Corey of Vermont Psychiatric Survivors. It was by chance that it opened just as Waterbury closed its doors. I interviewed six people and I wrote articles on four of them. But beyond the stories these people shared about how great the emotional support there was, I discovered that Alyssum had another exciting feature... its food!

They grew their own and stored bulk foods in the basement. High-quality fixin's were always in the refrigerator for anyone who wished to eat or simply snack. Yet their actual food cost was much lower than other facilities of the same size.

I had been considering updating my nutrition credentials to round out my professional skills as a home economist for years, and this inspired me.

So I bought a couple of college text books that presented nutrition at the Master's level and began to read, as I have found knowing a little about a subject in advance is very helpful if I decide to attend a class.

Then something very significant happened. A family came to me and asked if I would help them with their food choices. They ate very differently than I did, and what I chose to eat did not have great appeal to them. But the part of the contact with them that affected me the most was seeing their lovely young daughter, who wanted to control her weight, eat a lettuce salad for lunch. I knew lettuce has a low total amount of nutrients, but I did not have the specific information I needed to explain this to the family in a way that they could understand why this socially acceptable way of eating was health-negative.

So I have taken a multidisciplinary approach to learning more. (I have lived a nontraditional lifestyle for years.)

I studied alternative approaches to soil management.

I read Robert Whitaker's *Anatomy of an Epidemic* and Mark Kurlansky's *Salt.*

I took a class at the local Community College on basic nutrition. (I downloaded the online text and all recommended reading. By the end of the class I had 20 pounds of literature.)

I went to a presentation by NAMI on mental health. I consulted with a nutritionist.

I took a 21-day Master's level educational tour of the state of Vermont with the Higher Education Food Consortium (Vermont Food Systems Summer Study Tour 2015). That included visits to seven colleges in 21 days (all around food, with soil as a focus).

I've learned that after many years of research there is information now on some good and positive food guidelines out there, especially for individuals with autism. Some foods are more nourishing than others, and some are recognized health problems.

We need a home where families with members with autism can come to spend a couple of weeks and cook each of their meals with supervision around their personal food choices.

Contact me at s.snyderwestfield@gmail.com with your ideas and or needs around this issue.

Sandy Snyder is from Westfield

Discrimination Against DA Program Clients

To the Editor:

Vermont has begun to restrict services available to Medicaid recipients based on client status.

I am a client in the Community Support Program (CSP) in Chittenden County. It's a place where I have been accepted and supported wherever my journey has taken me since moving to Vermont fourteen years ago. It is also where I contribute back through work, even on some hard days.

Every now and then I need a "plug me in." I have found that attending partial hospitalization program (PHP) helped me gain a skill and routine recharge. Attending PHP had been something that helped me to integrate out of my regular system into a more intense system where different people from all areas of life came together as a mode of serious, structured self care.

There is an unrealized benefit of attending a program with people whose struggles come in from a variety of lives, that is also away from my regular routine. In the two to four weeks there, a light within happens that is an indescribable experience of somewhat saving oneself, reevaluating life, and remembering how to be in charge again. It's an odd combination but one that works for me, one I have been able to access the past twenty years until just this season at age 44, due to budget cuts in the mental health system of care. My CSP client status now prevents me from being able to utilize a partial hospitalization program going forward.

This feels incredibly disempowering. I consider option of attending a PHP, for me, one of the least restrictive means, meaning that this sort of plug me in has a long lasting effects. One coping card from the last time I was in the PHP three years ago left me with a tool of keeping option to take a leave of absence from work to do self care and attend a PHP should I need to.

Even with my frustration, I recognize that the mental health system is a place I choose to reside. It is where the support that I benefit from, in continuity and continually learning to accept the differences I face in myself, some days more than I like.

This feels both stigmatizing and discriminatory because of a status and classification I am in my life, due to my psychiatric disability, my choice of services, coinciding with my federal and state health insurance status.

Perhaps, should I feel the need to attend PHP and want to take that step, there will be a creative way to work with my providers to have it funded regardless of the weight of this current barrier. Yet, it just feels very wrong at this point in my healing journey to have such roadblocks up to a treatment that is empirically based intervention that has been proven beneficial for me.

At the same time, in my work, I feel tongue twisted to not be able to tell others about such resource that helped me on my way because, what is now not available to me, is now no longer available to my peers in CSP either.

