

Counterpoint

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From the Hills of Vermont

Free!

Since 1985

Summer, 2016

A State of Emergency



Some Hospitals React By Improving Care, Others With Violence And Patient Arrests

by ANNE DONAHUE

Counterpoint

"I screamed with pain for as long as they kept me like that... I was horrendously traumatized."

— Pamela Spiro Wagner, a patient held for six days and restrained in the emergency room at Brattleboro Memorial Hospital in January 2016.

"Got a knot in my stomach... Am paralyzed with fear and anxiety about having to take the stand in my own defense at upcoming trial." — Mary, being prosecuted for assault for striking a security guard who threatened her for refusing to remove her clothes in the emergency room at Rutland Regional Medical Center in October 2015.

"They said no hospital would accept me... They strapped me down and they shot me up." — Alana RaQuel Nancy Hodgkins, held for eight days at the University of Vermont Medical Center in May and June 2016.

► At Gifford Memorial Hospital in Randolph last July, a 64-year-old woman was being brought back into the emergency room after attempting to leave; the nurse "took her down real hard," to the extent that the State's Attorney, after seeing the video, brought assault charges against him.

► At Brattleboro Memorial Hospital in January, according to the state's Division of Licensing and Protection, police "used an arm-bar take-

down resulting in dropping [the] patient to the floor and pinning the patient's head to the floor by pressing a forearm against the patient's jaw" for verbally refusing — without any physical resistance — to move to a secure room.

In August of 2011, Tropical Storm Irene forced the closing of the Vermont State Hospital in Waterbury, which housed a third of the state's adult inpatient psychiatric beds.

Unprepared emergency rooms were suddenly backed up with persons in a psychiatric crisis waiting for days, or even weeks, for an admission. Those pressures were supposed to be resolved after tens of millions of dollars were invested in new community programs and replacement hospital beds — but today, five years later, the delays continue.

With those delays, patient advocates began complaining about repeated incidents of abuse of patients, and Licensing and Protection began citing hospitals for violations of federal standards for protection of the safety and rights of patients.

In 2014, as a result, the legislature directed that the Department of Mental Health make "every effort to ensure" emergency rooms were providing interim treatment in safe and least restrictive ways that respect privacy and prevent physical and psychological trauma.

The recent reports from emergency rooms suggest that two years later some hospitals — and the state — are still failing to meet those standards.

Commissioner Frank Reed acknowledges that the Department of Mental Health isn't collecting data on restraint, seclusion, or other indicators of treatment in emergency departments.

He said the Department's priority has been to reduce the long waits, and that the situation of multiple-day waits has improved. In April, for example, the longest patient wait was three-and-one-half days, he said.

That interview occurred before Hodgkins was left waiting for eight days at UVMHC in June.

In the first four months of 2016, 45 percent of all involuntarily admitted patients still waited more than 24 hours after being cleared for admission.

Some hospitals report they have made investments to learn how to appropriately address the needs of such patients and to create better emergency room space.

Disability Rights Vermont, however, routinely has four or five cases where it is investigating emergency departments, according to Supervising Attorney A.J. Ruben. "People regularly call" about force being used against them when it wasn't warranted,

(Continued on page 4)

Opportunities for
Peer Leadership and Advocacy

Meeting Dates and Membership Information for Boards,
Committees and Conferences

State Committees

Adult Program Standing Committee
Advises the Commissioner of Mental Health. 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. The committee is also involved in the redesignation process and review of all of the designated mental health agencies in the state. To apply for membership, contact Melinda Murtaugh (melinda.murtaugh@vermont.gov), Clare Munat (claremunat@msn.com), or Marla Simpson, M.A. (marla.simpson@gmail.com) for further information.

Local Program Standing Committees
Advisory groups for every community mental health center; contact your local agency.

Facebook and Web Sites

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

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

Mad in Vermont
www.facebook.com/groups/madinvermont Venue for peer support, news, and advocacy/activism organizing in Vermont. “Psychiatric survivors, ex-patients/inmates, consumers, human rights activists and non-pathologizing allies are welcome.”

March for
Mad Pride

July 14, 2016
Montpelier

Meet at Another Way,
125 Barre Street, at 2 p.m.

We will walk together
to celebrate mad pride and
stand together in solidarity
at the capital green.

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

Save the Date
Vermont Psychiatric Survivors, Inc.
Annual Meeting
Saturday, September 24
10 a.m. - 3 p.m.
Our Lady of the Angels Church
Randolph
Business meeting, program, lunch provided

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

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

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

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

Conferences

NARPA
The National Association for Rights Protection and Advocacy (NARPA) 2016 conference, will be held at the Pointe Hilton Squaw Peak Resort in Phoenix, Arizona, from August 25-28 (Thursday evening through Sunday noon). The theme is “Rights Under Siege: Fighting Back.” More information is at www.narpa.org/

Counterpoint

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

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Have News To Share?

Send It to Counterpoint!

Your peer newspaper

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

Counterpoint Deadlines
Fall (September delivery; submission deadline July 29)
Winter (December delivery; submission deadline October 7)
Summer (June delivery; submission deadline April 7)

How to Reach

The Department of Mental Health:
NEW NUMBER 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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Back Issues can be accessed at www.vermontpsychiatricsurvivors.org

Mental Health Bills Move in Congress

WASHINGTON — Bills that would make major changes in mental health law are nearing action in both the US Senate and House, and supporters believe they still have a chance to pass before the summer break. The House version of the bill, H.R.2646, was unanimously adopted in a 53-0 vote on June 15 by its committee of jurisdiction, Energy and Commerce.

Rep. Frank Pallone, who had led opposition to controversial elements, said it was a “vastly better” bill that removes forced treatment that “took an unnecessarily coercive and unproductive approach.” Vermont’s Congressman Peter Welch had strongly opposed the attacks on civil liberties in the original House bill, but voted in support of the revised bill.

Harvey Rosenthal, who thanked the committee for hearing from a person in recovery among the six who testified, spoke in support of some aspects but said there were still concerns. He has been the Executive Director of the New York Association of Psychiatric Rehabilitation Services for 23 years,

The Senate bill had been considered far less objectionable than the original House version by many mental health advocates. However concern has been expressed that further provisions could be added to either version if they are taken up on the Senate or House floors, and could thus still end up in a final bill.

The initial House bill included financial support to increase forced intervention, access to private medical records by family members, and elimination of much of the advocacy work done by Protection and Advocacy Systems (such as Disability Rights Vermont).It also narrowed the definition of peer staff and prioritized a medical model for treatment in a new federal agency that

would replace the Substance Abuse and Mental Health Services Administration (SAMHSA).

Changes in the new bill include:

► Removal of funding incentives for coerced treatment; extension of funding for a number of initiatives, with additions of \$5 million for community-based crisis response, \$30 million in suicide prevention, and \$9 million for police training in crisis response; assorted grants for training and recruiting a range of professionals and para-professionals.

► Requirement for rules to clarify existing privacy law instead of changing it, but still including language claiming that special accommodation is needed for persons impaired in recognizing they have a mental illness, who may discontinue medication.

► Requirement for more detailed reporting to show uses of federal funds, within the current lobbying restrictions, rather than expanding restrictions on Protection and Advocacy programs..

► Creation of a study on best practices for peer-support specialist programs; this led Rosenthal to caution, “While we very much appreciate H.R. 2646’s highlighting of peer support and its interest in... [a] report of nationwide peer support programs, it would be inappropriate for Congress to then move to define these standards. We are not aware that it takes this level of involvement for the other disciplines.”

► Continuation of its focus on the medical model and professional expertise for leadership roles. Rosenthal testified that, “The focus on evidence based practices is essential but, unless this measure devotes substantive research funding to evaluate whether an entire new generation of recovery focused innovations meet those standards, they will be lost.”

It also enhances enforcement of parity in insurance coverage for mental health and other health care, and creates new SAMHSA oversight but not elimination of the agency.

The national NAMI family support organization was an aggressive advocate of the original House bill. Its lobbyist presented at the Vermont chapter’s annual conference in the spring, and NAMI-VT Executive Director Laurie Emersen said it “supports the position of NAMI national on federal legislation,” saying that “they are the experts on federal legislation.” She declined to discuss any other reasons for its support of the bill. AD

How To Advocate On Mental Health Bill Make Your Voice Heard!

For the bill in the Senate (S.1945)

Sen. Patrick Leahy

199 Main Street, 4th Floor, Burlington, VT 05401; (802) 863-2525 or 1-800-642-3193
OR 87 State Street, Room 338, Montpelier, VT 05602; (802) 229-0569
OR Email via the web site
<https://www.leahy.senate.gov/contact/>

Sen. Bernie Sanders

1 Church St, 3rd Floor, Burlington, VT 05401; (802) 862-0697 or (800) 339-9834; fax (802) 860-6370
OR 357 Western Ave. Suite 1B; St. Johnsbury, VT 05819; (802) 748-9269; fax (802) 748-0302
OR Email via the web site
<http://www.sanders.senate.gov/contact>

For the bill in the House (H.R. 2646)

Rep. Peter Welch

128 Lakeside Avenue, Suite 235, Burlington, VT 0540; (802) 652-2450 or (888) 605-7270; OR Email via the web site: <http://welch.house.gov/contact/>

Phil

by DONNA IVERSON

His diagnosis was paranoid schizophrenia
But he disapproved of mental illness labels
Said they put people in a box,
Stigmatized them
But it was also his way of
Denying its power over him

As a child, he came from an abusive home
No love, no affection, only disapproval
It was so bad, he was removed from his home
And put in St Joseph's Orphanage in Burlington
Where a predator waited for him
In priest's clothing
He never recovered from the sexual abuse
It tormented him daily for decades and
decades

As a young teenager he rented an apartment
On Pearl Street in Burlington
For awhile things improved
He joined the Air Force, traveled
Became a Vietnam vet
Got married, adopted a daughter
Earned a Masters Degree in Education

But then the illness struck
He became a stay-at-home dad
He had difficulty holding down jobs
Then came divorce, and eventually
After many years.....Homelessness

He liked living on the street, he said
He would walk for miles along Lake Champlain

There was camaraderie with other homeless people
But also arguments and fights
Eventually he found an apartment
In public housing, a one bedroom apartment
But he never forgot the street people
Always greeting them with respect

He was basically a kind hearted soul
And most of his fellow tenants knew that
But some rejected him for his odd ways
And he didn't take well to rejection
He would occasionally blow up
Shouting in anger
Nothing serious, but alienating
More and more people in the building

Then a few months ago, the housing authority
Sent him an eviction notice
He didn't say why or what the offense was
But his mental health began to deteriorate
He no longer greeted people
He said things that residents took as
Threatening
His behavior on the street became erratic
Whispers filled the building
That he was being kicked out

On a Monday night in March
The first day of spring
A street counselor called police for a
Wellness check, concerned about him
The same day, the building manager called
police
Saying residents said he was threatening them

Over a dozen police cars showed up
Right outside his College Street window
They arrived with shields, guns and a drill
To drill a hole in his apartment
To see what he was doing
He was hiding in his shower
With two large kitchen knives

For five hours the police tried to remove him
They tazed him, tried to smoke him out
The longer the siege, the more he hunkered
down
He was helpless and alone
Again, being tormented by those who
Were supposed to protect him

The end came when police claimed he lunged
At a young officer newly hired on the force
Who was trained to fire and he did
About a half dozen shots into the body
Of a man who was by now 76 years old
Dead on arrival the news media said

Some praised the police for their
Patience, waiting five hours before
Pulling out a gun
But others questioned their methods
Which just increased his fear and paranoia
And literally backed him into a space
Where his only choice was to
Defend himself
The only way he knew how

Donna Iverson is a former resident of Burlington and writer for Counterpoint who now lives in Illinois.

Special *Counterpoint* Report:

(Continued from page 1)

he said. For Wagner, there was some vindication. The state's Division of Licensing and Protection found, based on her complaint and that of a patient who was "subjected to police holds, forced to the floor and restrained by handcuffs," that Brattleboro Memorial Hospital was not in compliance with federal regulations.

Mary, on the other hand, is still awaiting trial on the assault charge against her. Being required to strip "makes me feel humiliated and shamed," she said. She had previously asked for a trauma accommodation from standard disrobing requirements. That was after the experience of a security guard telling her "we can do it one of two ways: either you can take your clothes off or I'll take them off for you" — the same security guard who confronted her again in October.

The Rutland County State's Attorney's Office argued in May against a "motion to dismiss in the interest of justice," saying it was "important to send a message that you can't be assaultive" in a hospital. Conviction could carry a sentence of two years in prison. The guard was not injured and told police that the punch to her mouth did not cause any pain.

One of the responses by Brattleboro Memorial Hospital to the federal violation of calling police on a patient who had not committed any crime was to issue a reminder to staff of their rights to file assault charges.

For Hodgkins, left waiting in the UVMC emergency room for eight days, treatment varied greatly based on the staff on duty. "Some people are really nice here and some people are jerks." One night, she asked for a teddy bear to help her sleep. She was told they were only available to children. "You need to act your age," the nurse told her.

According to Reed, the Department of Mental Health has delegated responsibility for care and treatment of waiting patients to the local mental health agencies in the communities where the hospitals are located.

Data show that on average this year, 22 individuals per month being held involuntarily are left waiting for an inpatient bed. On any given day, between one and five persons are being held involuntarily waiting in an emergency room. Reed said fewer patients were experiencing multiple-day waits, but that he did not have data to show it.

Jill Olsen, who represents hospitals in the Vermont Association of Hospitals and Healthcare Systems, says while it's true the numbers are lower, it only takes one major episode in a small hospital to cause severe repercussions.

Mary's Story:

The system is driven by 'a foundation of control'

Mary said she was severely depressed, agitated, and "fearful of becoming suicidal" when she went to the emergency department in Rutland last October for help after a series of prior emergency room visits and hospitalizations.

After her prior experiences, she had communicated with the hospital about her trauma history and about how being asked to strip down felt stigmatizing and humiliating. She had also told the hospital that uniformed security guards were a negative trigger for her. Her sexual abuse history

means "I'm vulnerable," she said. When she explained that to the first nurse that day, "she understood," Mary said, taking her shoes and hoodie and having her empty her pockets but allowing her to keep her clothes on.

After being cleared medically Mary was in the hallway on a stretcher when she said the security guard threw a gown onto the stretcher and said, "get into this." Mary said she swore at her and said, "leave me alone."

The situation escalated and got really loud, Mary said. The hospital says its policy for a person who refuses to change into a gown is to add additional staffing for safety. Instead, the guard continued to insist that she strip.

"She says, 'We've been through this before' and she made a move" as though to move in to subdue her, so "I jumped off the stretcher and popped her." Mary said she acknowledged what had happened to the Rutland police when an officer arrived. She agreed it was not a "good idea" to have struck the guard, the police affidavit said. She was cited for disorderly conduct and simple assault, but the health care staff assault statute includes an additional, second potential one-year prison term.

She is now terrified of what will happen to her in the criminal court system. She has no criminal history and was working as a substitute teacher in Rutland before her recent mental health crisis. She is certified to teach in both Vermont and Connecticut, and has Master's degrees in both business and education.

Mary has lived in Vermont for 12 years, and "people here have had my best interests at heart." The system is driven by "a foundation of control" however, instead of a "foundation of connections." Using control only exacerbates people in crisis, she said.

Hospital disrobing policies interfered with her care once again when she went to the emergency room more recently at the University of Vermont Medical Center in Burlington.

Mary said she asked, "please don't make me change," and she was accommodated, but after a 12-hour wait in the "holding room" and a shift change the next morning, a new nurse brought her a gown and said, "well, you've got to now."

The nurse threatened to call security, so Mary left instead. "I was very emotionally upset," she said. "They were calling security... [expecting that] the threat of that would compel me."

Ruben, from Disability Rights, says he has been assisting Mary's Legal Aid attorney in her case, and that Rutland is the only place he is aware of where charges have been brought based upon an assault during an emergency room psychiatric crisis.

Rutland Regional Medical Center said it could not comment on the specifics of Mary's case, but that a decision about pressing charges when a assault occurs at the hospital is "primarily a decision of the victim of a crime."

Jeff McKee, Ph.D., director of the hospital's inpatient psychiatric unit, said the policy is to support that person's choice, but also to "try to educate staff" about situations where there is no value in pursuing it, when "we believe someone doesn't have the capacity to make a rational decision" about their actions.

Asked about the legislative history of the 2011 statute on assault on a health care employee, intended for individuals who were angry and deliberately assaultive rather than for mental health crises, McKee responded that "angry, deliber-

ately assaultive' is not mutually exclusive with being in a psychiatric crisis."

The Rutland County State's Attorney Rose Kennedy, who brought the charge that carries a heightened penalty for assault of health care facility staff, said she came into her elected office last year with a decision that "we're not going to ignore these cases" of assaults on hospital staff. "I do feel pretty strongly about it," she said.

Kennedy said that there are "safeguards in the law" that allow a defense attorney to argue they had a client "in a crisis who couldn't control their behavior" by using an insanity defense.

Kennedy dismissed the idea that a person seeking help for a mental health crisis presented a different situation. An emergency room is "always sort of this heightened, tense situation" and there are many crises that relate to mental health. "It's going to be a lot of people," she said, and you can't "blanketly excuse them all."

She said that she knew some people would assume a conflict of interest on her part because of family relationships (her husband is an attorney for the hospital) but she said it is "absolutely not" a factor.

In a hearing on the motion to dismiss in May, Judge Thomas Zonay said that the essence of the case was whether the security guard caused the conduct in question, noting that actions can be "technically correct," but can raise the question, "could she have handled it better?"

The mental health issues "seem to play into it pretty significantly," he said. He was critical of deputy state's attorney John Waszak's arguments on a number of points, noting of Mary, "she's there because she needs help."

"Did the security guard sign up to be a punching bag? Absolutely not," Zonay said — but the case was not like "a fight in front of Walmart."

However Zonay indicated that he thought the policy issue was more appropriate to the legislature or to the elective process for the state's attorney. A ruling that there was "not flexibility and compassion used" in choosing to prosecute a case is not the role of the judiciary, he said. Zonay said he would issue a written decision on the motion.