Why does this move away from "all ranges of services shall be available to individuals who need them, regardless of individuals' ability to pay." Is the system moving to cut services in order to use limited resources for service provider pay increases instead? As an employee in the mental health system, I do look forward to future pay increases, yet I wonder at what other service cuts?

MELANIE JANNERY
Burlington

Have an Issue To Discuss with Other Survivors?

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 or commentary. Please identify your town. **Letters or commentaries do not represent the opinion of the publisher, and may be edited for length or content.**

Arts

Louise Wahl Writing Contest

Tied, FIRST PLACE, Poetry

Broken

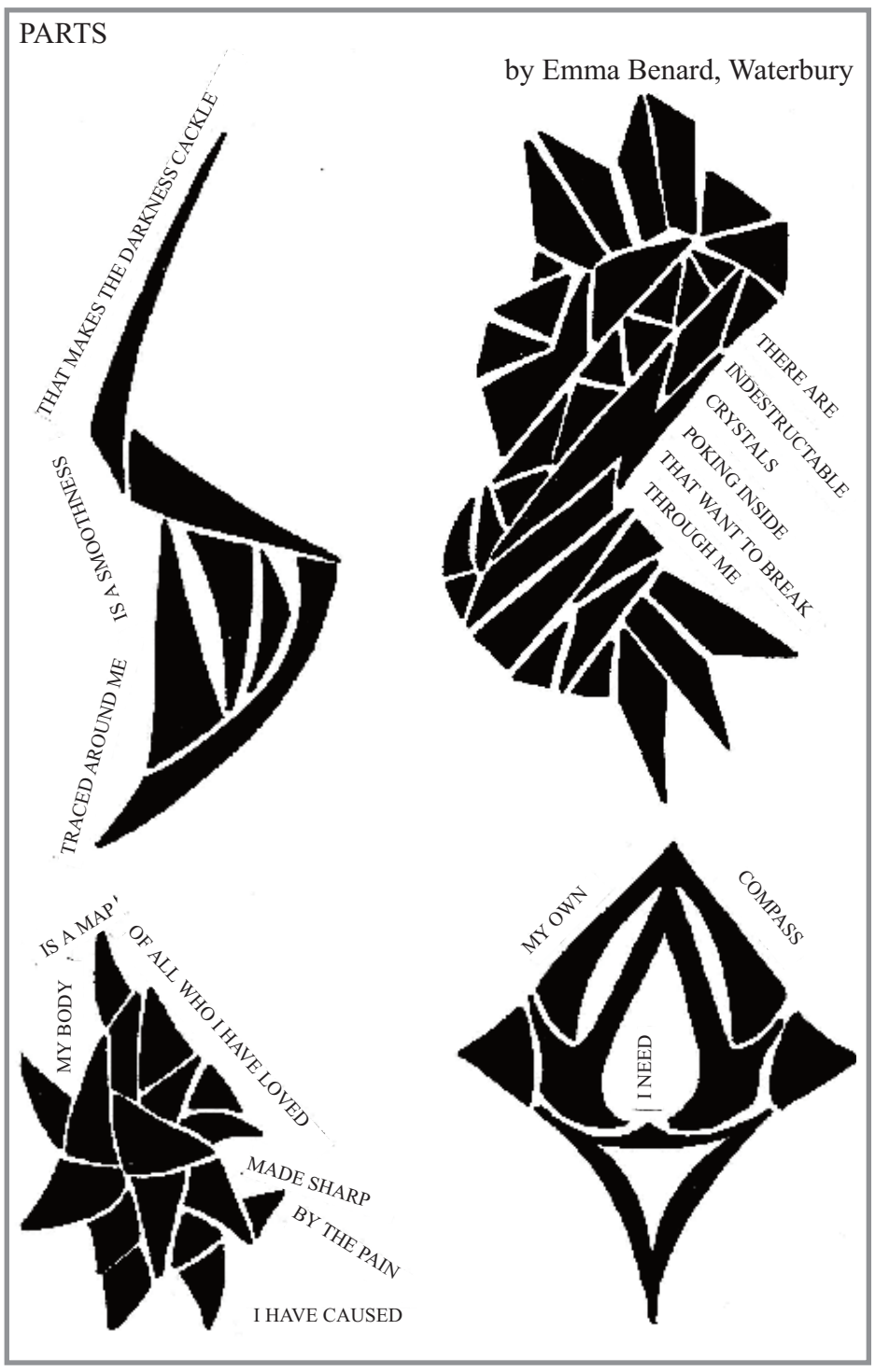
Tears fall from hazel eyes
onto a cold, stone floor.
Nowhere to go.
Nowhere to run.
No more can she hide.
She's alone, tired and broken.
A tortured soul she bears.
Life just doesn't seem to get better.

Where are the people who said
they would always be by her side?
Just as broken as her heart are
those promises tossed aside.
Even in her dreams
she cannot escape her pain.
She cannot escape her long-awaited
fate.
Of a life full of emptiness.
A heart full of hate.
She was only a mistake.

How do you take such pain and tragedy
and make it all ok?
How do you shake the nagging feeling
that you are an
unfinished masterpiece?
Hurried thoughts of suicide flutter
through her mind and the
Angels sing of glories and hallelujahs
that she will never find.
Tears are shed inside,
never to be shown.
These are the demons that
she must fight with on her own.

by Anna Bernier
Newport

SECOND PLACE, Poetry



THIRD PLACE, Poetry

Lies our Minds Tell

It starts with the internal screams
That fall from the beat of your chest
They dissipate beneath you, collapsing your rhythmic breath

The panic in your mind
Has become a recurring song
It built a path from self-doubt to self-hatred
The bridge, composed memories of everything you've done wrong

Your fear has become a distinctive shadow beside you
Weaving itself in unison with everything you do
It fools you by offering to intertwine with your pulsating fingers
Whispering the words, "I'll keep you safe"
And the manipulation lingers

You become a melancholy and narrow minded self-critic
Your own judgment turns on you, overpowering and parasitic
To pause the chaotic world around you and be present is all that you seek
You wish to release these antagonizing thoughts, to no longer feel weak

by Morgan Spurr, South Burlington

FIRST PLACE, Prose

Dead River Cafe

by JOHN FRANCIS MCGILL

In the not too brief eight months I lived up there in the port town of Marquette I would always go following the depressing winter nights, to the cafe.

No matter what the temperature was, and usually in the gloom of a large block of grey sky above, I would trudge down the hill on Fourth Street, the curbside snow banks up to my shoulders, and pass the golden-domed sandstone courthouse that Jimmy Stewart once argued for temporary insanity in, listening to the pitch of the wind.

But when getting to The Dead River Cafe, closer to the Superior shore, I was sure to be met with warm company. I'd usually go to the single table next to the shelf of cards and board games, and watch Dylan behind the wood counter roast the pale green Arabica coffee beans.

Soon as a brim of light appears he'd ready the beans delicately into the metal tub beneath his feet, and watch the paleness of the beans char. Then the regulars file in, one by one, giving Dylan notes on how they experienced the new waking day.

They'd always have insight, and a dynamite Yooper accent, describing the northern wind and the road conditions out on 41. I never really spoke to the other regulars at the cafe, but we recognized one another coming through the door.

Saturday mornings were the cafe's lifeblood. Dylan would be doing his roasting thing, usually with some music on, there'd be a highschooler manning the register for the to-go customers, and a group of men would be hunched around the center table, pitcher of coffee in the middle, entwined in a multi generational, Upper Peninsula conversation, that usually involved fishing.

I'd be there and just stare out the front window onto Baraga. There was a parking lot across the street, with a lot of trucks, but ahead at the top of the horizon I'd take in the three-story brick building.

This was quite the site of endurance; the people who had built these structures, that is. Sometimes, when I'd be in a bad place, I'd think about how doomed all this shelter is, how merciless the Lake can be.

But The Dead River Cafe was a small and cozy place. Usually, when I could get out of bed, I'd bring my notebook to the cafe, open up to a blank page, and watch the steam rise from my mug before nibbling on a butter croissant. Refills were just a quarter.

I wouldn't get much done at Dead River Cafe, but being there felt right, and it would feel nice when Dylan took a few minutes to stop by my table to tell me what music he was working on, and I what poem. The place was quirky enough to inspire.

It's said the Beats took residence at the cafe for some time and even painted Kiko, the owner, a mandala that hung in the bathroom in the back behind the curtain.

Progress was being made at Dead River, I always felt it, even if I didn't know.

———

John Francis McGill is from Vergennes.

Winners!