Meanwhile, Mary just hopes to be able to rebuild her life. She is now "regaining my mental health" and wants to be able to spend more time with her one-year-old grandson.

Nancy's Story

Eight Days in the Confinement Of UVM's Emergency Room

After Alana RaQael Nancy Hodgkins spent eight days being held in the University of Vermont Medical Center's Emergency Department this June, she managed to stay philosophical and describe the positive things she experienced.

"Ninety-five percent of the people who work in the emergency room are there for the right reasons... they're committed to making things better for people," she said.

This was the second time in a year that she experienced a wait of eight or more days at UVMC. "They couldn't find a hospital that would take me," she said, and, "Both times I came out with serious injuries."

Hodgkins, who is 50 and has her doctorate in clinical psychology, said she was restrained and

(Continued on page 5)

A State of Emergency

(Continued from page 4)

drugged twice during the stay from May 27 to June 4. She was not being a threat to anyone either time, she said. “Their idea of a restraint policy is if you’re doing something that’s pissing them off, they restrain you.”

Hodgkins had entered the hospital voluntarily to talk to a doctor, but was then blocked from leaving. She said she ran into the shower, turned it on, and was lying “curled up in a ball in the shower.” She was taken into the psychiatric holding room, where “they strapped me down” and “pulled out the needle,” giving her a total of three shots.

Several days later, she decided to try to call the hospital’s Chief Executive Officer. A nurse rushed in and told her “you’re being ridiculous, you can’t talk to the CEO.”

“I wouldn’t give the nurse the phone so she called security,” Hodgkins said. The nurse told the officers who responded, “you need to restrain her.” They ripped a bracelet off her arm, bruising her, and when she began choking on food she had just been eating, they accused her of spitting, and put a bag over her face.

Hodgkins said she was “crying and screaming,” telling them “I can’t breathe” and saying “you’re hurting me and I’m not doing anything.”

“What they really need is a lot more training in trauma,” she said.

“The most stressful thing,” however, was that the staff kept changing and “you didn’t know who might be coming in” to your bedroom next. “There’s a lot of bad communications,” she said, when what a person in an emotional crisis needs most is a sense of safety and consistency. “I [had] to explain the same things over and over,” even for something as simple as her need to have lights kept dim.

She also stressed that there are some staff there who “will bend over backwards for you.” The night she was refused the teddy bear, one of the psychiatric technicians made a toy elephant out of a towel for her. Staff provided access to art supplies, and guards took her for walks to get away from the one small room where she was being held. It included walks to the secure outdoor garden.

However she faulted the hospital for failing to provide required information on patient rights. “The information you need to advocate for yourself is not [kept] in the space [where] you are living.”

The problems are systemic, Hodgkins believes, rather than with individual staff. Hodgkins knows about mental health systems of care. She is a professional who has worked in that system for 25 years specializing in substance abuse counseling and then working with adults who had experienced trauma. She received her Sc.D. in 2001 at Antioch.

She later shifted to a focus on trauma in children. “I wanted to work with kids,” she said, because she realized “if you can make a difference when the kids are younger... you build the house from the ground up.”

Hodgkins said she experienced her first psy-

chotic break in 2010 after her hoped-for adoption of a daughter fell through. She has since experienced “extreme mood states” and post-traumatic stress disorder, as well as suffering a traumatic brain injury when she was struck by a tractor-trailer truck.

On June 4, Hodgkins was finally admitted to Rutland Regional Medical Center. She was discharged eight days later.

“But it’s time to ‘do no harm’ to those we’re hoping to be empowered to heal,” she said.

“The best way to make social change,” she reflected, “is to start with what’s positive, and know to not expect perfection.” When people make mistakes but learn from their mistakes, “that gives me hope.”

It is when they “repeat the same dynamics” that she becomes despairing of real change.

Which is true at the University of Vermont Medical Center?

“I see both,” she said.

Pamela’s Story

‘The position I was placed in... is a torture position’

Pamela Spiro Wagner was at the Brattleboro Memorial Hospital emergency room for six days in early January waiting for an inpatient bed. During that time, Wagner was repeatedly restrained, held in seclusion, and involuntarily medicated.

“The position I was placed in... is a torture position, and I screamed with pain for as long as they kept me like that,” she said. “In fact, I have had physical therapy for many weeks on my shoulder because my normal range of motion does not allow me to bring my arm beyond about two inches in front of my ear, yet they mechanically restrained me, despite my screaming, with my arm stretched *behind* my ear!”

Wagner said that staff there “also injected me with large doses of the deeply troubling drug, Haldol,” despite her advance directive, which “states explicitly is under no circumstances to be given to me at any time.”

“They didn’t pay the slightest attention” to it, she said. “Sometimes they would lie and tell me they were only giving me my usual drug, Geodon,” Wagner said, “but it turned out to be Haldol after all.”

The Division of Licensing and Protection report said that Wagner was kept in 4-point restraints even when she was sleeping or recorded as being “calm.” At one point, a physician ordered continuation of restraints because “patient shouts out periodically.”

At another point, a nurse had reported that “she and other staff had been pushed” by the patient when attempting to put a bandaid on a small cut on her leg. Based on her resistance and verbal threats, staff determined “application of 4-point restraints and chemical restraints was warranted.”

Licensing and Protection disagreed.

“If staff had left the seclusion room, the threat of imminent safety risk to them would have been resolved... [The patient] was not threatening staff until confronted by staff who wanted to put a bandaid on...” The restraints were then continued for more than two hours.

In one episode, she allegedly kicked and assaulted a nurse with her fingernails when being “redirected” to her room, but was then restrained and medicated again without being released for

more than three-and-a-half hours despite being calm or sleeping. The report said that Wagner’s treatment violated the standards for restraint and seclusion being “only imposed to ensure immediate physical safety of the patient and others” and only after less restrictive measures are attempted, and must be discontinued at the “earliest possible time.”

Wagner drew her self-portrait in restraints (pictured on page 1) a few days later, after she had been transferred and admitted to Rutland Regional Medical Center.

“If a picture is worth a thousand words,” she wrote, “then maybe this one, penciled and crayoned while I was involuntarily kept at Brattleboro Memorial Hospital’s Emergency Room at the start of the year, will speak volumes.”

Despite the findings of Licensing and Protection, Wagner is bitter that the word of a psychiatric patient is never given credibility. The findings were based on the hospital records, not her report, she said.

“I have no voice... because I’m a mental patient.” At one point she was placed in 4-point restraints specifically for punishment — something not legally permitted — but the hospital was not cited for that restraint because it was not recorded in her chart, Wagner said.

Wagner, a writer and artist, said she came to Vermont in 2014 because she “hoped to change [her] life” after years of abuse in the Connecticut hospital system. “Art is my life,” she said. She published a book in 2005 jointly with her twin sister, a psychiatrist, about their childhood, titled “Divided Minds: Twin Sisters and Their Journey Through Schizophrenia.” She has since published a book of poetry.

Only now, after her discharge from Rutland Regional, is she finding people who are helping to make positive changes — people from outside the mental health system.

She is finding hope, living in a new apartment with a new kitten. Her experiences in the system and with the medications she has taken for 35- to 40 years has changed the trust of the “medical model” expressed in her book. At 63, she is now beginning a gradual, supported effort at reducing the medications that have had such a negative impact on her life..

“They judge you when you’re taking anti-psychotics. They discount everything you say.”

Use of Police

Licensing and Protection Finds Further Violations

Only a few days after Wagner’s traumatic experiences, a patient with “a history of depression, anxiety and suicidal ideation” was brought to the Brattleboro emergency room “requesting treatment,” the same Licensing and Protection investigation stated.

The patient was “cooperative” until learning that a requested hospital had no beds, becoming angry and wanting to leave. When behavior escalated, staff called the Brattleboro police to provide an escort to a secure room. According to the investigation, the hospital report states that when the patient refused to go, an officer said “if s/he did not go of her/his own free will hands would be placed on the patient and s/he would be physically escorted” to the seclusion room.

“The patient again refused but demonstrated

(Continued on page 6)



Alana RaQael Nancy Hodgkins

Special *Counterpoint* Report:

(Continued from page 5)

no resistance. Per report, police officers seized [the patient] in a ‘non-compliant escort hold’ and pulled the patient off the ED stretcher.”

After being forced to the floor and being pinned down, the patient “remained on the floor struggling and head remained pressed to the floor” until being assisted back up, and “right wrist was placed in a front-supported wrist lock.” The patient was then handcuffed to a bed, and was later involuntarily admitted to a hospital.

Licensing and Protection said that the hospital violated requirements to provide “safe and appropriate care” by relinquishing decision-making to police officers for the room transfer.

The patient “was not in police custody, nor a prisoner, but a patient with psychiatric disabilities that required direct management and consistent therapeutic intervention by hospital staff.”

It is the hospital’s duty to assure sufficient staff coverage to be able to respond to emerging events and “to meet the needs of patients demonstrating psychosis or other behavioral symptoms,” the report said. Instead, Brattleboro Memorial acknowledged that “night staff resources are slim” so police are used as back up and to provide “a show of force.”

The hospital’s plan of correction was accepted by the state in April, and it was found in compliance after a re-survey in May. The plan included staff education, rewriting of the “Code Green” policy for use of law enforcement, and collaborative planning meetings with the Department of Mental Health, the Windham County Sheriff’s Department and the Brattleboro Police.

The new Code Green policy relies on an in-hospital interdisciplinary team and permits calls to police only by a team leader. “Police involvement is a method of last resort when caring for our patients, but does remain a tool for violent circumstances when all internal resources have been exhausted,” said Gina Pattison, a hospital representative.

It also established a quarterly “Regional Psychiatric Strategy Meeting” to improve quality of care “along the continuum of care delivery.” It includes the Brattleboro Retreat and Healthcare and Rehabilitative Services (HCRS), which is the area’s community mental health center.

The meetings do not include mental health clients or consumer representatives, Pattison said, but patient input is solicited through other mechanisms. She said that the hospital was open to other suggestions for consumer involvement, and would “seek input from our community mental health partners — HCRS and Retreat — as to their successes in patient participation and applicability at BMH.”

The hospital also told Licensing and Protection that it was conducting educational seminars “regarding the rights of health care workers assaulted while engaged in official duties” and the role of the administration in “supporting its nursing personnel through the process of filing charges and the felony’s adjudication.”

A staff newsletter published in May said that the hospital was cited for violations by Licensing and Protection recently “because law enforcement was called into the ED to assist in moving a violent patient from one room to another. L&P cited this as the relinquishing of care to law enforcement as there was not enough supporting documentation to determine that this was needed or within the regulations for law enforcement assistance.”

The newsletter goes on to say, “The Patient Bill of Rights does not mean that being assaulted is just part of your job,” and reminds staff that it is a crime to assault health care staff.

“[I]f during the rendering of care, you are threatened, touched with intent to harm or harmed, you have the right to press charges against the assailant. BMH Administration will advise and support any nurse, tech, aide, provider or Code Green responder who experienced assault during the rendering of care if they choose to press charges...”

The Director of the Division of Licensing and Protection, Suzanne Leavitt, responded, “That’s all well and good” to call in police to file charges if an assault actually takes place, but not if the situation is precipitated by staff.

“You read the report,” she told *Counterpoint*, referencing the staff role in the situations at Brattleboro Memorial Hospital. “Just because someone’s got a mental health issue doesn’t mean you get to restrain them.”

Gifford Assault Nurse Charged in ‘Takedown’ Of Emergency Room Patient

The failure to comply with federal regulations by Gifford Memorial Hospital in Randolph involved three patients in a mental health crisis, but the situation played out in two ways that were very different from the other hospital incidents.

First, the Orange County State’s Attorney found grounds to charge a nurse with assault. It is “the first time I can remember [in 13 years at Disability Rights Vermont] that staff has been charged” for assault against a patient, attorney Ruben said.

Will Porter, the State’s Attorney, said the case involved a 64-year-old woman who was in a crisis and left the hospital against the doctor’s wishes. The situation was captured on a hospital video, he said. The woman was “outside in her nighty” visible to the camera, standing by the door. The nurse, Michael Colbeth of Bethel, was asked to bring her back in.

He said she kicked him, Porter said. “He took her down real hard.” That led Porter to consult with an expert, and a determination was made that Colbeth’s action “wasn’t consistent with his training,” resulting in the assault charge.

In May, Colbeth was accepted for court diversion. “They [the hospital] probably shouldn’t have asked him to do it,” and he probably was not trained appropriately, Porter said.

In addition, the victim was moving out of the area thus potentially unavailable to testify and Colbeth had no prior record, so Porter decided that “in the end it seemed appropriate for diversion.” That means that Colbeth had to accept responsibility for his actions and must follow conditions, but will have his record cleared if he remains without any further charges over the next six months.

Although Porter saw that patient as a vulnerable person, the hospital’s administration painted a different picture of the pressures on it at a meeting with legislators last fall. Gifford argued that the state needed to take greater responsibility for involuntary patients in the Commissioner’s care and custody.

That led to the second way in which the restraint episodes were addressed very differently.

At a meeting with local state senators and representatives called by the hospital, administrators exploited stigma to make its case for the needs of small hospitals for additional support.

“Some of these patients are dangerously violent” said Alison White, RN, Vice President of Patient Care, in a broad-brushed allegation against mental health patients. She asserted to the legislators that, “One wanted to go out and murder a bunch of people.” The hospital asked the legislators to require that the Department of Mental Health provide security when patients are left for days in small hospital emergency rooms.

In contrast, the Licensing and Protection report described the woman who was assaulted as having a diagnosis of schizophrenia and post-traumatic stress disorder, and said there were insufficient staff on duty to address the “emergency situation” when the patient left.

According to the report, the nurse manager said later that the nurse who responded “may have felt stressed that no one was available to help.” He failed to follow hospital policy, which directs that restraint never be attempted alone and that “a non-confrontational manner” be used, the report said. Instead, the patient was “grabbed roughly” and, according to the patient, was pushed to the floor by the nurse, who then fell on her, causing pain.

The second incident involved a patient described as “agitated and delusional” who left several times and was returned by police.

“During the emergent incidents on July 4 (which placed staff, patients and the general public at risk), the available staff on duty proved to be insufficient to meet the essential needs for all patients,” the report said.

In a third incident, restraints were improperly left on after a patient was asleep and calm.

A Gifford representative later emphasized that the findings last year “led us to exhaustive education with staff” to improve responses. Ashley Lincoln said she could not comment directly about the charges brought against the nurse because it was a personnel matter.

Positive Reports

‘Psycho Hell’ Transformed; Other Efforts Described

Hospitals are reporting progress in some areas, and, though uneven, it is being noticed by peers and survivors.

Bennington

In Bennington, psychiatric survivor advocacy made an impact. Peer advocate Greg Burda took on Southwestern Health Systems last year regarding its new “Emergency Care Area” for persons in psychiatric crisis. He called it “psycho hell.”

Burda said hospital officials followed up on their commitment to meet with peers at United Counselling Service, and both the environment and the staff response have been transformed.

The physical improvement “has turned that very unfriendly, sterile prison into a place of visual peace,” he said. “Everyone’s delighted with what’s been done.” (See Burda’s full commentary, page 9.)

Central Vermont

Central Vermont Medical Center in Berlin invited several advocates to visit its new emergency

(Continued on page 8)

A State of Emergency

Hospitals Describe Their Emergency Room Policies

Counterpoint asked all of Vermont’s hospitals to identify key emergency room policies relevant to psychiatric care. These are representative excerpts from their responses. (Where answers are not directly responsive, it is because the hospital did not provide a fuller answer.)