The 2017 Louise Wahl Memorial Writing Contest

Prose

First Place — $75

Dead River Cafe

John Francis McGill, Vergennes

Second Place — $50

Long Live the King

Joe DiMinico, Granville

Poetry

Tied, First Place — $25 each

Fight Demons, Anna Bermier Newport

Broken, Cheryl George, Rutland

Second Place — $15

Parts, Emma Benard, Waterbury

Third Place — $10

Lies Our Minds Tell, Morgan Spurr, South Burlington

Named for a former Vermont activist to encourage creative writing by psychiatric survivors, mental health consumers and peers. One entry per category (prose or poetry); 3,000-word preferred maximum. Repeat entrants limited to two First Place awards. Entries are judged by an independent panel. 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.

2018 Contest Deadline March 15, 2018

SECOND PLACE, Prose

Long Live the King

by JOE DiMINICO

He wiped his greasy hands through his greasy hair. He reached the left one down and aimlessly scratched his wrinkled, aged, pot-bellied midsection. Then he wheeled himself out from under the car and, laboriously, stood up.

"Well...," he started, before noticing that glint in the eyes of his customer. That glint had gotten a lot less frequent as he'd aged, as he'd put weight back on, as he'd gotten grimier, as his hair had gotten whiter, as his sagging jowls had gotten more pronounced. But here it was again.

He tried to ignore it and continued "...it looks like she can be fixed. Parts won't be the biggest cost on this one, though. See, it looks like I'm gonna have ta get inside the gas tank to look at that sensor. Now, that ain't such a big part, but it is a big job. The computer says everything with the gauges checks out, an' everything looks alright under there, so its gotta be the sensor in the tank. Now..."

That gleam, that glimmer, that glint was still there...

"...now it can be done, but it's one helluva job. Might have to actually pull the tank out of the car. Which seems like far too much trouble than it's worth. Gotta tell ya, actually, replacing the whole gas tank is too expensive parts-wise, and replacing the sensor, if I even could on this model, is just plain silly labor-wise..."

He had started to miss that gleam, that glint, that glimmer. He had actually started to miss it. It was easy to miss. Sudden oohs and aaahs and heys and demands for autographs, those, those he could do without.

That sparkle in the pupils, however...it was why he got into the business to begin with. But there were so many impersonators and imposters and Las Vegas and Reno sideshows and sideburn sporting, lip-curling wannabes floating around that eventually, people just kept that glimmer in their eyes, that small spark of recognition.

Once, he had cut his hair clean off and shaved himself cueball, just to see it in the mirror, just to try and get that glint out of his own eyes. Then, as his head had grown back, he let his face grow out, he'd let a mustache form as well as the sideburns, into a full beard. But these days... these days, in his age, wizened, he'd let it go back to just those big, almost mutton-chop sideburns, silver and grey, and somehow, he hadn't known how, but somehow, he'd let his hair grow a bit longer than he'd been keeping it.

He guessed that just now, it was his hair that had given him away. Hair, eyes, and sideburns... and the ears. You combine those attributes with the small, almost always ignored ears on his head, it made a distinctive impression. No doubt about it...he'd gone so long trying to hide from himself that he'd almost forgotten he was hiding from everyone else too.

So many imitators, so many lookalikes you'd think the original would somehow, eventually start to look like its own carbon copy. But not today. Maybe, just maybe, the customer didn't entirely get it themselves. Maybe, just maybe, this one customer only recognized him a little bit, and couldn't place it. Maybe he'd been lucky. A lot of people had passed by him in the last 25 years with that glint in their eyes, but denial had saved him. That one thought in their minds of naw, couldn't be, that one spark of denial of Reality, was all he'd ever needed to snake by. But this one had caught him by surprise...

"So, what, do you, um, recommend, then?" His customer was looking straight at him. The glint was still in her eyes. She was a bit young to have ever seen him, personally. A bit young to have ever seen him, back in the day. Five and a half feet tall, dirty blonde hair – dirty in color, clean in style – carefully clipped just below the shoulders, a simple pink t-shirt hugging a young bosom and jeans hugging hips that were years away from bearing children. But that glint was still there.

He answered her question: "Well, what does the tank hold, on this model? You know?"

"No sir."

"I think we can solve this problem for ya. It ain't nuthin' but a simple bit o' math..." He'd let himself slip, again. Years of cigarettes and whiskey, cigars and bourbon, had stained his voice in ways he'd never expected. It growled, it grated, it rumbled, it hummed like so many automobiles he'd worked on over the years in this quiet college town. It certainly wasn't the voice of his youth, but, then, you could never hide music like that.

Music had slipped into his speech, and he was sure his old accent, covered by so many years of California shine and, before that, Yankee winters in New England, had poked through. His own throat hadn't twanged like Tennessee in years. But somehow the rhythm of his last phrase had brought out the music of a subtle drawl. He knew it had, because that glint wasn't going away.

On the contrary, her eyes had widened considerably. She almost stammered out the words "Could you repeat that?"

"Well, it's really just some math. See, what you need to do is get yourself three jugs that hold 5 gallons apiece, fill 'em up, and keep 'em in the back of your car here, in the trunk. Then, just drive 'er dry."

"Dry?" Her eyes were still wide.

Who would believe her, he mused, she still doesn't even believe it herself. "Yep. Just drive her until she's totally out of gas, fumes and all. Then, you'll know she's on empty. Won't matter what the gauge tells ya, you'll know. Then fill her up, right there, on the side of the road, wherever you run out. It might be a shade embarrassing, but then you'll know what 'full' is."

"And...how would that help?" her eyes weren't wide anymore but the glint of recognition was still there...

"Well, then ya just set your trip meter to 0. See, this model gets about, what, 26 to the gallon, 20 in the city, right?"

She just nodded.

"Well, easy enough to know how much gas won't fit. So you fill the tank up, set her to 0, run her dry, fill on the side of the road, and measure what you've got left. Probably between a gallon and a gallon and a half. So if you've got...say, are you following this?"

"Just because I'm a college girl doesn't mean I'm stupid."

(Continued on page 25)

Tied, FIRST PLACE, Poetry

Broken

In broken pieces you fell
upon my soul
Two broken pieces that would
make each other whole

Once wandering alone
in a world of sin
Now we have each other
a new life can begin

Like the phoenix we rise
from the ash and dust
Into the sky, toward the sun
separate beings exist as one

No more doldrums
no more tears to cry
It's just you and I now
let's fly, fly, fly

But let us not get too close
because the sun, it burns
Be humble always and let
us learn

In broken pieces you fell upon
my soul, though the circle is complete
Now, we have made each other whole

by Cheryl George, Rutland

Arts

Louise Wahl Writing Contest

Long Live the King

(Continued from page 24)

"Just because you're a college girl doesn't mean you're numerate, either. Are ya followin' this?"

She nodded.

"Good. So let's say your tank holds 13 gallons. That's roughly 325 miles. So, whenever your trip meter hits 325, fill 'er up! Then nuthin' needs fixin' 'cept pressing the button whenever you fill 'er up. And if she only holds 12 gallons, figure 300 miles even. But first, before running her bone dry, I'd fill her up all the way, and set it to 0. That way, you'd know exactly how far that tank got you."

She'd been wondering what was so familiar about this old, rusty, crusty, kinda creepy car mechanic, anyway. He almost looked like he could have been handsome once, when he was young. He looked like a fat, wrinkled, old version of some icon or something. Maybe an old movie star, or some black and white image. Somehow, he looked familiar, like a Warhol portrait come to life.

It was the eyes that gave him away... that, and the hair, she mused. He probably didn't even know what running his hands through it had done, but it almost looked like that haircut her grandfather used to call a "D.A." for some reason. And those sideburns! Right out of the mid 70s. As if they were meant to go with a jumpsuit or something. She kept pondering while responding:

"So, what you're telling me, is that I don't have to fix it? I mean, I'll never know how much gas I have left?"

"Well, it seems like the only problem with that is runnin' out. So, if you know when you'll run out, say, if the tank goes from full to dry after 300 miles, then never let the trip meter top 280 or so. But you'll still have to fill 'er up whenever you get gas. It doesn't matter what the gauge says if you know you can't pump any more in. In any case, you're gonna need to know how much gas you've got, and how many miles you can drive her, whenever you set this trip meter back to 0..."

She drifted off. He just seemed so familiar. Old, but familiar. Like Burt Reynolds, or William Shatner. Finally, she just blurted out, interrupting "Hey, don't I know you from somewhere?"

This stunned him. Briefly. "Well, you've never been in before, and I don't recognize you, so ah doubt you'd be recognizin' me."