Hospitals, in order of size, with licensed bed capacity and psychiatric bed capacity	What is your policy for...				Do you have a designated room for psychiatric patients? Can it be locked?
	...assigning a ‘sitter’ and/or a security guard?	...searches of patients?	...removing clothes and putting on a gown? What if the person refuses?	... visitors?	
University of Vermont Medical Center Burlington (562 beds; 28 inpatient psychiatry)	Assignment of one-to-one observers in any part of hospital is based on clinical need, including risk of harm to self/others or other conditions	If expressing concerns, or assessed at risk of harm, asked to change into scrubs and personal belongings are secured	Patients may be asked to change into scrubs based on presenting issues, including risk to self/others; if patient IDs this as triggering, or refuses, will “work with patient to come up with a solution that will keep both patient and staff members safe”	Few exceptions, e.g., patient presenting risk of harm; sterile procedure	Two rooms can have medical equipment secured; used if assessed as a safety concern; not locked but patient may be required to have escort if needed to ensure safety
Rutland Regional Medical Center (188 beds; 19 inpatient psychiatry including 6 “Level 1” beds)	Sitters anywhere for any safety reasons if at risk based upon presenting condition; also for persons in an unlocked area who is in care and custody of DMH commissioner	In cases of reasonable belief of items dangerous to self/others, “it may be necessary for RRMHC staff to conduct a search to eliminate these items”	All patients routinely asked to change; if refuse and assessed as safety risk, additional staff supervision is provided	Balance of visiting rights and medical necessities; may impose restrictions if clinically necessary for safety	Two rooms are modified for environmental hazards (See article page 8 for pending changes)
Central Vermont Medical Center, Berlin (122 beds; 14 inpatient psychiatry)	Assessment for appropriate level of care based on needs may indicate use of one-to-one observation by assigned MH technician or patient sitter	If behavior exhibited raises safety concerns, may be asked to turn over possessions; if refused, higher staff supervision used	All patients asked to change; people who refuse “often remain in their street clothes”	Usually permitted unless space or privacy issues require limiting numbers	Two treatment rooms to reduce environmental hazards; in process of creating a new area for “more therapeutic environment” when waiting for a bed
Southwestern Vermont Health Care, Bennington (99 beds, no inpatient psychiatry)	Patient safety associates used for those assessed at high risk based on “current presentation”; security called for “immediate safety risk”	Patient property secured based on assessment of threat of self-harm or violence	All patients are asked to change; person refusing would be assigned security for safety	Visitors encouraged if respectful of patient needs	Emergency Crisis Area established for long waits (See commentary by Greg Burda on page 9)
Northeastern Vermont Regional Hospital, St. Johnsbury (75 beds, no inpatient psychiatry)	Case-by-case basis for any patients for many safety reasons (e.g., fall risk), in ED and elsewhere	Only if reason to believe person may be danger to self or others	Anyone needing medical exam or being transferred; “staff is trained to be sensitive to a person’s triggers”	Visitors based on patient preferences	No; two rooms designed for easy removal of items that could be safety hazard
Northwestern Medical Center, St. Albans (70 beds, no inpatient psychiatry)	‘Sitters’ if suicidal or waiting for voluntary bed; security/police/sheriff if violent/threatening or if involuntary and waiting for bed	If suicidal/homicidal, given paper scrubs, because more private and more sense of control for patient	In rare cases where suicidal patient will not undress, allowed to leave some clothing on after first disrobing and ensuring to staff nothing is hidden	Permitted; limited for all patients to persons who are supportive and non-disruptive	No; one room that is more private can be used for long stay or if at risk of violence and may need restraint
Springfield Hospital (69 beds, 10 inpatient psychiatry)	Springfield Hospital did not respond to repeat emails and phone messages.				
Brattleboro Memorial Hospital (61 beds, no inpatient psychiatry)	Sitter decision by clinician (aided by patient, family, other staff) for any type of safety risk (e.g., falls, self-harm, assaultive behavior)	Conducted if “high index of suspicion” that patient may harm self/others and presents immediate risk	Generally all patients asked to disrobe; If wishing to remain in own clothing and deemed at risk, asked for “pat down” or use metal detection wand, also assign sitter. Only if deemed immediate risk “would BMH insist upon the patient changing out of their personal clothing”	Decisions “may fluctuate with patient condition or unit/facility safety issues”	Five rooms able to be transformed for levels of safety needs; one room that can lock, only used by order of provider if imminently threatening
Mt Ascutney Hospital and Health Center (60 beds, no inpatient psychiatry)	Patients at risk of falls or self-harm throughout hospital are assigned sitters or security guards	May conduct a search to eliminate items with risks, to protect patients and others from potential injury	All patients are asked to change into hospital gown	Flexible based on comfort, clinical tolerance and safety of all	No
Gifford Medical Center, Randolph (52 beds, no inpatient psychiatry)	Based on assessed need for any patients for many safety reasons (e.g., fall risk), in ED and elsewhere; always assigned if in care and custody of DMH commissioner	If necessary based on safety, asked to change in a private room with two staff	All patients asked to change to gown for medical exam; “patients have the right to refuse... and will be assessed to the best of our ability in their personal attire”	To ensure rest and quiet needed for recovery, visitors may be restricted based on clinical or emotional needs	No; ED has five unlocked rooms; for safety needs, try to use room in sight of nursing station and remove high risk items
North Country Hospital, Newport (49 beds, no inpatient psychiatry)	If presenting condition indicates risk to self or others, “appropriate level of staff supervision” is used	If assessed to be at risk, patients told they must turn over items that could be used to hurt self/others	Routine for all; if refusal and assessed as safety risk, provided with additional staff supervision	Visitors welcome unless adding stress or safety risk	One designated room; others can be modified to remove unsafe items
Porter Medical Center, Middlebury (45 beds, no inpatient psychiatry)	Porter Medical Center did not respond to repeat emails and phone messages.				
Copley Hospital, Morrisville (43 beds, no inpatient psychiatry)	Based on presenting condition and safety in any situation and throughout hospital (e.g., risk of pulling out tubes, falling, suicidal)	Search for dangerous items only if reasonable belief of harmful items	All patients asked to change; paper scrubs for risk of harm to self/others. If refused “clinicians work together with the patient on a case-by-case basis to do what is best for the patient”	Encourage supportive role; sometimes restrictions needed based on clinical aspects or for safety of patient/ others	One room modified to remove environmental risks for any patient, with observation
Grace Cottage Hospital, Townshend (19 beds, no inpatient psychiatry)	All suicidal/self-harm and homicidal, or other conditions presenting risk (e.g. delirium, fall risk, intoxication)	Right to request “revelation” of any items to ensure safety; request for personal belongings to be removed from room if suicidal/homicidal	Request all suicidal/homicidal patients be robbed in gown “but cannot force the issue”	Allow visitors; “will not tolerate” if “agitate or threaten a patient’s condition”	Currently creating “safe room” for patients when needed

The Veterans Administration Hospital in White River Junction, which is not licensed by the state (70 beds) responded, but with general national policies, and most answers saying “up to local policy” regarding any specifics. The Brattleboro Retreat (149 beds, all psychiatry, with 14 ‘Level 1’) and the Vermont Psychiatric Care Hospital (25 beds, all Level 1) do not have emergency rooms and thus only admit patients screened by other hospital emergency rooms.

Special *Counterpoint* Report:

(Continued from page 6)

department suite for persons presenting with psychiatric issues and solicited input for improvements.

The three rooms there have bright colors and include regular beds and a desk; a shower room is available and a couch will be placed in the common hallway to encourage nursing staff interaction with patients who desire it, hospital staff said.

“In general the consensus was an improvement over what previously existed,” said Michael Sabourin, the patient representative from Vermont Psychiatric Survivors. “We do hope they’ll take into account some of our recent suggestions.”

“My feeling is that they are making an earnest effort to change the experience of patients in the ED,” he added.

The department has also created a new “Welcome! How Can We Help?” form that asks about challenging feelings, things that “make it more difficult for you,” and things that help.

Examples are listed, along with space to add personal items. The section on triggers includes items such as “being touched,” “being around men/women,” “not having choices,” “being forced to talk,” and “people in uniform.”

Staff also said they have added visits from the inpatient psychiatrist when a person is waiting for transfer to another inpatient bed.

University of Vermont

Ruben, from Disability Rights Vermont, said its patient advocate had noticed significant efforts at change in the Burlington hospital, attributed to the emergency department charge manager.

“Things are going really better” overall, Ruben said. By his staff assessment, the hospital is “really doing treatment,” he said, with access to a sensory items cart and mental health workers, and a psychiatrist who sees patients when they are waiting for a transfer.

Kristin Baker, RN, said that hospitals were initially “all in a denial phase” about the emergency room crisis. An emergency room staff perspective is about a short term crisis response, and “long term care is not in our wheelhouse, generally.”

Two years ago UVMMC began working to create a model that would be more like an inpatient unit.

“We can do this better,” she decided, and over time “we really tried to educate ourselves.” Emergency rooms aren’t set up for long term stays, even for basic things like showers, she said, and “it may not sound like a big deal,” but the addition of shower access was significant.

They recognized that staff communication was a critical issue; once several shifts go by there could be 25 people involved and communication breaks down.

Patients were saying that “rules seem to change depending on who the nurse is.” They are trying to address this through a “huddle concept” among all the key staff, and inclusive of Howard Center crisis staff, patients and family. It has started for situations with a child and is expected to expand to include adults.

In addition, the inpatient unit is providing support. “Now it’s a guarantee” after 12 hours that a resident psychiatrist comes down.

“It’s not to say we don’t have a long way to go,” Baker said, but she believes they have come a long way in learning things they were not even aware of before. She credited Disability Rights Vermont staff with helping.

Two weeks earlier, a patient who was waiting for days in the emergency room had a birthday. The ED staff arranged for a cake and they all signed a card. It was “one of those moments,” Baker said, when she could be very proud and say, “Look what the staff pulled off” to make a difference for someone.

Rutland Regional

In Rutland, individuals who are admitted as inpatients are reporting positive care and the inpatient director, Jeff McKee, Ph.D., says that change is underway to export those improvements to the emergency department.

Wagner, who had the traumatic experience in Brattleboro and who also later reported a very negative experience with one staff member at RRMC, praised the hospital for its inpatient staff being “kind and warm-hearted almost to a one.”

“Their philosophy, even in this small, rather constricted space, is, ‘Whatever the patient needs to get better, let’s say, ‘Yes’ rather than find some tired reason of saying ‘No’ again.’”

“I have been amazed by their professionalism and their concomitant deep commitment to patient well-being and to ‘accepting the patient wherever he or she is.’”

Similarly Hodgkins said the inpatient staff there were “great” and were really working to avoid all use of restraint and seclusion. She was, however, critical of the initial inpatient admission process, where she was strip-searched after being transferred in shackles via sheriff.

“They and the ER should be giving out rights and at least a welcome,” she said.

McKee, although acknowledging that he could not comment on any specific cases, said that the emergency department is in the process of reconstruction of its space to include up to five beds for persons in psychiatric crisis.

He said he had seen the unit at Central Vermont Medical Center and that the new Rutland ED unit would be “at least as welcoming.” Review of the space and input on the finish materials will include the Community Advisory Group that meets regularly to discuss issues in the inpatient unit.

McKee said the new ED space would be staffed with psychiatric technicians from the inpatient unit who have had the “Six Core Strategies” training on avoiding restraint and seclusion. Rutland is also in the process of recruiting an additional physician so that a psychiatrist can be covering the emergency room, he said.

State Oversight

Law Requires Care Standards; Department Moving Slowly

Two years ago, the legislature added new requirements for state oversight of emergency room care for patients in the involuntary care and custody of the commissioner.

Act 92 states that, “The Commissioner shall make every effort to ensure that a person held for an emergency examination pending a hospital admission is receiving temporary care and treatment that:

“(A) uses the least restrictive manner necessary to protect the safety of both the person and the public;

“(B) respects the privacy of the person and other patients; and

“(C) prevents physical and psychological trauma.

It also requires that a notice of patient rights be provided for any individual being held in the custody or temporary custody of the commissioner.

The Department of Mental Health says it is actively monitoring care and is working with the hospitals to assess their support needs. Others are less convinced.

“I haven’t seen any evidence” that patients are receiving their list of rights, receiving visits from psychiatrists, or having their preferences followed when [there is a necessary] use of force,” said Ruben, from Disability Rights Vermont.

The department seems to think its “only duty is to call around” looking for open beds, whereas a recent decision by the Human Rights Commission in Vermont makes it clear that DMH has the duty to make sure anyone in state custody is getting appropriate care. (See article, page 10.)

“The only real change” is that it issued a notice of patient rights to hospitals — another requirement under the new law — but “hospitals are not giving it to patients” because staff don’t know about it or know what the patient’s rights are, he said. What they need is “highly trained therapeutic mental health workers” in the emergency departments, Ruben said.

That is what is beginning to happen in large hospitals that have inpatient psychiatric units, as reported by UVMMC, CVMC, and RRMC, but according to Olsen at the hospital association, smaller hospitals are still working to identify what would help them most for when they face a crisis. Once they have greater clarity, they will be meeting with the Department of Mental Health to seek those supports.

That is consistent with what DMH Commissioner Reed said is underway. There “wasn’t full agreement among hospitals” about what resources DMH could bring, he said. “They wanted to problem-solve it internally” before meeting with the state. Reed and Olsen both said they expected that next step to come soon.

Reed also shared a memorandum sent to the community mental health agencies last year that said responsibilities under Act 92 were being delegated to them. The memo gave two pages of instructions about assessment and support services that the designated agency crisis clinicians are expected to provide in the emergency rooms.

The problem with that approach, according to Olsen, is that there is a great deal of variation around the state in terms of what local community mental health agencies can do to provide support.

The agencies are also under other pressures.

According to Nick Emlen of Vermont Care Partners, which represents the agencies, “the DA crisis teams are experiencing an unprecedented degree of pressure, mostly due to understaffing.

“In my 15 years working at the Council I’ve never seen anything like it... the situation is deeply concerning.”

Reed said the department is monitoring care for involuntary patients through its ongoing care management system, tracking what is happening with any patient waiting for an admission. That includes ensuring that “they are being seen” by a clinician, he said. However, asking for data that would monitor for criteria specific to issues referenced in the statute would be “duplicative” of the monitoring that is done by the Division of Licensing and Protection, he said.

“We’re trying to not create more redundancy,” he said. “We are relying on them” for formal re-

(Continued on page 9)

A State of Emergency

(Continued from page 8)

view, and DMH receives copies of the reports of Licensing and Protection investigations.

Licensing and Protection does its surveys based upon specific complaints and through random chart reviews when it does full hospital inspections every several years. It does not request data or track trends, Reed acknowledged.

“You have to work with these folks [the hospitals],” said DMH medical director J Batra, MD. It would be very burdensome to ask for restraint or seclusion data, he said, because the hospitals do not separate out voluntary and involuntary patients in their emergency room data.

Reed also acknowledged information from

L&P is not “timely,” in the sense that DMH does not become aware of violations of federal rules until many months later, after its survey is complete and the hospital’s Plan of Correction is filed. L&P is a state agency under the Department of Disabilities, Aging and Independent Living, but also acts as the state branch for federal Centers for Medicare and Medicaid Services violations of the “conditions of participation” for federal funds and must act under its rules for disclosure of information.

One new point of accountability is that the notice of patients’ rights must be signed by the patient to show receipt, Reed said. He acknowledged the department does not monitor

to see if those now exist in patient records. He said he would check to see whether that was an item Licensing and Protection could add when it reviews chart samples.

Under existing law, DMH has the responsibility to “designate, control, and supervise the property, affairs, and operation of hospitals and institutions equipped and otherwise qualified to provide inpatient care and treatment for individuals who are mentally ill.” That statute has been interpreted over the years to apply only to care of involuntary patients.

That is a part of the problem that Baker, at UVMMC, says she has been trying to address in
(Continued on page 10)

A SURVIVOR’S PERSPECTIVE

From ‘Psycho Hell’ to ‘Psycho Hope’!

by GREG BURDA

If you’re a regular *Counterpoint* reader, then the title to this piece may conjure a memory of the lead article from the winter 2015 issue. This is a follow up to that article, showing the power of advocacy.

That article shed the spotlight on the very unfriendly atmosphere in the Southwestern Vermont

Medical Center’s (SVMC) Emergency Care Area (ECA).

The ECA is SVMC’s attempt to address the needs of those of us in a crisis that might be stuck in an emergency department (ED) examination room while waiting for an



Greg Burda

inpatient bed somewhere. Because that wait may be days or even longer, SVMC constructed a 3-bed quiet area, just off the ED, so our wait may be more comfortable, devoid of the hustle and bustle of the ED itself.

It was a very commendable act on the part of the hospital, but lacked in any creature comforts conducive to lessening some of the crisis while waiting.

It’s only been recently that I was able to visit the ECA to see the improvements made, although I had heard from those that did see it (whether by choice or not) that there were positive improvements. When I was finally able to get in to see it, I found that the changes were not just about the décor and the availability of distraction supplies, such as crafting, CD players for music, movies, and a whole slew of other items to help alleviate/distract one’s mind from whatever brought the crisis on.

What was most impressive was the new found attitude of the staff towards those who might be waiting there.

The winter *Counterpoint* article highlighted my initial frustration with SVMC as to the lack of action by the hospital in making the much-needed improvements. Time dragged on and I felt I was getting stonewalled, which added to my frustration.

Then, during a meeting of my peer support group, I was informed of Wilda White taking the helm at Vermont Psychiatric Survivors (VPS). It was then an “ah-ha moment” hit and my ‘Cyko Hell Hidden Away at SVMC’ (my original article title) was off, headed to Wilda’s inbox.

It was at that point that my mouse-like voice turned into a lion’s roar, with VPS now having my back and shaking things up with SVMC management.

That’s the history. Now for a focus on the improvements, and on those who deserve credit for them. It seems what caused much of the frustration was a breakdown in the hospital chain of command. My apologies to Mary Anne Cushing for being a pain in her tush, and also to anyone else that I may have offended with my persistence. It’s only now that I’m in contact with the right people.

First, and in my eyes, the most important, person is Susan Robbins, the hospital’s Director of Emergency Services.

I see Susan as a person with an over abundant amount of caring, compassionate, empathetic conviction for those in her direct line of care, and I’ll bet even beyond. In my dealings with her, she was clear that she knew improvements to the ECA were needed, but wasn’t exactly sure where or how to begin. As Sue admitted, it took a lot of self-educated trial and error.

Yes, there is the décor improvement, which has turned that very unfriendly, sterile prison, into a place of visual peace. For that part of the ECA equation, she’s not finished, and is taking the time to consider more highlights.

But it is her consideration for the people who need the ECA that’s more impressive. It shows in her comments to me about how she instructs and counsels her staff on how to treat our silent suffering brothers and sisters while in their care.

Sue goes out of her way to be sure those in the ECA know what types of things, such as help or activities, are available to them. If she observes that an ECA staff member is, for lack of better words, slacking on interactions with those in the ECA, there is immediate interaction with that staff person to rectify the situation.

It’s not difficult to see that Sue handpicks her staff people. I had the great pleasure to meet one of her staff members, an Emergency Department Technician and fulltime ECA staff person, Brenda Mattison.

Just being in Brenda’s presence, and in speaking with her, it was more than evident that she has

the same conviction in her care for those in the ECA as Sue.

All this is such a refreshing delight to experience, since none of this was the case during my stay in the then ‘Cyko Hell.’

Many things for most would go unnoticed, like the Dutch Door to the nurse’s station that gives the ECA residents direct access to converse with staff, get a snack, or maybe just vent as needed. Or the puffy cloud sky scene, light diffusers, that seeing them while lying in bed, can distract the chaos filled mind into a more tranquil place. All this and more were mostly the brain child of Susan.

I then learned that almost 50 percent of ECA clients are under the age of 18. That is shocking in its own way to comprehend, and some are as young as elementary school age. They may be suffering from some childhood related trauma, which developed into PTSD; some may be autistic, and maybe victims of bullying; stuck in the throes of bipolar disorder; issues with suicidal or homicidal ideation; angry outbursts; or possibly the parents just can no longer handle their child.

When there, staff helps them with homework, and if need be, their school is called to help keep them up to date with assignments.

Brenda keeps up with self-education on some of the most recent research findings and uses that knowledge in a matter-of-fact way to help the children, which goes to prove her commitment of care for these suffering juveniles. Just something as simple as cutting out sugary drinks, or the elimination of artificial dyes, has changed some of the behavioral problems exhibited by these children.

If that’s not educated “outside the box thinking” and caring conviction to physical and mental health, I’m not sure there could be a better example.

Many, many months ago, I vowed not to give up the fight on something that seemed almost an impossibility to change. At that time my expectations were only to remedy the frightening appearance of the ECA.

Now, as things finally fell into place because of those people who truly have empathy for others and are willing to fight the good fight, at this point all I can say is I couldn’t have dreamed a greater outcome.

Greg Burda is a member of the Vermont Psychiatric Survivors peer support group in Bennington.

Special *Counterpoint* Report:

A State of Emergency

(Continued from page 9)
communication with the department. When DMH tracks only the patients in its care and custody, it fails to have the full picture of the actual emergency room pressures and environment.

If only one involuntary but nine voluntary patients happen to be in a mental health crisis, that is a “huge tax on the resources of the ED,” she said, but it wasn’t being taken into account. She now provides that information.

Baker said, however, that it remains the small hospitals that lack the ability to respond to the statewide crisis, and they need to be the priority for DMH. “We’re not always the focus” and the large hospitals “totally understand.”

Ruben, from Disability Rights, agreed that small hospitals are in a bind when a patient with severe symptoms must be held for days, because they cannot maintain the level of experienced staff just in case such a situation occurs. “The little hospitals do not have the training or systems [for] when an acutely ill person shows up,” he said.

Reed stressed that the department’s primary focus is on “continuing to try to not have people waiting in the ED.” Data show that the average number of involuntarily-held individuals who had to wait for an inpatient bed after being cleared for admission dropped from 25.5 per

month in 2015 to 22 per month in the first four months of 2016. The percentage of those waiting for more than 24 hours dropped from 49 to 45.

Reed said that while avoiding waits is also the priority expressed by the small hospitals, the level of urgency from them tended to “wax and wane” depending on whether they had a crisis situation at the moment. “As long as they have nobody waiting, it sort of goes off their radar,” he said.

Those lengthy waits rarely occurred prior to the closing of the Vermont State Hospital after tropical storm Irene in 2011, testimony in the legislature has indicated. Data was not being collected prior to that, but anecdotal evidence was that some waits were just beginning to occur in 2010 and 2011 because of system capacity issues.

It was after the start of lengthy waits when VSH closed that extensive abuse of patients in the stressed system began to emerge. Major violations were cited by Licensing and Protection in the Springfield Hospital emergency department in 2014, and crisis conditions across the state were reported to the legislature. The Brattleboro Retreat attributed repeated violations that nearly resulted in a loss of federal funds in 2013 to the admission of so many patients who would have otherwise been at VSH.

In 2012, in response to the closing of VSH,

Act 79 expanded community services including new “intensive recovery residence” capacity and \$1 million invested into peer services. It also authorized expenditures to build specific new inpatient units for persons who would previously have required admission at VSH — identified as “Level I” capacity — that would have a “no refusal” status for patients meeting clinical criteria, as long as the unit had beds available. That capacity included a 14-bed unit at the Retreat, a 6-bed unit at Rutland Regional, and a new, 25-bed state-run hospital in Berlin.

The “no refusal” concept became interpreted to only apply if the hospital had the clinical ability to admit a given patient. After opening in 2014, the Vermont Psychiatric Care Hospital in Berlin frequently closed beds when it had staff shortages. Now, Reed said, new competitive salaries for nursing is expected to allow VPCH to maintain full staffing and bed capacity.

DMH has also attributed ongoing emergency room delays to the need for the system as a whole to adjust and to fully utilize new outpatient capacities.

Others remain skeptical.

The bottom line, Baker said, is that regardless of improvements, “the system... is clogged” and there are “still very long delays” for patients waiting for a bed.

Delays Take Their Toll in Corrections, As Well

The lack of access to inpatient care has also continued to result in persons charged with a crime who need hospital care facing lengthy waits in correction facilities, according to Disability Rights Vermont attorney Ruben.

In April, the Human Rights Commission found that both the Department of Mental Health and the Department of Corrections had violated the rights of a person with a mental health disability by failing to provide adequate care while he was waiting for an inpatient bed in 2014.

He was locked up for six weeks, including 10 days in “the equivalent of solitary confinement” when he belonged in a hospital, the Commission said. The individual was supposed to receive an inpatient evaluation for competency after he arrested on a charge of disorderly conduct.

The Commission disagreed that the continuing impact of Tropical Storm Irene on access to Level

I beds excused DMH. Both departments were responsible under state law “to make sure that the services received by D.C. [the inmate], while in the custody of DOC and awaiting a Level I [inpatient] bed, were adequate to his mental health needs,” the Commission found.

“It is abundantly clear that D.C. should never have been placed in a correctional facility at all,” the report said. The investigation found that D.C. was being held on a warrant after he failed to show up for a court hearing as a result of being in a hospital emergency room; police waited outside the hospital to arrest him as he left.

The ruling means that the state must negotiate a settlement with the individual or face a possible lawsuit by the Human Rights Commission.

In May, in a separate case, federal District Court Judge Geoffrey Crawford ruled that there was a legal cause of action against the DOC men-

tal health contractor in regards to care provided between February and April of 2014, when an inmate was determined to be in need of inpatient care but remained on a waiting list for an available bed.


The outcome of the lawsuit will still depend on whether the facts at trial prove that a failure to provide appropriate care was the cause of the physical and emotional harm the inmate suffered.

According to Disability Rights attorney Ruben, the underlying issue is ongoing.

“This definitely remains a capacity problem and people being held in inappropriate circumstances solely due to lack of capacity in the appropriate environment,” he said.

“We continue to seek a systemic legal action that will address these problems in lieu of the Legislature and Administration effectively addressing them.”

New! Counterpoint Telephone Poll



Issue: Emergency Room Waits

Question: Should Vermont add more psychiatric hospital beds as the solution?

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.

Expediting Forced Drugs Rejected

By C.B. HALL

Counterpoint

MONTPELIER – The Legislature rejected an effort by Governor Peter Shumlin’s administration this session to significantly speed up the use of legal force for psychiatric drugs.

The proposal was inserted into the administration’s budget proposal at a claimed cost savings of \$5 million through reducing the length of hospitalizations, with an assertion that people who oppose treatment with the drugs “present an economic burden to the state of Vermont.”

The proposed language to shorten timelines and remove steps in the court process was eliminated after the House Human Services Committee said that “a revision of this magnitude to a major policy in mental health treatment has no place in the budget,” and termed it a “proposed wholesale repeal of a law” passed just two years ago.

The committee’s position came without hearing testimony from persons who might be subjected to forced drugging, which led to complaints about the process. However, the committee memorandum from the Chair, Rep. Ann Pugh, referenced the weeks of testimony and the public hearing in 2014 that led to “a very careful balance between the desire of the Department of Mental Health and designated inpatient providers to medicate patients who choose not to consent to psychotropic drugs and the basic civil rights of individual patients (who have the right to refuse any particular treatment under Vermont law).”

Reaction to the surprise proposal in January was swift and angry. Even the Commissioner of the Department of Mental Health, Frank Reed, denied advance notice of the governor’s plan and had an email exchange with his boss objecting to the way it was made public through the presentation of the governor’s budget to the legislature in January.

Jack McCullough of Vermont Legal Aid’s Mental Health Law Project said that the legislative process in 2014 gave the Department “everything it asked for” regarding easier access to forced drugs, and accused DMH of an attitude of, “Maybe we should go back and see what more we can get.”

The initiative took shape in the Department of Vermont Health Access (DVHA), which manages publicly funded health insurance programs. DVHA documents obtained by *Counterpoint* asserted a “conservative estimate” of “over \$10 million annually” in savings, although the administration ended up claiming \$5 million in savings as part of the budget it presented to the legislature.

Advocates disputed even that figure as unsubstantiated, and the Human Services Committee, in a memo to the House Appropriations Committee, said it “does not see the basis” for the claimed savings. That meant that the legislature had to find savings of that amount elsewhere in order to balance the state’s budget.

The House Human Services Committee heard from 14 witnesses, both pro and con, in formulating its recommendations. Only three of those witnesses were from the advocacy community, and none were mental health peers or psychiatric survivors, which led to objections by Vermont Psychiatric Survivors Executive Director Wilda White.

“I made requests in writing and orally to testify on the forced drugging measure. My written requests were ignored,” she told *Counterpoint*. “My oral request was flatly and curtly refused without any explanation” by the committee’s chair, Rep. Ann Pugh, she said.

Pugh told Counterpoint that she regretted White “felt left out” but that testimony was limited when the committee resolved not to accept the changes proposed to the law.

Reed, the mental health commissioner, objected to the fact that he had been left unable to have any discussion of the issues with stakeholders before the Governor included the proposal in the budget made public on January 21.

“Introducing that this is a DMH proposal without any discussion with our constituency prior to this announcement is throwing DMH ‘under the bus,’” Reed wrote to Agency of Human Services Secretary Hal Cohen that evening, in an email obtained by *Counterpoint*.

“No heads up on this content in the [governor’s budget] speech is also wrong at many levels,” Reed continued.

“The communication could have been better,” Cohen responded in an email, but he told Reed, “DVHA may have initiated it but both you and me [sic] believe that this is the right thing to do... DMH is going to have to carry the water on this, so it’s reasonable that you now need to get 100 percent behind this and do everything possible to make it happen.”

In an interview with *Counterpoint* in early May, Reed reported that his department had had “conversations” with the governor’s office and DVHA about “individuals who are waiting a long time for medication when medication is a recommended method of treatment,” but that “the governor’s office had not indicated its full support for the changes in question until the budget message came out in January. We hadn’t known about that.”

The fact that a proposed change in statute was buried within the budget bill appeared to have annoyed the legislature as well.

“Legislators were quite upset about the process,” Disability Rights Vermont executive director Ed Paquin told *Counterpoint*. “I think there are people who would be leaning towards this sort of policy who were dead set against it” because it was slipped into the budget bill.

Some advocates speculated that the Shumlin administration inserted the proposed changes in the bill as a deliberate non-starter, knowing that the legislature would reject it, but thereby forcing it to seek the same budgetary savings somewhere else. That would then place the political blame for the loss of services that other cost-cutting might cause.

In an email interview, Shumlin spokesman Scott Coriell termed such assertions “completely ridiculous. Whoever spun that conspiracy theory should join the Donald Trump campaign...”

At a February 9 public hearing organized by DMH there were passionate differences of opinion on the state’s position that the time to get forced drug orders “fails our duty of care” to patients.

“Our family member was forced-drugged,” an Addison County woman testified. “Physical and brain changes were induced.” She called for keeping the law as it stood and advocated “a medical system that provides hospitality, that meets us at the front door and talks to us.” She requested that her identity not be disclosed.

White, of Vermont Psychiatric Survivors, recounted the experiences of her older brother, a trumpeter, who was forcibly drugged after being diagnosed with schizophrenia. The regime of medicines, she said, led to a thyroidectomy, tardive dyskinesia, kidney failure and diabetes.

But psychiatrist Gordon Frankle of the Rut-

land Regional Medical Center spoke up on what he saw as the benefits of the proposed statutory change. He described the current court process as “complicated and tough to keep track of” and involving “longer disconnects from family.”

In one written statement to the House Human Services Committee, Michael Billingsley, a Plainfield social worker, described the effects of the drugs differently.

“To suddenly have patients unable to recognize me after weeks of interaction, and to watch them turn into slobbering, slurred-speech versions of their former selves, was cruelty to them and everyone who cared about them. Why did it happen? Because that patient ‘acted-out’ when pushed by some uncomfortable moment with staff, and yelled in upset tones, or refused to follow instructions. Hit them with the needle. Drug them into a blurred, compliant lump.”

In its budget proposal, the Department of Vermont Health Access used best practices and due process arguments to justify the change.

“Under current practices found only in Vermont, a patient deemed in need of involuntary inpatient mental health services waits for their due process for a median of 60 days in a facility before beginning treatment,” the presentation stated. “This practice is no longer viewed by the medical and psychiatric communities as an effective or ethical approach to helping these patients.”

The governor’s budget book stated that “persons who are involuntarily psychiatrically hospitalized for acute psychosis and who refuse the standard of care treatment (i.e. medication) present an economic burden to the state of Vermont.”

After the House Human Services Committee made its recommendation, the Appropriations Committee proceeded with a budget that did not include the governor’s changes to the law. When the budget passed the House and went to the Senate, there was no move there to add it back in.

After the end of the legislative session, Reed told *Counterpoint* that “we need to continue to collect the data and continue to talk about those individuals... The person may be acutely in need of treatment, and it may be only a limited means of treatment if medication is not a recourse.”

The proposed changes in the law would have reduced the deadline for all court hearings on applications for involuntary hospitalization from 20 days to seven, with the involuntary medication hearing within seven days later, and would have allowed medication hearings to routinely be consolidated with hospitalization hearings.

It would have reduced the court’s latitude in postponing hearings and allowed an examination by a defense psychiatrist “only if the examination can be completed as to not cause a delay of the hearing.” It also would have eliminated the probable cause review on whether there were adequate grounds to hold a person in the hospital – a review that had just been established as part of patient protections two years ago.

The changes would have extended forced drugging to persons in the Department of Corrections without the current requirement that the corrections facility meet designated requirements for treatment capability. It would have also eliminated language on hospital preference, and removed the requirement for a special showing of need for orders of long-acting drugs.

Since the closing of the Vermont State Hospital following Tropical Storm Irene in 2011, the annual number of applications for involuntary treatment has nearly doubled from 40 to 76.

ECT Risk Ratings Contested

The federal agency responsible for regulating medical devices and drugs issued a proposed order in December to reclassify the device used to administer electroconvulsive therapy (ECT) from its current “high risk” classification (Class III) for all purposes to “moderate risk” classification (Class II) for the treatment of severe depression associated with major depressive disorder or bipolar disorder in patients 18 years of age and older when other treatments have failed.

If the proposed rule becomes final, physicians would have to warn patients being treated for depression that the side effects of ECT can include confusion and memory loss, and that ECT’s long-term safety is unproven. Physicians would also have to monitor patient’s memory and thinking skills before and during ECT treatment.

The use of ECT for psychiatric diagnoses other than depression, and in children under 18 would continue to be classified as “high risk.” However, the proposed rule introduces a new provision that would require manufacturers of ECT devices to conduct clinical trials to prove the safety and effectiveness of ECT for conditions other than severe, treatment-resistant depression. Manufacturers are expected to decline to do so because they do not want to spend money on costly clinical trials.

A “high risk” rating may also mean that insurers will refuse to pay for ECT for conditions other than severe, treatment-resistant depression. Doctors may also be reluctant to prescribe ECT for conditions other than severe depression for fear of malpractice liability.

The Food and Drug Administration (FDA) classifies medical devices into three categories based on the risks associated with the devices. Class I devices are deemed to be low risk and are subject to the least regulatory controls. Dental floss is an example of a Class I medical device. Class II devices are higher risk devices and require greater regulatory controls (usually warning labels) to provide reasonable assurance of the device’s safety and effectiveness. Condoms, for example, are Class II devices. Class III devices are the highest risk devices and require the highest level of regulation. Class III devices must typically be approved by FDA before they are marketed. Replacement heart valves, for example, are Class III devices.

Although ECT devices have been in widespread use since the 1950s, ECT manufacturers have never been required to prove the safety and effectiveness of ECT through clinical trials, as is typically required of “high risk” devices, because the devices were in commercial distribution before 1976, the year the FDA received authority to regulate medical devices.

Over the years, attempts by the FDA to reclassify ECT devices have been met with significant resistance and did not pass. In 1978, the FDA proposed a “moderate risk” rating for ECT devices. However, after receiving reports of patients suffering memory loss and permanent brain damage after ECT treatment, the FDA classified ECT devices as “high risk.” In 1982, the American Psychiatric Association (APA) submitted a reclassification petition requesting that ECT devices be reclassified “moderate risk.” The FDA tentatively agreed to reclassify to “moderate risk” for depression and schizophrenia. However, in 2004, the FDA withdrew its proposed order.

In 2009, the Government Accountability office recommended that the FDA require all pre-1976 devices be either reclassified as “low risk”

or “moderate risk” or undergo pre-market approvals, which typically requires manufacturers to conduct controlled clinical trials.

In response, FDA officials suggested that ECT devices might be able to be reclassified based on existing scientific evidence rather than requiring controlled clinical trials. In reviewing the existing scientific evidence, the FDA decided that existing scientific evidence only supported the “moderate risk” classification when ECT is used to treat severe, treatment-resistant depression in adults.

In its proposed order, the FDA acknowledged “significant risks associated with ECT but believes that for the specified population — patients 18 years of age and older who are treatment-resistant or who require a rapid response due to the severity of their psychiatric or medical condition — the probable benefit of ECT outweighs these risks.”

The FDA received 2,040 comments on its draft rule. The agency has not said when it will issue a final rule.

ECT Opponents

A New Hampshire woman who had electroconvulsive therapy (ECT) in 2015 after a series of hospitalizations for depression told *Counterpoint* that the treatments helped her, but the side effects were beyond anything she had been warned about.

“They said my short term memory would be bad for a while, and I probably wouldn't remember the time in and around the treatment, maybe the months leading up to it... but that it would come back eventually,” she said.

“OK. I can accept that. But what about my other memories from the rest of my life? What happened to them? Where did they go?”

The woman, who asked that her name not be used, said that she did research on the Internet, but found, “there wasn't any research that even began to explain what I was experiencing.”

“I feel so alone, angry, misunderstood, lost,

saddened. I just don't understand why this hasn't been researched more. It does not matter that it happens to only a few people. The fact that it happens at all should be enough for the medical profession to do something about it.”

The Law Project for Psychiatric Rights and the Committee for Truth In Psychiatry (a national organization of former electroshock patients) noted that in theory, if harm was identified, further ECT would be stopped, but that is not required in the proposed order, it is not the practice, and is unlikely to occur, as well as being too late.

“The practice is for the people administering the Electroshock to ignore patients' reports of harm and to falsely state the harm will go away. There is absolutely no reason to believe that the cognitive monitoring special control will be implemented in any meaningful way even after harm has been inflicted.”

The groups’ letter cited “the large body of evidence that demonstrates physical harm, cognitive harm, brain damage, high mortality, suicides, and lack of proven efficacy, especially for anything more than a few weeks.”