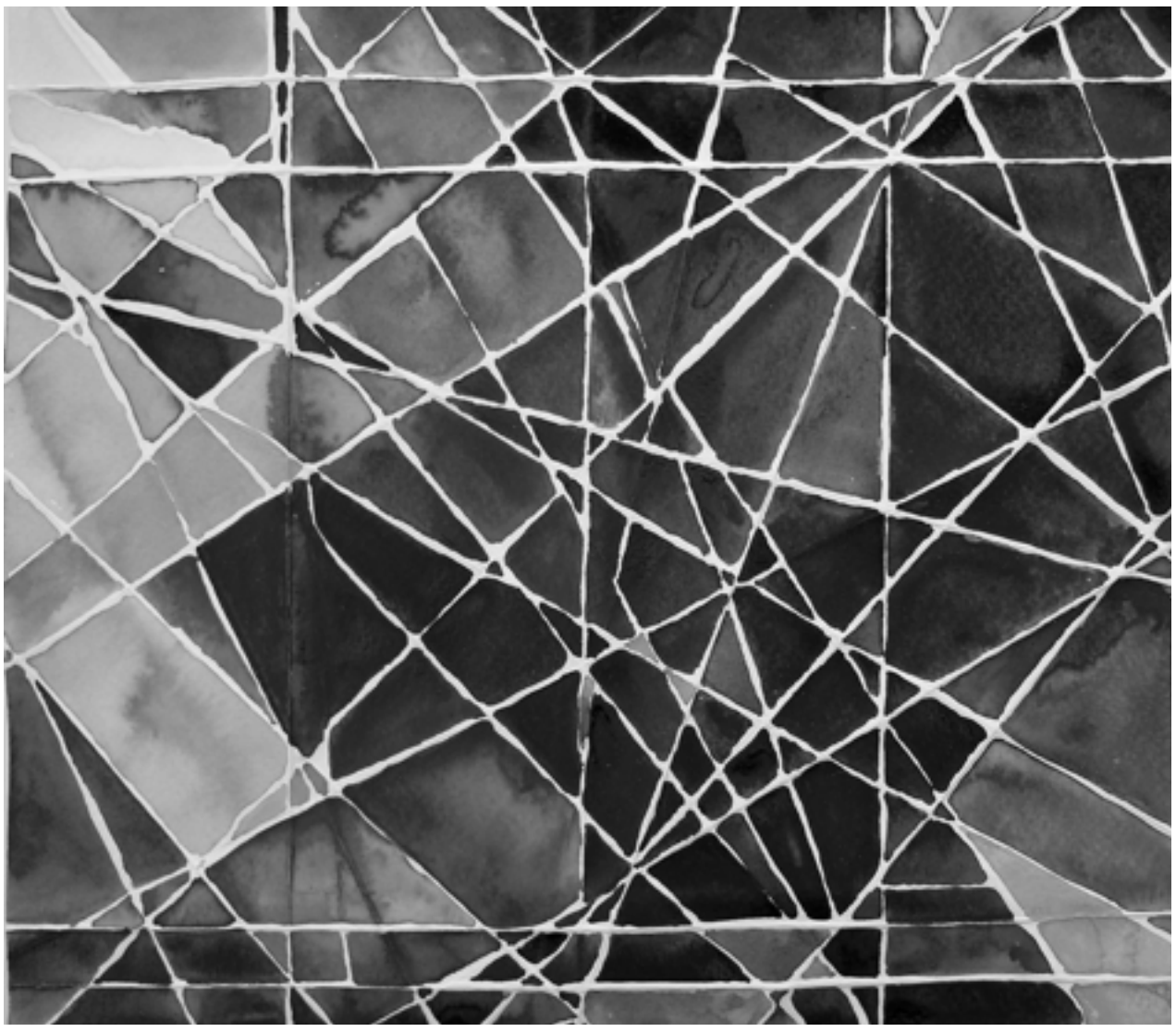
"You just seem...familiar."

"I must have one of those faces." He was almost nervous. Could he finally be caught after all this time? Impossible. No one would believe her. It would be just another tabloid hoax. Most everyone knew he was dead, anyway.

"It's not just that. It's your voice. Sometimes a southern drawl slips through just so...so you sound like someone my father used to play in the car on roadtrips. And your hair... looks almost like a haircut from the fifties, with that big lip out front..."

"Miss, I just fix cars. That's all I been doin' for almost two decades in this town, and everyone knows it."

"You still seem familiar."