ECT Proponents

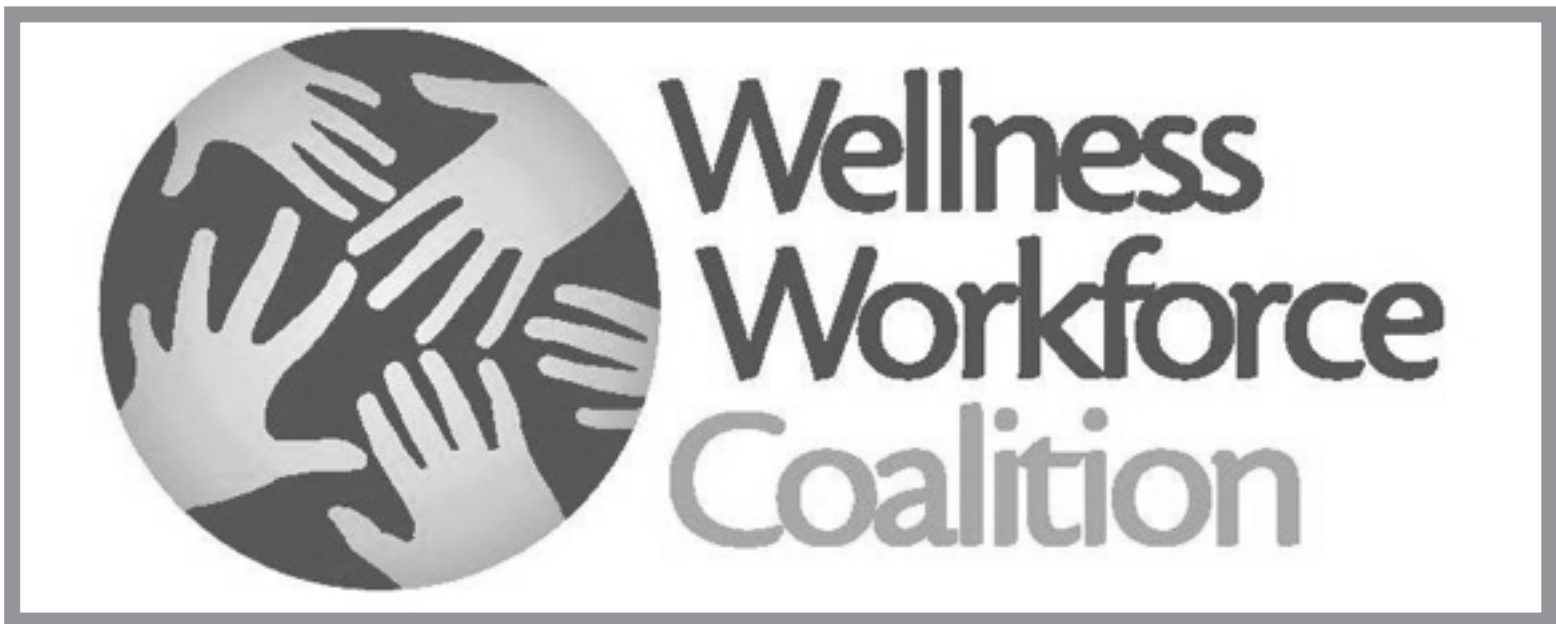
The APA opposes the requirement for a “formal neuropsychological assessment,” saying that screening assessments would be adequate to determine whether more formal cognitive testing is needed. It opposes the labeling that limits findings of effectiveness to short-term use, insisting that there is extensive evidence to support long-term maintenance use of ECT. It also recommends that the Class II designation include ECT treatment for children and adolescents.

ECT in Vermont

Vermont requires hospitals to distribute an informed consent package to patients that includes more detail about potential cognitive problems than either the current APA guidelines or the proposed FDA warning. Vermont’s required warning includes possible long-term effects. (See chart.)

Comparison of Warning Statements About Cognition

	Current Vermont Informed Consent for ECT	American Psychiatric Association Sample Patient Consent	FDA Draft Order: Patient labeling must be provided and include:
Generalized Warning	There is not enough research to accurately predict which person will experience a return to improved thinking and memory, have temporary problems, or have more severe difficulties and/or memory loss for which there is no known treatment.	Memory loss is a common side effect of ECT.	“Warning: ECT device use may be associated with: disorientation, confusion, and memory problems.”
Warning on Thinking Skills	There may also be difficulty in aspects of thinking such as learning and remembering new events and problem-solving.	During the treatment course [patients] may have new difficulties in attention, concentration and other aspects of thinking. These problems rapidly go away after the completion of ECT.	None specific
Warning on New Memories	[P]roblems with making new memories should be short-term and will most likely be gone within several weeks...	For a short period following ECT, [patients] may also experience difficulty in remembering new information.	ECT treatment may be associated with... short-term (anterograde)... memory loss following treatment.
Warning on Memory of Past Events	This spottiness in memory for past events may go back to several months before ECT, and in some people, to one, two, or more years... However, individuals may be left with some permanent gaps in memory, particularly for events that happened close in time to the ECT... [S]ome people have memory loss that is much more serious, long-lasting or permanent.	[A]s time from treatment increases, memory improves... the spottiness in memory for past events may extend back for several months... and less commonly... for several years or more. [A] minority of patients report problems in memory that remain for months or even years.	ECT treatment may be associated with... long-term (autobiographical) memory loss following treatment. These side effects tend to go away within a few days to a few months after the last treatment with ECT. However, some patients have reported a permanent loss of memories of personal life events (i.e., autobiographical memory).



PEER SUPPORT MAILING LIST- SIGN ME UP!

Want to be connected to upcoming trainings, events, conferences and conversations on peer support worker information?

We invite you to connect to us through our electronic mailing list.

The Wellness Workforce Coalition is made up of 13 peer-directed organizations with a shared mission of developing a strong peer-to-peer workforce in Vermont through advocacy and training. You can check out our website at: <http://wwcvt.org/>.

In our first years we came together in coalition as organizations interested in working together. Now, we want to connect directly with people who are working (paid and unpaid) in peer-to-peer support.

The WWC wants to be able to reach out directly to peer-to-peer workers about training opportunities, our state legislative action day, conferences and conversations that affect people working peer to peer and supporting one another.

If you would like to be added to our contact list, please use the following link:

<https://vcil.wufoo.com/forms/wellness-workforce-coalition/>



HONORED AT THE STATEHOUSE — Doug Dorain and his wife Ruth rise for their introduction at the Vermont State House after the reading of a resolution to urge the Veterans Administration to complete research on the use of service animals for veterans with post traumatic stress disorder. The VA currently refuses to fund such service animals, saying the evidence is insufficient. Dorain received a standing ovation for his work in advocating for the cause. (Counterpoint Photo: Anne Donahue)

Marine Confronts Discrimination In Access to Service Dogs for PTSD

by ANNE DONAHUE
Counterpoint

HARTFORD — As a Marine in the Gulf War, Doug Dorain was used to relationships in the Corps that were “intensely reliable to each other.”

He has regained that kind of relationship, 25 years later, with a German Shepard named Anya, and he wants younger veterans to have that same opportunity for help in coping with post-traumatic stress disorder (PTSD).

That goal led Dorain, 59, to overcome his personal challenges to appear publically at the State House this spring in support of a resolution that urges the U.S. Department of Veterans Affairs to complete research on the use of service dogs to benefit veterans who have been diagnosed with PTSD.

“I know there’re young men and women... just barely hanging on. They can’t get a dog,” he said in an interview several weeks after the resolution was adopted by the Vermont House of Representatives. “Somebody had to do something.”

Dorain was united with Anya last year, and thanks to her, he is building his life back. He soon discovered, however, that the Veterans Adminis-

tration does not authorize support as basic as veterinary care for service animals like his, because they have not been formally recognized for use by those with PTSD.

There are “hundreds of vets that can’t get a dog” because the VA mental health system staff don’t know how to connect them with the right program, and because they don’t have the financial resources to obtain a service animal and provide care for it.

“I did all the research,” Dorain said. “I was so angry. Twenty-two vets kill themselves every day.”

He followed Facebook sites that reported “a couple of times a week” on “guys waiting for dogs” — and then would read an entry, “today, he lost his battle.”

So one day he “unloaded” on his friend and former neighbor, state representative Gabrielle Lucke. She had the resolution drafted, arranged for Dorain to be present when it was read, and introduced him in the House chambers.

He received a standing ovation for his efforts to bring attention to the need for the VA to complete its research on service animals for veterans with PTSD. There are two research projects currently underway.

Dorain said it was hard for him to be there, in such a public place in front of a room full of people, but it was worth it. “All of a sudden, I [had done] something for someone else,” he said. “I gave back.”

“I hope nobody else has to feel rejected and shitty after getting a dog and [having to] decide whether to get groceries or to take care of my dog.”

Young veterans with PTSD “need help,” he said, but they are told to just “fill out a form and get disability.”

According to the House resolution, the RAND Corporation reports that at least 20 percent of veterans who served in either Iraq or Afghanistan have PTSD or depression.

Dorain’s journey to Anya was long and difficult. After ending his tour of duty, he struggled with returning to civilian life and finding that his work values didn’t mesh with those of others: he was “too helpful, working too hard” and

coming in with too many new ideas.

“I had difficulty dealing with other people... I gave up on people.”

Dorain later suffered a traumatic brain injury in a fall from a roof. He has not been able to work since 2011.

One of the obstacles for service personnel with mental challenges is that “we’re groomed and trained to [say] ‘forget, don’t worry about it’ and go on to the next thing.”

“This wasn’t supposed to happen to me,” he said.

When it came to asking for help, “the biggest step was me saying to Ruth [his wife], ‘do you think I should go and talk to somebody?’”

He reached out to the White River Junction Vets Center, and the “next humbling step” was “walking into the veterans hospital” for counseling appointments. Among the challenges he faced was “the trust thing” when therapists were reassigned, or when there was a fear, “they’re going to take me away from my family.” That leads to not being able to be fully open, he said.

Last year, after 17 years of struggle and six-and-a-half years of therapy, he had had “enough of the years of feeling that I wanted to die... end it” and the feeling of “not being worthwhile.”

He turned several times to the emergency walk-in clinic, and reached such a point of depression that he was urged to agree to hospitalization. “I’m going to feel trapped” as an inpatient, he thought, and talked his way out of admission.

It was then that his counselor said, “You need a dog.” Through a Marine Corps friend, he was connected with an owner-donor and went to Ohio for eight days of training in working with a service dog.

“You don’t just get the dog; there is a work process,” Dorain explained. It is “all about bonding; for her to trust me and me to trust her.”

The expenses of that trip would have been covered if he were getting a service dog for a physical disability, but, because it was for PTSD, he had to use his own resources. It was something he was able to afford, but younger veterans would be less likely to have those resources, he said.

Steve Feldman, executive director of the Human Animal Bond Research Institute Foundation, explained in a 2015 article in *Military Times* that “The VA’s most recent regulations on service

(Continued on page 15)



Doug Dorain gives a drink to Anya while waiting for his resolution to be read in Montpelier.

Who Does the Commissioner Serve?

“Let’s ask these questions to each of the candidates [for governor]: Will you commit to soliciting input from psychiatric survivors, family members, designated agencies and peer support programs when appointing a new mental health commissioner? Will you appoint someone who will honor and protect our human and civil rights?”

by MALAIKA PUFFER

Once a month, I attend a meeting of the Adult State Program Standing Committee, a small group of providers, family members and “consumers” that attempts to, among other things, advise the Commissioner of Mental Health (currently Frank Reed).

When policy changes to involuntary medication procedures were slipped into the 2016 Budget, Frank shared with the standing committee that expediting involuntary medication is a change that the Department of Mental Health supports. Frank explained his reasoning for this at the February meeting, which I understood as:

- There are plenty of protections in place for people’s rights.
- Judges shouldn’t be making decisions about medical care; doctors should. Reducing legal barriers to forced treatment will let doctors do their job faster and easier.
- We don’t let people with any other condition “languish” without treatment in the same way; “timely treatment” is a parity issue.

Marine Takes Up Cause for Service Dogs

(Continued from page 14)

animals say they would fund them for physical disability but not for mental disabilities because they said there wasn’t enough scientific evidence that shows animals help with PTSD.”

“We believe they do,” Feldman said.

The research currently underway will assess “whether a dog trained to help a veteran with PTSD influences medical symptoms, social anxiety, relationships and more,” according to the article.

The VA’s web site asserts that while dogs have emotional support value as pets, they don’t meet the training and task requirements to qualify as service animals for veterans with PTSD.

The site acknowledges that “research is underway to better understand if dogs can provide a disability service for persons with PTSD... to determine if there are things a dog can do for a Veteran with PTSD that would qualify the animal as a Service Dog for PTSD.”

It was during training with Anya that “the magic began to happen” for him, Dorain said. He needed shoes and was placed in a situation at a shopping mall surrounded by walls of high boxes.

“I was freaking out,” and Anya “became the person who looked [out] for me.” They found a corner where Anya lay down and he could pet her.

Lucke, his state representative, recalls the day that her sons – friends of Dorain’s sons – came rushing to tell her, “the old Doug is back!”

Since becoming involved in Dorain’s quest for recognition in the VA for use of service dogs for PTSD, Lucke says she has learned a great deal about their value for veterans. She has heard many veterans say, “This dog saved my life.”

That’s exactly what Dorain wants to hear said more often.

• Unmedicated people are taking up bed spaces which backs up the system such that others are having to wait for long periods in the emergency room.

• Expediting the process will just make our laws similar to those of other states.

“Timely treatment,” he kept saying. People deserve “timely treatment.” Later in the conversation he used the words that this euphemistic term actually refer to: Forced Drugging. But he put “forced drugging” in air quotes, as if it wasn’t just the plain English words for what we were talking about, as if “timely treatment” was the unbiased and factual descriptor.

I felt like a cartoon thermometer ready to spew mercury and glass across the room. Grasping for composure, I explained how it was difficult for me to hear someone with so much power talk about such an invasive state-sanctioned act of violence, an act that the United Nations has described as torture.

I challenged, in particular, his argument about parity. His mind was clearly made up and not open to questioning.

“We’ll have to agree to disagree,” he said.

At our April meeting, Frank and I had another discussion about this issue after he said “it’s not about the beds,” referring to the reasons he supports expediting the involuntary medication process.

I challenged him on this, arguing that it very much sounded like part of his reasoning was related to moving people out of the hospital to make room for others. I mentioned that psych drugs appear to cause chronicity, that detaining someone is a different issue than forcing a powerful substance into their body, and that most experiences that get called mental illness are time-limited. It would be better if we could give people time to go through their process. Frank said, “Well, where would we put them then?”

So it’s not *not* about beds.

We had to move on from the conversation for the sake of time.

“You don’t have to like my opinion,” he said. “I don’t like it,” I confirmed.

“One more question, real quick,” another standing committee member added. “When do you get replaced?”

Later that meeting, we reviewed the minutes from February. My comment about the UN regarding forced drugging as torture was followed by this editorial, added to the notes at the request of the Commissioner without discussion:

Special note: Members and others interested in reading more on this topic should see the Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment by Juan E. Méndez for the Human Rights Council of the UN. The information clarifies that the United Nations has not taken a position on this report. See the document online at: http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf.

The Standing Committee unanimously agreed to strike this sneaky editorial comment from the minutes, as it was not part of the discussion.

There’s another issue with this special note, however. Based on the following direct quotes from the article cited, Frank either did not read the report or intentionally misrepresented the content:

“Both this mandate and United Nations treaty bodies have established that involuntary treatment and other psychiatric interventions in health-care facilities are forms of torture and ill-treatment.”

“...there are unique challenges to stopping torture and ill-treatment in health-care settings due, among other things, to a perception that, while never justified, certain practices in health-care may be defended by the authorities on grounds of administrative efficiency, behaviour modification or medical necessity.”

“Impose an absolute ban on all forced and non-consensual medical interventions against persons with disabilities, including the non-consensual administration of psychosurgery, electroshock and mind-altering drugs such as neuroleptics, the use of restraint and solitary confinement, for both long- and short-term application.”

To be very clear, Vermont’s mental health system, while better than that of most other states, falls far short of these international human rights-based standards and our Commissioner is trying to move us even further away from them.

There are strong rebuttals to each of Frank’s arguments in favor of forced drugging and there are alternatives. Psychiatric survivors are hoarse from making these counter-arguments over and over and being ignored. I will reiterate and clarify these arguments for the Commissioner in a public debate, if he is able and willing.

The person with the most power in the mental health system should represent the expressed interests of the people he’s meant to serve, not the interests of politicians, private guilds, and corporations.

In response to the question from another committee member about when he gets replaced, Frank reminded us that commissioners are appointed by the governor and that Vermont will be electing a new governor this fall.

Let’s ask these questions to each of the candidates: Will you commit to soliciting input from psychiatric survivors, family members, designated agencies and peer support programs when appointing a new mental health commissioner? Will you appoint someone who will honor and protect our human and civil rights?

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



Malaika Puffer

Access to Means

Suicidal Feelings, Suicide Ideation, Suicide Attempts, Choosing Life, Choosing To Talk

by MELANIE JANNERY

Maybe suicide is not the leading cause of death for my age group. There seems to be more funding for the younger, for the older, even though statistics show among my age group there are more completed suicides. I have had discussions, been to many trainings and heard national presenters talk on living as a choice. I have carried the discussion, “I choose life,” into my circles. Unfortunately, in spite of my openness, countless times, I have been talked to about the details of suicide attempts, after the fact, and even called from the ICU one Thanksgiving morning. Thankfully, I have also been called in the middle of the night and have helped people feel safe; yes, to “feel” that beautiful “system word” we all love — “safe”!

I live with “suicidal feelings” and “suicidal ideation” and I want to feel “safe.” Although my last attempt was not in recent years, I live with the fact that, several times around, I have tried to take my own life and have not succeeded. Medical interventions for my body’s physical needs extended my natural life. Yet, I am petrified to re-engage in taking medications because of negative past experiences, their ineffectiveness for me, and my fears of my impulsivity coming back should I take them again, likely putting me more at risk for suicide. I fear antidepressants and live with depression, so I keep talking, as talking is good medicine! I am deeply affected when there is a suicide in my community, amongst my friends, people I have received services and shared meals with, people I have engaged in mutual support with, people who have been providers in my realm, former colleagues, famous folks and people I hear about that I do not even know, but one day may have met had only they not...

I see a parallel between the concept of quitting cigarettes and completing suicide. Statistically, having past “quit attempts” one is more likely to succeed, generally it takes several attempts before a person quits smoking. Similarly, those of us who have had previous suicide attempts are at greater risk (more likely to succeed at “quitting” life). I am not okay living in a state where a number equal to the gathering at a mid-size wedding dies each year by their own hand. Yes, 110 to 124 deaths by suicide in Vermont happen every year. My experiences give me belief that we can begin to reverse these statistics. By reducing attempts the suicide rate should go down.

I went to a training on non-suicidal self injury that was incredibly triggering, trying and revealing for me, that talked about the more successful ways and the less successful ways of dying by suicide. Sadly, I know several people who have succeeded at the less successful ways. I heard descriptions of methods and sat through the flashes in my mind of various people who have passed using methods being described. I learned of self-injurious behaviors I never would have thought of on my own, or ever contemplate. Sitting there, I remembered my “self-harm” behaviors, as we called them many years ago, then, giving me more confidence in moving toward the death-seeking behaviors.

Did this training intensify my fears? It sure did, and I am grateful for the opportunity to process the experiences my mind takes me on more often than I’d like. This training was reaffirming that I should continue reducing my access to means and keep communicating my fears. I can use talking to keep myself safe, safe from the part in me who lives with deep-seated pain that surfaces quickly at unexpected moments.

In escaping the years of cutting myself, I learned to keep with the intention (and by my choice) to not keep razors or other cutting materials in my space for impulsive moments. Like an alcoholic, or chocoholic, I can’t stop the cravings, but I can reduce my intake, keeping space between myself and what I am thinking about. When moments of relapse happened, space, again, sometimes with support, became my saving grace. Building on these experiences has helped me embrace similar motivation to keep myself from having uncomfortable access to suicidal means.

‘I want to be a statistic: one who has lived out her natural and medically intervened life!’

Conversations with service providers, online networks, and friends helped me realize I didn’t want access to much medication in my home. Overdosing was one of the ways I fantasized about dying and is a past trial toward death. A community resource helped by holding the bulk of my meds at times when my thoughts about having access to them became excessive. Today my choice to keep meds out of my home is a permanent comfort with the exception of a collection of a few single pills that are replenished with support should I (or my animals) need them.

Scary to think how educated I became with suicides happening, bringing me to question my own ability to live away from this choice, and question if I am strong or weak for living in spite of my pain. How can I reduce access to means when I learn about a death by burning at a gas station? I always get gas with my service dog in the car and keep a lighter out of it. How can I reduce access to means owning my own home with a garage and a car and a childhood fantasy of dying in a car chatting with a friend inhaling the exhaust? Aware of my impulsive past patterns, I keep animals I love in my home at all times and my garage just a little too full to fit my car. Having four animals in my home and not owning charcoal makes it a little bit of a process to board them all to light charcoal in my living space. I commit to life with them, loving them, knowing I won’t harm them. Driving my car, I trust that I won’t ever swerve off the road with my service dog in the car and at times that he is not, I keep accountable with a trusted friend that I openly communicate with when I feel the need or leave a reflective voicemail on a paid supporters line, having had prior discussion around this.

Reducing access to lethal means for death by hanging is not one I have quite managed to figure out. Options are all around me that I cannot escape. I have specific invasive thoughts. I have to consciously move the belt from the door where I routinely hang it. I cannot have it in the room I sleep in. I have put my rope in the shed because it scares me. I don’t allow myself to look up knot tying or do research on this method. I have talked about it. Somehow, sharing in this dialogue helps me better face and sit with my discomfort, not alone. So, the belt is out of my home... for right now that gives me a break from its pulling energy.

I have talked about the other things that are around that could harm me and how impossible it feels to truly escape all of it. I have laughed at myself in my discomfort in the comfort of a caring,

nonjudgmental, reliable ear. I talk, I write, I feel, I hug, I cry, I inhale, I exhale, I breathe again. I have begun to have conversations in our state so I, and others who want, may be able to put ourselves on a “please do not sell a gun to me” list to reduce our access to this mean when in a grounded, non-impulsive state. It is also a way to invite and encourage these sorts of conversations in our communities big and small.

I live with a disability that at times is incredibly painful, devastating. At other times, I am able to embrace the beauty of my struggle, strength within and beauty all around, but the reality is that my life becomes very hard because of my disability. Many years ago, I realized that I would never want to do anything to make my experience in this world more difficult. If I had an unsuccessful suicide attempt, I could end up suffering more and then live in true hell. I was able to identify my life as not all that bad, knowing there are many wonderful moments. Building on positive experiences is my desire.

Stress and engaging in a world that feels unnatural makes my experience with depression harder. In more difficult times I set intention to let go of the harder stuff, recognizing that right now, “I get to live”, understanding that my life and what I do in it is my choice. I get to choose to do things that bring me peace and meaning, uncovering and embracing the woman I love within.

A “measurable outcome” to me is that I have someone to call in the middle of the night, someone I call a friend, who is actually there, no matter what. Knowing this, knowing I am loved unconditionally, knowing someone is there, helps. Knowing I can call, because I have. Knowing they will be there, because they have been. Knowing I have the option to write out my feelings to a place every word will be read, helps. Knowing in the middle of the night, if it feels too overwhelming in my home, I can leave; I know this, because I have. Knowing in the middle of the night, if I am too petrified to move, I don’t have to. Knowing morning will come, because it has. Knowing I can share my fear experiences where it feels emotionally safe for me, is vital. Knowing, always, that I have access to different ways of communicating my feelings and fears in different places in whichever way suits my communication means at that time helps. Sometimes when non-verbal, this is through scribble or building things.

Morning always comes. Every day I have lived, daylight has come, stayed and darkness returned. Daylight comes again, and so does the darkness. My life, similarly so predictable? There is beauty in the darkness, a silence, a stillness, a presence like no other. Sometimes, there is a heartbeat I hear that is not my own. Sometimes, I notice my own light within the darkness.

I want to be a statistic: one who has lived out her natural and medically intervened life! So, I consciously choose to reduce my access to lethal means and communicate freely.

Melanie Jannery lives in Burlington.



Melanie Jannery

Mental Health Budget Increases Small, But Give Agency Raises

by C.B. HALL

Counterpoint

MONTPELIER — The Legislature appropriated \$224.26 million for the Department of Mental Health (DMH) for fiscal year 2017, which begins July 1. The amount was a 1.8 percent increase from the fiscal 2016 outlay of \$220.22 million.

Agency Pay Increases

The total included \$2.7 million more than what Governor Peter Shumlin had proposed, as a result of the addition of a two percent increase for salaries of staff at designated agencies, beginning in September.

The additional funds were in response to testimony that community mental health agencies are suffering from high turnover and difficulty in filling positions as a result of salaries that are not competitive.

The legislature directed that “priority shall be given to total compensation of direct care workers and non-executive staff.”

Prior Authorization

A proposal from the Department of Vermont Health Access (DVHA) to save money by requiring prior authorization for services after 24 outpatient mental health visits in a year became a source of controversy regarding parity with other health care services.

DVHA projected that services would be reduced as a result of the requirement, with savings of \$2.2 million. The department’s presentation asserted that the changes would “keep provider payments and methodologies on par with the private insurance community.” The House Health Care Committee objected, noting that “the private insurance community in Vermont discontinued the use of all prior authorizations for mental health visits after the new federal regulations were enacted in 2014 barring the practice as a violation of parity law.”

The final budget instructed DVHA to “ensure its clinical utilization review practices with respect to mental health services are consistent with State and federal mental health parity laws.”

Rep. Anne Donahue, who fought for the parity provision, described the outcome “as outstanding work by the House conference committee members to not permit backsliding on parity. There was just a meeting of the minds... that the best way to resolve the dilemma was to say to DVHA,

‘You can exercise any appropriate utilization review, but you have to be following the law on parity.’”

Reach Up Benefits

A controversial provision last year that counted \$125 of income from Supplemental Security Income payment toward the determination of the amount of a family’s Reach Up grant was revised, but only by a reduction of \$10.

Group Therapy

Another budget debate focused on rates that were reduced earlier in the year for providers of group therapy, who testified that access to group therapy would be significantly reduced if the reduction continued.

The budget directs DVHA to analyze the trends in use of group psychotherapy “to determine if the reimbursement rates currently in place for group therapy are sufficient to sustain access to cost-effective and appropriate psychotherapy services.”

Suicide Prevention

Additional funding of \$40,000 proposed by the governor for suicide prevention work was cut by the House but then restored by the Senate.

Psychiatric Survivors

Vermont Psychiatric Survivors received \$521,795 of the DMH budget, the same amount as appropriated in fiscal 2016.

Homelessness

Funding of \$40,000 was appropriated to the Agency of Human Services for an initiative to reduce homelessness, with training on best practices for housing and human services collaboration.

The budget directs that the analysis examine savings in other program expenditures resulting from the provision of homelessness services, including savings in health care expenditures. It is also to include “a comprehensive plan for substantially reducing homelessness in Vermont, including necessary strategic investments and concrete recommendations for implementation.”

Prescription Dosing

The budget directed the Department of Vermont Health Access to analyze data from Medicaid prescriptions “including prescriptions written to treat mental health conditions,” to determine whether health care providers follow the U.S. Food and Drug Administration’s recommended dosage amounts.



REDEDICATION — Rev. Susie Webster-Toleno leads a reflection at the rededication ceremony for the cemetery at the Brattleboro Retreat. (Counterpoint Photo: Anne Donahue)

Retreat Restores Burial Ground

BRATTLEBORO — The Brattleboro Retreat held a rededication ceremony this spring at a burial ground used for patients in the mid- to late 1800s and recently restored through a \$10,000 grant from Ben and Jerry’s.

Several dozen people attended the ceremony, most of them current or former staff or board members. One peer from the hospital’s consumer advisory council, Calvin Moen, was present.

The rededication ceremony in May included comments by the Rev. Susie Webster-Toleno. She read a poem written by Carl Sandburg that she said reflected the common humanity of persons who are sometimes considered less worthy.

Moen later commented that he wished more had been said about those who were buried there, who they had been and why they were laid to rest there. “There was no recognition of the tragedy that all these people died while institutionalized and were so estranged from their families and communities that no one could claim their remains,” he said.

According to the Retreat, little is known about whose remains are actually there. Only 37 stones remain in the small cemetery, and the grounds do not appear ever to have had capacity for the more than 600 patients whose names are recorded in an early journal under a listing of “Records of Burials in the Asylum Burying Grounds.”

Even those with named markers may no longer have remains there, according to Brenda Nichols, an unofficial Retreat historian. According to the Retreat, Vermont laws changed in the late 1800s to require towns to provide burials for their residents, and many remains are believed to have been relocated at that time. No records have been identified to indicate removal of remains.

The original cemetery also included a vault, which was removed in 1874, according to information in an application for the Retreat’s historic sites designation. A new vault was then built on an embankment along Linden Street, but there are no records of remains in either vault.

Between the time the Retreat was founded as “The Vermont Asylum” in 1834 and the opening of the cemetery in 1840, bodies of patients at the Retreat that were not claimed by families are believed to have been buried at Prospect Hill cemetery, at one time known as the Village Burial Ground. According to one internet blog, that cemetery’s “poor section” includes a few stones listing patients from the Vermont Asylum. The stones “are scattered few and far between leaving large areas that most likely held other burials... [of] the earliest patients to die at the Asylum.”

Legislature Directs Safety Measures For Site of Repeated Suicide Deaths

MONTPELIER — The state’s annual transportation funding bill included a directive this year for safety measures to be adopted at the Quechee Gorge bridge. It has been the site of multiple suicide deaths in the past 10 years.

The House Transportation and Human Services Committees held a joint hearing on the issue of high risk locations and successful prevention measures. Family and friends of individuals who died at the bridge in the past several years testified and urged legislators to take action. One survivor also testified.

Rep. Curt McCormack, who presented the bill on the House floor, said that the committees learned that 90 percent of the time, a person who has survived a suicide attempt does not then com-

plete a later attempt. As a result, successful interventions do not merely divert a person to a later death, but actually save lives.

The bill directs the Agency of Transportation to take steps in two phases. This summer, crisis information, including emergency contact information, is to be posted on the bridge — a measure which has been shown to be successful.

A more detailed review will then occur to determine if there are physical improvements to the bridge structure itself that can be developed. That review will include “suicide prevention as well as pedestrian, first responder, and other safety measures for all users,” including “costs and benefits” and any concerns about impacts of such improvements on tourism.

‘Healing Voices’

RUTLAND – Vermont joined in a world premiere of the documentary “Healing Voices” with film showings in four locations across the state on April 29.

Quotes from the documentary, *Healing Voices*:

Some 20 members of the community took part in a wide-ranging conversation hosted afterwards here by Vermont Psychiatric Survivors.

The event was called “One Night One Voice Global Event,” with more than 125 communities hosting screenings and community dialogues across the country and internationally. Groups in Brattleboro, Burlington, and Middlebury held events along with the one in Rutland.

The film project hopes to “encourage a shift in our thinking and understanding of mental health, or what society refers to as ‘mental illness’” as it “explores the experiences commonly labeled as ‘psychosis,’” the Healing Voices web site says.

“Discord between mind, body and spirit is what gets called mental illness.”

The documentary focused on the lives of three individuals over a period of almost five years as they worked to overcome extreme mental states. It described the supports they found from alternatives to the traditional model of mental illness as a brain disease – most often, from others who had gone through the same experiences.

“The beauty of the film was the honesty of the people” who shared their journeys, one person said during the conversation afterwards.

“Being in a place I don’t want to be, and not being able to find a way out.”

The discussion ranged among topics such as how to support others having a crisis, how to acquire voices to fight

for rights, use (and dangers) of medications, and misdiagnoses.

One community member said he was impressed by seeing people helping others who had lived through the same mental experi-

ences. He noted that in other areas of everyday life, “when someone has a problem, they typically try to find someone who has the same problem” to help resolve it. There is complete logic in that, he said.

Another, who observed the amount of caring that was shown, asked, but “what about all those people who don’t have that support? Are they the people who are left behind?”

A participant answered that “you can know you’re in trouble” and want to reach out for support, but “the stigma is still there” that makes it “an embarrassment and a strain to ask people for help.”

There is also fear. “The power of the system is profound,” she

said, noting the recent efforts in Vermont to speed the use of forced drugging. “There are a lot of reasons people aren’t reaching out, aren’t daring to.”

If you look at society as rungs on a ladder, “people with mental health issues are on the bottom rung,” another participant said. “Where is our voice coming from?”

“Because of our issues, we don’t speak up. We tend to withdraw and allow things to happen.” He pointed to Martin Luther King, the gay rights movement, and women’s liberation. “We

A “reaction to an emotionally overwhelming environment.”

don’t have a really loud voice like that. It’s

hard to see where in the future we’re going to [get] that voice.”

Wilda L. White, who is the Executive Director of Vermont Psychiatric Survivors and who facilitated the Rutland discussion, said the parallel to gay rights was a good one because being gay was once “treated the same way they treat psychosis.”

(Continued on page 19)

COMMENTARY

Meeting Halfway:

by CALVIN MOEN

I am in a meeting with a psychiatric hospital patient and her psychiatrist, whom she’s recently met. She says she would like to be discharged, that she doesn’t feel safe here being pressured to take medication that she believes may kill her.

The doctor tells her that if she requests discharge, he will file paperwork to have her involuntarily hospitalized.

He says the only way out of the hospital is to take the medication he’s prescribing. She is urged to do it willingly. Implied is the threat of force.



Calvin Moen

Sitting in that room, I think of Joseph Heller’s *Catch-22*. The title refers to the nonsense logic applied to the novel’s World War II pilots who ask not to fly any more missions: They can get out of flying them if they’re found to be insane. But as

soon as they say they don’t want to fly anymore, they’re proven to be sane. Because you’d have to be crazy to want to pilot a bomber plane under enemy fire.

In the hospital, you can’t leave until you understand that you need to be there. Wanting to leave is proof that you need to stay. Not wanting the drugs is proof that you need to take them. The patient at this table with us is here voluntarily and therefore has a right to be discharged. However, in the brand of irony described in *Catch-22*, this patient is at risk of “jeopardizing [her] [...] rights of freedom and independence by daring to exercise them.”

To this doctor who is offering nothing but ultimatums, I suggest a dialogue approach: “Whenever someone tells me they have stopped taking their medication, they usually have a reason. Maybe we could hear from ____ about what the problems were.”

She tells us she stopped taking her medication because she started to feel like it was no longer effective and possibly causing health problems.

Missing her point, he reasons with her: “If you are a diabetic, and your blood sugar is fine one day, you don’t stop taking your insulin.”

I don’t know why I’m shocked, since I hear similar arguments almost weekly, from the entire

range of hospital staff — clinical managers to social workers to mental health workers. But I thought we all knew better by now.

Journalist Robert Whitaker chronicles in his new book *Under the Influence* the decades-long public relations campaign waged by the pharmaceutical industry along with the American Psychiatric Association to convince the public that psychiatric drugs are corrective medicine treating organic diseases of the brain.

While most academic psychiatrists currently understand this to be unproven, an astounding number of prescribing doctors seem to believe neuroleptics (often called “antipsychotics”) to be as necessary for their patients as beta blockers for someone with high blood pressure. That’s what they’re telling their patients, anyway.

This doctor tells his patient he would never prescribe anything that would harm her, much less kill her — that this would be morally, ethically, and legally wrong — and he seems sincere.

I wonder if he’s heard the oft-cited statistics that those labeled with “serious mental illness” die 15 to 25 years earlier than average, which has been shown to be linked to neuroleptic use.

I wonder if he knows about the brain shrinkage and permanent muscle twitching caused by

(Continued on page 19)

A Community Discusses a Documentary That Sheds Light on Extreme Mental States

(Continued from page 18)

“They used shame and stigma to silence people” until people “came out” and stood up for themselves. “We have to not be

“Why aren’t we focusing on what’s creating this?” rather than the symptoms being created.

ashamed of being psychiatrically labeled,” White said. “That is the only way we are going to be able to say ‘stop killing us.’”

“We have to be brave and speak out and get each other’s back.” A community member responded that “I consider it a gift when people share what they’re going through. It’s how we learn.”