Mosaic

Caroline Tavelli-Abar, Rochester

"I am grateful for this week's conversation about mental health [by the Counterpoint *news editor] on Vermont Public Radio. It is making a huge difference for my husband and I. This past fall* Counterpoint *was brought to my attention while I was staying at the psychiatric hospital. I remembered there was a request for art work. Here is an image I made during my first hospital stay in 2011. Creating art work is a tremendous catalyst in helping me heal and many images I make while in the hospital lead to other bodies of work when I leave... The images bring me tremendous hope. They are at times the only words I have to connect with others."*

"You seem young. But, back to your car: you don't have to get her fixed. Might be a bit inconvenient to only fill the tank up, but that's the best way to go about this problem right now. 'Course, a problem like this won't help your resale value much."

She was silent.

His eyebrows twitched, almost uncontrollably.

She knew. Maybe not exactly who he was, but she knew he was somebody. Then, he started, to wonder, what did it matter, really, who would believe her, who would know? It had been so long since anyone had noticed him for anything other than a hack impersonator... and maybe that's all she was thinking right now. Maybe that was enough.

He did miss it, after all. He missed the fans, the people. But what he had missed then was being a person. Back in the day, he could never just be a person. He couldn't really just talk about baseball, or go to the grocery store. He couldn't really relax. He couldn't unwind.

After a while, back in the day, the persona had started to strangle his sanity away from his soul. There was no real blending into a crowd. There was no real time to just walk down the street. When he first showed up in this small town, his nose healing from a barfight break, even stubble all over his head and down the beard line of his face, people had just taken it for granted that he was another drifter, tired and ready to put down some roots.

He'd managed to get odd jobs around the station, paying just enough to cover the cost of crashing at the local campsite. Over time, they let him do some oil changes and tune-ups, just from being short of the labor that knew how; then, after some more time, they trusted him enough, had found him reliable enough, to give him real hours but keep him off the official payroll. They knew he drank cheap booze by the gallon and smoked cigarettes by the pack, but he never showed up too hung over to work and he never lit up near anything flammable.

Eventually, they'd taken it for granted that he worked hard, played hard, knew cars, and kept to himself. He'd managed to get a life back, a life of near anonymity, a life where he could just be an ordinary, everyday asshole rather than a rich and famous one. As his thoughts trailed off, he heard her say,

"You do good work here. I mean, you're telling me how to save money on repairs. The dealership told me it would cost $2,500 to fix it, and... well, I mean, you're just more honest than, you're just well, thank you, for not — most mechanics just try to squeeze money, I mean, that's a nice solution to the problem."

Then he thought What the Hell and cracked a grin, a wry grin, a sly grin, a mischievous Dionysian stretch of lips with impish delight; years drizzled off his face, and he let the young man, curled in the swallows of his hallowed secret, amble forth with such fervor his voice almost cracked with adolescent glee, with the sensation of diamond lightning and silver thunder melting butter, he heard himself say:

"Thank you, thank you very much."

———

Joe DiMinico is from Granville.

Arts

Clara Martin Center Show

Untitled, acrylic painting
by Rose Richmond

CELEBRATING ART — As part of its 50th anniversary celebration, the Clara Martin Center in Randolph hosted an art show at the Chandler Music Hall this past winter, along with a concert featuring the Me2 Orchestra. The show was titled "Celebrating Creativity in Mental Health, Wellness and Recovery." Clara Martin is the community mental health agency for Orange County.

Untitled, pen and ink drawing
by Chris Sawyer

Stitching Himself Back Together, woodblock print
by Kohl Comtess

The Crazy Title
student, East Valley Academy

Family,
acrylic painting
by Marla Simpson

Freddy's Bay, acrylic painting
by David Piper

The Fight
black and white drawing
by Truman Beckett

Untitled

For Sonia
To die like this —
In an apartment room in Senior Housing
Alone, nobody knocking at the door,
Nobody calling, nobody knowing.
To die, simply to disappear
In an instant, soul leaving the flesh
Urgently, as if hurrying to heaven,
Pepto-Bismol by the bed,
Bible on the floor,
Your painting of Mt. Mansfield on the wall,
Your hands folded in prayer.
Five days later
Someone finally found you,
Flesh decomposing, face like a mask.
What were your last words,
Your last thoughts,
Was it Love or Anger or Peace?
Maybe there was no time
To think of anything or anyone at all
Just a simple "thank you life
For the miracle of Dark and Light."

by Vesna Dye
Burlington

Untitled
by Elaine Gawrys, Rutland

Christmas All Year Long

When I speak of Christmas all year long
I don't mean Christmas trees, presents,
Parties, dinners, stockings by the
fireplace and Santa Claus.