Going through **“All behavior has meaning.”**

mental crisis is often seen as all negative, but “there are all kinds of insights and wisdom” that can be gained, another person replied. “There is a lot more to the experience than the pain.”

Someone then reflected that “we are a society where everybody has to be perfect,” but the reality is that “we are not all perfect” and “we all have differences.”

One person said that in her own experience, she felt both sides

What is mental illness? “It’s behavior decided by a committee of the American Psychiatric Association.”

of the issue of forced drugging, because “when you need immediate help, sometimes you have to get it,” even if involuntarily.

Another, who had worked in a hospital in the past, added that she, too, had mixed feelings because she saw situations where “at that point it helped people, even if it was forced,” until an individual became less acute and could have drugs reduced.

The documentary itself shared in-

formation from experts such as writer Robert Whittaker, who discussed the false promise of medication that was built up through the last quarter of the 20th century.

We have a “mistrust of our own abilities” and “too much [trust] in the professional community,” one person reflected during the discussion. She noted the powerful influence of drug manufacturers, and said that although medications were helping her, the industry is “over pushing” them.

They turn “everything into a mental illness” and “everybody into a cookie-cutter person.”

Even the language about drugs is manipulated, another person said. “They don’t like somebody saying there will be withdrawal” from a medication, because that would mean admitting it was an addictive substance, so instead it is called “discontinuation symptoms.”

And it can be worse for children.

“I really feel some of it is a societal thing,” one woman said, when kids are medicated because parents have no time in their lives to deal with a difficult child.

Both medical and psychiatric doctors fail to engage with their patients, a participant commented. They have “talked *at* me instead of talked *with* me.” They need to remember “Don’t do *to* people; do *with* people.”

Article by Anne Donahue

“Acknowledge that trauma exists, that we all go through trauma.”

“Look at [people] as going through a difficulty.”

“I’m convinced that compassion is our only hope.”

Informed Consent for Psych Meds

(Continued from page 18)

long-term neuroleptic treatment. But I don’t want to jeopardize my seat at this table, or hers, by suggesting to the doctor he is in fact doing harm by not allowing room for his patient’s experience and expertise on her own life, that he is misled and misleading in his understanding of how psych drugs work, that morally and ethically he ought to be discussing the risks and rewards of these drugs equally.

From my vantage point as someone who works with folks across the spectrum of inpatient, residential, and community settings, I see the cycle many are caught in: hospitalization with its coercive medication agenda, followed by discharge and brief stability, followed by discontinuation of intolerable psych drugs, followed by crisis or perceived crisis, followed by re-hospitalization and re-medication.

Legislation proposed earlier this year that purported to offer Vermont financial savings by speeding up the involuntary medication process would merely speed up this expensive, damaging cycle, effectively institutionalizing those it claims to be benefiting.

The Department of Mental Health has made some tentative investments in alternatives to this model, including Soteria House, a five-bed resi-

dence for individuals experiencing a first “break.” As of its first anniversary in April, the program had provided a home and medication-neutral support to 12 residents. While this is an important beginning, we are far from having an accessible alternative for everyone who needs it, and structured programs offering support for getting off psych drugs in the community are still a long way off.

In February, Malaika Puffer and I presented on harm-reduction approaches to medications and withdrawal as part of the Brattleboro Retreat’s luncheon series. The responses were overwhelmingly positive, but the few negative comments on the feedback forms were telling.

To paraphrase a couple of them: The presenters relied too much on their own personal experiences and not enough on scientific data. (We discussed three major studies comparing long-term outcomes of med use versus med tapering.) The presenters were judgmental toward people who need to be on meds. (We devoted one of our slides to stating that there is no good choice or bad choice, as long as the individual is fully informed of the risks.) I’m reminded again of *Catch-22*, in which Heller says of a particular army general, “When people disagreed with him he urged them to be objective.”

Of that same general, Heller also says, “If the

people who worked for him met him halfway, he would meet them more than halfway,” with the result that “there was never any meeting of the minds.” I think back to the doctor who, instead of meeting his patient halfway, went right past her, taking up more than his share of the space.

All of this leads me to wonder what real objectivity could look like for medical professionals. I wonder what it will take for doctors to be held accountable for discussing all aspects of risks associated with pharmaceuticals. I wonder how we can shift toward a moral, ethical, and legal imperative for professionals to guide patients to make informed choices about their own bodies and lives.

Heller’s novel is about power and who controls reality. There is no meeting of the minds if one of the minds is declared to be “delusional” by the other.

It might be that the way out of the catch-22 is to shift the power dynamics, to define reality in the terms of the person being treated, and to insist, again and again, upon informed consent as a fundamental patient right.

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

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

Editorial

A Blow to Privacy

Vermont’s Supreme Court delivered a punch in the gut to the psychiatric survivor community this spring.

In one broad brush, it relegated everyone who has been in the hospital with a psychiatric diagnosis to a status of incompetence, and took away a fundamental privacy right.

It is discriminatory, and it is stigmatizing, and it is just plain inaccurate to suggest that a person lacks capacity to make decisions simply because they needed (or were required, involuntarily) to receive inpatient care.

The court made this staggering statement when it decided that HIPAA — the federal health care privacy law — did not apply to a young man who was being discharged from the Brattleboro Retreat.

He was an adult, going home to stay with his parents. The court said that the Retreat “transferred custody” to his parents. But the Retreat didn’t have custody! And his parents couldn’t take custody! He was an adult. They were not his guardians.

The court’s opinion addressed the question of whether the Retreat and Northeast Kingdom Human Services failed a duty to warn the parents that the young man — who was discharged by the Retreat and then was receiving outpatient services from NKHS — presented a high risk of violence, and therefore were liable for the injuries to a man he assaulted.

The court decided the Retreat and NKHS had that duty to warn them, and to give his parents information about his illness so that they would realize how important his treatment plan was, including the importance of making sure he took his medication.

What would his parents have done with this information? Who knows what the court was thinking? He was an adult, free to stop taking medication, free to move out from his parents’ home and free to live as he wished.

Information about someone’s diagnosis and treatment plan is confidential information, protected by the federal HIPAA law, but the court said he came under a HIPAA exemption.

If a person is unable to consent or object “because of the individual’s incapacity,” information can be given to others who are involved in giving care. The court said that it was “evident from the facts” that the young man was “sufficiently incapacitated” that he was unable to consent to disclosure.

What made that evident? He was an adult; he had been a voluntary patient at the hospital; he was receiving outpatient care; no court had found him incompetent... but the Retreat and Northeast Kingdom Human Services were supposed to be ignoring his right to privacy and giving his parents information about his treatment plan and his risk of violence.

That leaves none of us safe from being found to be too “incapacitated” to decide whether to consent to the disclosure of information.

It is the kind of discrimination based upon a psychiatric diagnosis that we have been fighting for years. It is a huge step backwards to hear it endorsed by Vermont’s highest court.

Save the Date

Vermont Psychiatric Survivors, Inc.

Annual Meeting

Saturday,
September 24, 2016

10 a.m. - 3 p.m.

Our Lady of the Angels
Church, Randolph, VT

Business meeting,
program, lunch provided

Op-Ed Page

Opinions

The Blessing of Finding Meaningful Work and Life

To the Editor:

The Clara Martin Center has truly blessed my life. Today I have meaningful work, meaningful life, and valuable love and connection in my life.

When I was struggling incredibly in Chicago with a bipolar I diagnosis, my therapist at the time there discussed with me the concept of “work.” I could not work at all at the time, was sleeping almost 20 hours a day, and life felt torturous. I felt a lot of worthlessness and clinical debilitating depression and fatigue. It was a painful walk just to make it to my once a week therapy sessions. My marriage was falling apart and I was a wreck.

Fast-forward to the summer of 2001. I had been off “meds” for a year and found myself in an extreme state (labeled mania by doctors) and in the hospital. My current Clara Martin case manager was the first professional to visit me in the hospital. I was just happy to have a visitor.

CMC stuck with me the whole time, during a period of heavy drinking and pot use. Some days were better than others, but my therapists over the years and many staff at CMC remained compassionate towards me.

Today, April 25, 2016, I celebrate multiple years of clean and sober time. CMC has sup-

ported me going to a 12-step program for community and sobriety. My initial diagnoses propelled me professionally and personally into the complex healing world of mental health. I have, by the grace of God, degrees in theatre from a world-class liberal arts college and even a Master’s Degree in Clinical Mental Health Counseling. I figured that as a client of therapy for 20+ years that I could obtain the degree. I received excellent grades and the whole time had the gentle but firm support of CMC.

I now have 13 years of experience working in the field as a professional.

But it is also, as you know, the personal quality of life that matters. CMC stresses good diet, exercise, and of course good therapy. Every week I experience “meaningful work,” a meaningful life. I have the honor of helping people stay alive and strive to let them see the goodness within themselves. I deal with every subject you can possibly think of at work, and it is because of my own vast experiences that I respect confidentiality so very much.

CMC stays with me through the laughter and the tears. In Vermont they are regarded as one of the best designated mental health agencies.

To be totally transparent, when I was 29 years old I found myself unable to afford housing. I found a home then through CMC and have stayed the course over the years. I can literally say they might have saved my life.

Additionally, my psychiatrist at CMC treats me as the whole person that I am and is very kind. I also have very good relationships with the Vermont Department of Mental Health (DMH). I have been on national and local radio as an advocate. I have testified, along with others, at the Statehouse in Montpelier. To move forward in a transcendent and modern way involves the work of many in a collective fashion.

I am a proud native Vermonter and Randolph is the longest I have lived anywhere. I came back to my roots in central Vermont and am happy to make it my home. Before that I was constantly moving, sort of like a gypsy. Today I am grounded, with the help of my loved ones and CMC.

Personally I also met the most wonderful man in Randolph, and he is my strength and the love of my life.

Because of all these valuable things, it is a part of my destiny to give back to me what has been so freely given: meaningful work, a meaningful life and one worth being healthy and thriving in.

Thank you, Clara Martin Center and wellness in Vermont. You have given this spirit the wings to fly.

NAME WITHHELD
Randolph

Seeing Gradations In Human Nature

To the Editor:

Vermont can be proud of new Commissioner of Mental Health Frank Reed for reminding us that “it is the gradation of issues that separates me from every other person.”

While certain degenerative diseases are inevitable in any era, the modern Age of Anxiety need not go on indefinitely. People take it way too for granted that we can never be as good as the saints and martyrs we’ve read about.

A confused vision of human nature cuts into every individual’s day-to-day heroism, separating us from our godhead and Mother Nature. The healing needs to take place at basic levels.

Newspapers like this prove that we are working steadily to sort out these issues.

JOHN SAVLOVE
North Bennington

OBITUARIES

Amos Beede

BURLINGTON — Amos Beede, 38, died on May 25, 2016 at the University of Vermont Medical Center from trauma sustained several days earlier as a result of a beating at a homeless encampment.

He was known by many in the survivor/consumer community as Amy, his name prior to his transition to a male about a year-and-a-half ago. A memorial was hosted by the Pride Center of Vermont on June 8, “to remember, grieve and celebrate Amos Beede’s life.” Beede was from Milton, where he was a graduate of Milton High School.

Four persons have been arrested in his death. Police said they have not ruled out the possibility that it was a bias homicide based on his transgender status, but that it appeared to be based upon a dispute.

Dirk Nakazawa

BRATTLEBORO — Support group facilitator Dirk Nakazawa, 46, died March 7, 2016.

Nakazawa was an active volunteer and member of NAMI Vermont. In 2009, he became a Connection Recovery Support Group facilitator and he started the first in-hospital NAMI Connection meeting at Rutland Regional Medical Center. The weekly meeting continues today and has branched out to other hospitals.

Nakazawa was born in Nyack, NY, on January 24, 1970, the son of Maria and Hiroshi Nakazawa. He was raised in Valley Cottage, NY, and attended Green Meadow Waldorf, Dwight-Englewood and The Hill schools. He graduated with a B.S. in International Political Science from Middlebury College, VT.

He was a member of Grace Congregational Church and a member of the Nyack Field Club. He leaves his parents, Maria and Hiro Nakazawa, sister, Aniko DeLaney, and former wife, Rosangela Borey.

Save the Date!

Sept. 12, 2016

**Toward a More
Authentic Coalition:
Uniting Three Statewide
Peer Networks for More
Powerful Advocacy**

Vermont Psychiatric Survivors is joining with the Vermont Federation of Families for Children’s Mental Health and the Vermont Recovery Network to host a conference that will focus on crafting a preliminary strategy for collective advocacy. Don’t miss this unique opportunity to be a part of building a powerful coalition for advocating for our self-determined needs. For more information or registration, contact Hannah Rose at hrose@vffcmh.org

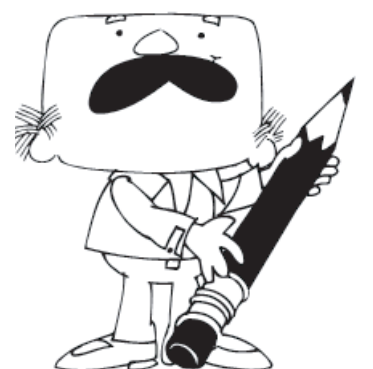
Concerns? Kudos? Complaints? Share Your Thoughts Here!

Send comments to:

Counterpoint, The Service Building, 128 Merchants Row, Room 606, Rutland, VT 05701,

or to counterpoint@vermontpsychiatricsurvivors.org

Names may be withheld on request, but must be included in letter. Letters do not represent the opinion of the publisher, and may be edited for length or content.



Again and Again

by LAURA LEE SMITH

In the dark alley I hear in the background what sounds like sirens of an ambulance and the police. I smell refuse, vomit and something putrid and even less desirable.

“I have been giving her CPR for three minutes sir, no response.”

“Let us take over, IV drip and adrenaline, have it ready!”

“I don’t think this one is gonna make it.”

Who, who isn’t going to make it? I feel a panic rise up inside of me. Damn, I am so cold, deep-freeze cold. Everything goes black like in the movie theatre when the movie is over and everyone has left. It feels ominous.

- - -

The monitor beeps intermittently. There is a fly buzzing annoyingly around the room. Hanging in the air the claustrophobic feelings of sorrow and regret. Someone speaks, “There’s not much time...” I don’t recognize the voice.

The smell of sterility, bleach solutions and cleaning chemicals flare my nostrils with a slight burning sensation. “Just a reflex, nothing more.”

Who is that? I don’t know who you are and I don’t understand why you can’t hear me, and who are you talking to if not me?

“It’s best to pull the plug.” What? What plug? I feel trapped in here.

I rage against the darkness, against the prison my body seems to have become. It is darkness without being dark, light without any light; beyond human explanation. There is a moment of such distinct clarity; my two sisters, my father, and my boyfriend are gathered around me.

I can see the top of the doctors’ head; he

is wearing a scrub cap, blue with penguins. I sense the love these few people have for me as the doctor gives them time with me. I notice the floor is clean, the sheets tightly tucked around my body.

A machine makes my chest rise and fall, rise and fall with a swish-click sound. It stops. The beeping is one long beep that sounds as if it will go on forever. It begins to sound more distant.

Then nothingness. I am back to the darkness without dark. There are other presences around me. I feel them, sense them, I hear them mumbling to themselves.

I realize I didn’t make it, but I am not full of pain anymore. I have no more need of machines, monitors and needles or doctors. I am free. Free at last, a spirit that momentarily understands the meaning of all life. A profound peace I surrender to.

All too suddenly, I hear a heartbeat and the rushing sound of blood running through arteries and veins. It feels somehow comforting, like a lullaby or a crackling fire in the woodstove on a cold winter’s night.

I feel buoyant, safe. It is dark here but it feels right. It stays this way as I feel changes in my body. I begin to move and stretch, I can kick and punch, am I a ninja?

Then I am no longer buoyant. I am being squeezed all over my body-self in wave upon wave. It hurts, I feel alone. There is screaming. Is it me? I am not sure.

There is light but it hurts, things are blurry, I can’t keep my eyes open. I am so cold. I am so tired. I do not feel safe anymore. I am wiped off and again have some sort of sheet tucked in tightly around my body. So tired and I believe hungry are the sensations I feel, and alone.

The stringent smells of bleach solutions and cleaning chemicals slightly burn the inside of my nose. I don’t like it. I wrinkle my nose. I hear people chuckling.

Someone says, “It’s a girl, a healthy beautiful girl!” I feel like I am traveling through space and find I have landed being given over to something. Some soft, warm mountainous thing gives me milk if I suck. I feel a connection to this warm thing.

She? Yes! I recognize her, she is my sister. I try talking to her but all that comes out are bubbles and babbles. There are other voices in the room I recognize. One of them laughs and says, “She is trying to talk already.”

I am beginning to understand that I have died and am now the child of my sister, merely drooling in her arms. What happened to my soul? How is it that I am here? I don’t believe in reincarnation.

My sister who apparently gave birth to me says, “I am naming her after Pella. I think she should be Pella.”

I have my name again? Someone else says, “She even looks like her.”

“She should be here,” my other sister says.

“Honey, your sister is here, right now. I can feel her.” That was my Dad.

This is too surreal.

- - -

Time goes by, memories fade. I am a child with a great mom and dad, grandparents, too. They do not need to know. I have no longer a reason to remember. I am making new memories and a new life. Maybe I will get this one right.

Laura Lee Smith is from Marshfield.


Enter

The 2016 Annual


Louise Wahl Memorial Writing Contest

Prose or Poetry

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.



Contest Deadline *extended to* July 29, 2016



Total Prizes of \$250!

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.

Commentary and Reflections

Keys: Out of My Hands

by KELLEY L. MURRAY

I am supposed to be unfamiliar with this object, but, alas, I know it all too well. It should be unfamiliar. For a decade there were long stretches of years in which I did not have my own set of keys.

Attendants carried the fashion items of the mental hospital. They were both loved and despised. An attendant both opened doors and slammed them shut. The noisy clatter of an object that would rather be forgotten, was far too loud.

I come and go now, no longer imprisoned, no longer without my own keys. Liberated by my ownership. These keys are my keys.

Now keys represent both security and freedom to me. They ensure that my stuff stays my stuff. They are to my room at my parent's house, my mailbox, my file cabinet, my front door, my apartment

door and my friend's door. Protect your home and your belongings. Buy locks and keys. You can't live without them.