What I mean is the true
Christmas Spirit,
Peace on Earth, and goodwill to all.
Love and Kindness all over the world,
A true state of mind,
And that is what I mean by
Christmas all year long.

by Neale Gilson

Howard Center Collective Seeks Artists for Show

BURLINGTON — The Howard Center Arts Collaborative is again issuing a call to artists for an art show. The show will open in July at One Main Street. Artists from any parts of the state are welcomed.

For more information, contact Adam Forguites at AForguites@howardcenter.org.

Share Your Art!

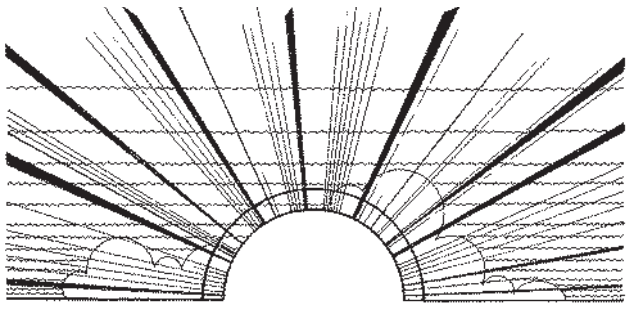
Express Yourself in Drawing, Prose and Poetry...

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, 05701

Please include name and town



Resources Directory

Survivor Peer Services

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 Wednesdays, 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 Tues, 4:30- 6:30 p.m. Leave message for Keith at 802-782-1387
Rutland - Wellness Group, VPS Office, 128 Merchants Row, Suite 606; 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

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.; 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

Vermont Psychiatric Survivors Outreach and Patient Representatives

802-775-6834 F: (802) 775-6823
info@vermontpsychiatricsurvivors.org

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 website for weekly calendar.

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; tpfcdirection@gmail.com
St. Johnsbury, Kingdom Recovery Center, 297 Summer St; 751-8520; c.boyd@stjkrc.org; j.keough@stjkrc.org; www.kingdomrecoverycenter.com
White River Junction, Upper Valley Turning Point, 200 Olcott Dr; 295-5206; mhelijas@ secondwindfound.net; http://secondwindfound.org

Counterpoint publishes this resource list to allow readers to seek out choices for support. _Counterpoint_ has not reviewed or evaluated the quality or biases of these resources, and makes no representation about their value for any individual.

Vermont Federation of Families for Children's Mental Health

Statewide support for families of children, youth or young adults in transition who are experiencing or at risk to experience emotional, behavioral or mental health challenges. 800 639 6071, 802 876 7021

Women's Holistic Outreach Learning Environment (W.H.O.L.E) peer support groups

in Springfield for "women who struggle with mental, emotional, and behavioral health issues." Tuesdays from 7 to 8:30 p.m. at the Calvary Baptist Church, 156 Main St. Entrance at back on right side of building. More info at www.wholevpweb.com/

Pride Center of Vermont

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.

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

Trans Crisis Hotline

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

Crisis Text Line

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

LGBTQ Youth Crisis Hotline:

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

NAMI Connections Support Groups

Bennington: Every Tuesday 12-1:30 pm; United Counseling Service, 316 Dewey Street, CRT Center
Burlington: Every Thursday 3-4:30 pm; St. Paul's Episcopal Cathedral, 2 Cherry Street (enter from parking lot)
Montpelier: Every Friday 2-3:30 pm; Another Way, 125 Barre St.
Newport: Every Wednesday 6-7:30 pm; St. Mark's Episcopal Church, 44 Second St.
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.

National Alliance on Mental Illness-VT (NAMI-VT) 802-876-7949 x101, 600 Blair Park Road, Suite 301, Williston, VT 05495; www.namivt.org; info@namivt.org

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

Public 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, 05701; 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: Involuntary Custody Screening

(Addison County) Counseling Services of Addison County 802-388-7641
(Bennington County) United Counseling Service, 802-442-5491 (Manchester) 802-362-3950
(Chittenden County) Howard Center (adults) 802-488-6400; First Call: (child/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

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

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

Homeless?

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

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.

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
Jericho 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

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 Jnct) 802-295-2908

Vermont Vet-to-Vet peer support groups: contact www.vtvettovet.org