Reasons to hate keys: you must carry them everywhere. In the event that you lose them, you must replace them and/or change the lock. If you do not, then you run the risk of having an intruder enter your apartment and check out your mailbox and file cabinets.

Small, they fit in my closed hand. Together, they make a pleasant noise. Color coded, they are aesthetically pleasing.

The smallest is of great importance, it is to my world of correspondence, my world beyond my home, my mailbox. The next in size is to my file cabinet where I keep my really private stuff, and old photographs. Then there is my front door key. It serves as a reminder that I share my living quarters with other

apartment renters. We have a little community. I like my neighbors.

I have two door keys to my apartment, a top and a bottom. I also have a key to my room at my parent's house. It prevents snooping around by family members.

The use of keys represents a strange kind of intercourse. Insert key, turn key, lock opens, door opens.

We are animals of territory, we claim stuff and places as our own. We defend our space against others. We do this constantly and consistently.

Keys are both my security and my freedom. I come and go now at will -- liberated through ownership. They are my keys.

Kelley L. Murray is from Brattleboro. This piece evolved into a performance piece as Purchase.

'Love Is the Answer'

Reflections After Losing a Friend

by MARLA SIMPSON, MA

John Lennon said that all human emotions and reactions are based in two things: fear and love.

When we live in a love-centered space we treat others as we would have them treat us. When fear takes over then a lot of depression, anxiety, and suicidal feelings begin or get worse.

After hearing about the passing of my friend to suicide, I was bereft. I felt extremely sad for him and for my loss. The loss for a whole community.

I wish there is more I could have done. That is why people need to express love to each other while we're still in physical body.

The spirit is eternal. Spirits are aware of us and have some more insight into things than we

might consciously have. Trust your own intuition, and always forgive yourself for the past. Do not regret it. The past is there so we may all learn from it for the present.

Have great hope for the future. Too often I talk with people who are very hard on themselves. The expectations and fears are overwhelming.

When I read the book "The Power of Now," by Eckhart Tolle I realized that whatever time it is, it is right now. So don't delay. Let your loved ones know you love them, that you think of them. But above all love yourself.

Things and practices that help me stay very grounded are prayer, meditation, exercise, animal therapy, reading, and expressing myself with safe

people. Safe people are those who are not judgmental. They keep an open mind and are accepting. Take all things one day at a time. If people just break their lives down into 24 hour periods, life is much more manageable.

Love is the answer. Love is the key.

We are all here on earth-school to love. We have all lost people, we have all felt joy and sadness and grief. But for today I am very happy. I have contentment.

Body/Mind/Spirit Health is the key to happiness. God Bless. Thank you for reading and I wish you all the very best.

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

Four Broken Steps Lead Down

by PAULA SPERRY

The process of going into deep depression is easily delineated — in hindsight.

There is first the sense of a shaking at your core, a very mild tremble, the view just a tad off focus; you think perhaps it is akin to water in the ear or the necessity of having your glasses prescription adjusted slightly.

Quite easy to brush off, though if you have been in this territory before, you are conscious of what it portends.

Then comes a marked struggle in maintaining a semblance of what your routine life may be. You still feed the cats, read the books, albeit desultorily; ask your partner about their day and fake interest in things you vaguely remember having liked.

This point in the descent is more an earthquake at sanity's foundation than a slight shift in balance.

Then comes the worst. Terror. Rumination. The critics in your head who won't shut up. You can't do anything, but the problem is you still care.

I think of it as similar to a person with Alze-

heimer's, recently diagnosed, who has been losing their memory for some time, but is still aware enough to be deeply troubled and haunted by it... who can see the train coming through the tunnel at them and yet knows there is no time to get out of the way.

It's this period that is most deadly, for you still have awareness of the hell you are in, and are entirely incapable of changing it.

You still have the energy to end it all and be plunged forever into the deepest level of true selflessness. You are of no value, and worse, you are a thousand pound weight upon those who love you.

A neutral presence in someone's life is one thing; an overwhelmingly negative one is quite another.

The truth of existence has been laid bare, for the first time it seems. You were blind to think there was anything useful about you. It's not depression, it's the truth.

And, finally, there is the utter disintegration of the self. While this period may be more troubling for those around you, it is just fine for you.

Because there is no longer a you. There is no

more trying. No more self-recriminations. Because you are utterly anesthetized.

In a coma of the mind and soul, nothing that happens about you has any significance. And nothing is happening within you either.

The "you" is simply nullified, and while you will later, in retracing these steps out of the pit (if you get out at all), remember some adjectives to describe to others, you will have no somatic memory of what occurred or for how long.

This deepest period is death without a God or devil. It is only noteworthy to others.

Climbing back out is never linear. There may be one day of mild tremors, followed by one of nullification.

Stages of decline and ascent look remarkably similar and you often can't tell which way you are going. As if you were underwater, drowning, without knowing which direction is the surface.

If you finally let yourself sink to the bottom without protest, you have a better chance of gaining purchase on the ocean floor and pushing yourself back up, toward oxygen.

Paula Sperry is from Rutland.

Arts

Poetry and Drawing

Dusk

Dusk
Dusky air
I drink
myself full
gratitude, I think
of wind
And the smell of salt
of surf breaking on water
my body sleek, round
A pod of Orcas swims by
The seal in me no longer basking

OCEAN CHANCE
Michigan



Two Worlds

by Emma Benard

Lost Time

For Melissa

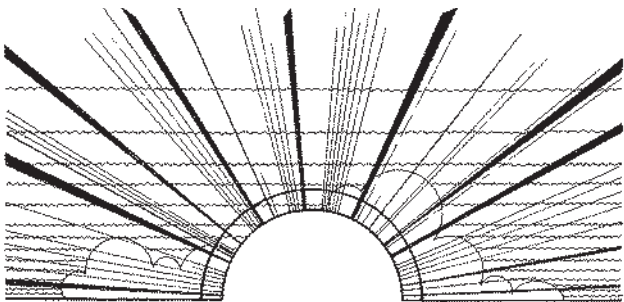
We almost had an accident
Driving fast on the highway to Lyndonville
Trying to catch up with the lost time.
It seems we're always in a hurry –
You – having a job with the phone company
Taking care of two boys, a dog and a husband.
Me – housesitting friends' houses, working part-time,
Writing and getting ready for my trip overseas.
On the back seat is your mother-in-law
Worrying about spending another winter alone
As there's no space for her in the assisted living.
It's October in Vermont
The most beautiful of seasons
The sky ash-blue
Above the golden sparkling leaves.
We are going to see "Kitka" –
The women's vocal ensemble
Singing traditional songs from Eastern Europe.
You stop at the scenic view
I take pictures of serene countryside.
with the river flowing
between a meadow and a hillside,
Farmhouses and horses, it reminds me
Of my native country.
Half of me is already back –
The landscapes blend together
But I feel I am flying with the birds
And feel homeless in both places.
We leave your mother-in-law
In her home near Lyndonville;
I am concerned about the old woman
Living alone in the isolation.
You say it's OK she's used to it.
Sometimes, you say, you wish to live alone
Instead of breaking your back
Under family responsibilities.

by VESNA DYE
Burlington

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





by Pamela Spiro Wagner, Brattleboro

This One Heart Beat

to my son

In all my brokenness, my heart, my heart, has one beat — and because you tell this to believe, and so it does —
With this one heartbeat it clings to your big brown eyes, and with this one heartbeat it clings to your smile and
your laughter that helps me get through this darkened week that feels like a broken road
With this one heartbeat it clings to your voice like I'd cling, to you as if you were right here in my arms
This one heartbeat clings to the very twinkle in your eyes and every tear drawn from them
This one heartbeat clings to your joy, your happiness, your sadness, your weakness and the very sadness in your soul
This one heartbeat clings to the strength just by strength of your faith, your hope, but above all is your love that
connects us to this one heartbeat

To Elijah Judd Barrett
Love, Mom

SERENA CHURCH
Brattleboro

The Imaginary Place

The imaginary place where I keep my private thoughts
In the floating empty silence with my stomach tied in knots
I perceive the perfect riffs for the six string on my lap
I receive the higher voices which I cultivate and tap
It can sound like choirs of angels with a fine orchestral grace
Or the whisper of a woman - I can almost see her face
It can leave me feeling something that is greater than all pain
If I wonder in my torture how her hair smells in the rain

CHRISTOPHER HAYDEN, Burlington

Peer Worker Celebration!
August 3
Branbury State Park,
Lake Dunmore
11 a.m. - 3 p.m.

The Wellness Workforce Coalition will honor people who work by providing peer support at this lakeside event. For more information, check the Wellness Workforce Coalition website at <http://wwcvf.org/> or call 802-224-1818

Death of the Imposter

I. Once alcohol was her water

In mommy's liquor store
sitting atop one wine box each
with two white beer boxes stacked between our chubby legs
Shiny glass bottles of brown liquid surround us

We finish our bagels
Cinnamon sugar
Blueberry

Watch tall men hurry around to the back room
Rough steps heavy
steps all the way down to the wine cellar
Icy cold

She gives us each one mini shopping cart
We smile and choose our favorites
Rows of snacks and sodas
It is fun to be at the store

II. On the drive home one can of beer
unhidden
next to her thigh

III. She knows every name, flavor, customer preference, price, seasonal favorite,
shipment date
The way it seeps into her slowing down
the pain

IV. Of grief
 Brain tumor - death
 Slipped under the car tire paralyzed her tail can still wag
 when I stroke her curly black ears put down - death
 Phone ringing fallen off the roof coma phone ringing - death
 Car accident stroke paralyzed surgery coma waiting waiting -

Me fading
quietly, hollowly away

Please save mommy

Praying fails me
Praying holds me

V. In the small kitchen
We have to tell you something...
Pulled over, drinking, heads bowed down
Tears soak her worn gray sweater
Daughters begging:
But you won't do it again? It will be okay?
Empty
silence

This was the day her eyes changed

VI. All kinds of bottles
In the basket underneath sports magazines and newspapers
Behind the stained curtain of
the cigarette-stale entryway
Slipping secrets under daddy's folded sweatshirts
at the top of the closet where he doesn't go in the summertime

VII. I am paranoid about her dying

I find her bloated body
spread across the couch after softball practice
Her glossy wet eyes roll up and open
I collapse into myself

VIII. Change

Thank you Maple Leaf thank you AA thank you Higher Power thank you will thank you
choices thank you for not taking us away from her thank you second chances thank you
shiny sobriety coins thank you Styrofoam cup filled with coffee thank you long busy
days at the recovery center, late nights, square rooms, cookie jars full, humming of
stories, shuffling of feet, nods of unconditional understanding
Thank you

Mom, you're back

by EMMA BENARD

Arts

Poetry and Drawing



by LISA CARRARA, *Weathersfield*

#50

I've not enough time to hold you in my mind
nor had enough moments for reaching out in time
I've tried to live without you living with me
and found it can't be done so easily

what do I mean when I say I'm missing you
what do I mean when I know I'm losing you
I've blocked you away cause the pain cuts deep inside
what can I say we've never had our time

my sister I miss you, now you're so far away
there's so many times I wish I could hear you say
'won't you hold me tightly in your arms'
'won't you make the sadness go away'

we all go away from each other every day
we've all got our reasons for being what we say
but you were ripped from my life so suddenly
I don't know how to let go too easily

oh woman I miss you, I keep hoping to hear you say
that you are missing me in a very special way
be in my dreams, come knocking at my door
tell me just once what the hell I'm living for

I've not enough time to hold you in my arms
nor had enough moments for reaching out in time
I've tried to live without you living with me
and found it can't be done so easily

m.e. wakeman
north bennington

Heart's Surrender

The true feelings within me
Your silence leaves you breathless
Your eyes tell truth
Your smile brings cheer
Your sadness brings rain
Your nature gleams light
Your being brings sunshine
Your tears show true emotions
Your pain will make you grow
Your courage will help you strive
Your loneliness finds a happy place
Your boredom helps you stay busy
Your dreams discover reality
Your sorrow helps to grieve
Your weakness finds you strength
Your hate helps to forgive,
but not to forget
Your love shows
and grows forever

Laurie Bevins
St. Albans

That Second Night

I gather the candles
I scatter them about
I light them all
then I turn out the lights
Welcome the night my friend,
starlight
Sometimes the pattern of the
candles
The pattern of the stars
They match reflect
To my eyes
To my mind
It made me wonder
It will always make me think of you
The slow smile gently given
Like a rainbow in the late
Afternoon's misty sunlight
Oh yes I remember well
That second night

E. E. RICE

Resources Directory

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

Contact us if your organization’s information changes:

counterpoint@vermontpsychiatricsurvivors.org

Vermont Psychiatric Survivors Peer Support Groups

Brattleboro:

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

Bennington/UCS

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

Northwestern

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

Rutland

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

Springfield

- First Congregational Church, 77 Main St., every Thursday from 2-3:30 p.m., Call Diana at 802-289-1982
VPS is a membership organization providing peer support, outreach, advocacy and education; 128 Merchants Row, Suite 606, Rutland, VT 05701. 802-775-6834.

www.vermontpsychiatricsurvivors.org

Community Mental Health

Counseling Service of Addison County

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

United Counseling Service of Bennington County;

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

Chittenden County: Howard Center

300 Flynn Ave., Burlington, 05401; 488-6200

Franklin & Grand Isle: Northwestern

Counseling and Support Services

107 Fisher Pond Road, St. Albans, 05478; 524-6554

Lamoille County Mental Health Services

72 Harrel Street, Morrisville, 05661; 888-5026

Northeast Kingdom Human Services

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

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

800-649-0118

Orange County: Clara Martin Center

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

Rutland Mental Health Services,

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

Washington County Mental Health Services

9 Heaton St., Montpelier, 05601; 229-6328

Windham and Windsor Counties: Health Care and

Rehabilitation Services of Southeastern Vermont, 390 River Street, Springfield, 05156; 886-4500;

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

49 School St., Hartford, 05047, 295-3031

24-Hour Screener Crisis Lines

(**Addison County**) Counseling Services of

Addison County 802-388-7641

(**Bennington County**) United Counseling Service

(Bennington) 802-442-5491

(Manchester) 802-362-3950

(**Chittenden County**) Howard Center

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

(children and adolescents) 802-488-7777

(**Franklin and Grand Isle Counties**)

Northwestern Counseling and Support

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

(**Lamoille County**) Lamoille County Mental Health

Weekdays 8 a.m.-4 p.m. 802-888-4914; Nights and

Weekends 802-888-4231

(**Essex, Caledonia and Orleans**) Northeast

Kingdom Human Services 800-696-4979

(**Orange County**) Clara Martin 800-639-6360

Rutland Mental Health Services 802-775-1000

Washington County Mental Health Services

802-229-0591

(**Windham,Windsor Counties**) Health Care and

Rehabilitation Services 800-622-4235

Peer Support

Warm Lines

Vermont Support Line (Statewide):

888-604-6412; every day, 3-11 p.m

Peer Access Line of Chittenden County: 802-321-2190, Thurs-Sun,6-9 p.m.; for residents of Chittenden County.

Washington County Mental Health Peer Line: 802-229-8015; 7 days/wk, 6-11 p.m.

Mutual Support Network

The Hive: info@hivemutualsupport.net

www.hivemutualsupport.net

802-43-BUZZ-3 (802-432-8993)

Crisis Respite

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

information@alyssum.org

Crisis Text Line

Around-the-clock help via text:

741741 for a reply explaining the ground rules; message routed to a trained counselor.

GLBTQ Youth Crisis Hotline:

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

Text - Available on Fridays (4-8 p.m.).

Text the word “Trevor” to 1-202-304-1200. Standard text messaging rates.

Trans Crisis Hotline

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

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

Peer Centers and Employment Support

Another Way, 125 Barre St, Montpelier, 229-0920; info@anotherwayvt.org; www.anotherwayvt.org; see web site for events calendar.

The Wellness Co-op, 279 North Winooski Avenue, Burlington, 888-492-8218 ext 300; thewellnesscoop@pathwaysvermont.org; www.thewellnesscoop.org; check web site for weekly calendar.

NEW! 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.; Montpelier currently organizing. Call or watch for future announcements.

Brain Injury Association

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

DBT Peer Group

Peer-run skills group. Sundays, 4 p.m.; 1 Mineral St, Springfield (The Whitcomb Building). http://tinyurl.com/PeerDBTVT

Vermont Recovery Centers

www.vtrecoverynetwork.org

Barre, Turning Point Center of Central Vermont, 489 N. Main St.; 479-7373; tpccvbarre@gmail.com

Bennington, Turning Point Center, 465 Main St; 442-9700; turningpointbennington@comcast.net

Brattleboro,Turning Point Center of Windham County, 39 Elm St.; 257-5600; tpwc.1@hotmail.com

Burlington, Turning Point Center of Chittenden County, 191 Bank St, 2nd floor; 861-3150;

GaryD@turningpointcentervt.org or

http://www.turningpointcentervt.org

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

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

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

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

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

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

www.kingdomrecoverycenter.com

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

Vermont Veterans Outreach:

Bennington Outreach: 802-442-2980; cell: 802-310-5391

Berlin Area Outreach: 802-224-7108; cell: 802-399-6135

Bradford Area Outreach: 802-222-4824; cell: 802-734-2282

Colchester Area Outreach: 802-338-3078; cell: 802-310-5743

Enosburg Area Outreach: 802-933-2166; cell: 802-399-6068

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

www.MakeTheConnection.net

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

Homeless?

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



VA Mental Health Services

VA Hospital: Toll Free

1-866-687-8387

Mental Health Clinic:Ext 6132

Outpatient Clinics: Bennington: 802-447-6913; Brattleboro: 802-251-2200; Burlington Lakeside Clinic: 802-657-7000; Newport: 802-334-9777; Rutland: 802-772-2300; **Vet Centers:** (Burlington) 802-862-1806; (White River Jnct) 802-295-2908

Veterans’ Services:

www.vermontveteransservices.org

Homeless Program Coordinator: 802-742-3291

Brattleboro: Morningside 802-257-0066

Rutland: Open Door Mission 802-775-5661

Rutland: Transitional Residence: Dodge House, 802-775-6772

Burlington: Waystation/Wilson 802-864-7402

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

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