

vermont
psychiatric
survivors

COUNTERPOINT

VOL. XXXII NO. 2 • FROM THE HILLS OF VERMONT • SINCE 1985 • FALL 2017

VOSHA Sets Novel Standard: Hospital Staff in Padded Gear

By ANNE DONAHUE

Counterpoint

MONTPELIER – In an unprecedented action, the Vermont Occupational Safety and Health Administration imposed a \$7,000 fine against the Vermont Psychiatric Care Hospital for failing to protect workers by not requiring them to wear “arm guards, shin guards, chest guards, mouth guards” when dealing with patients “engaging in assaultive behavior.” VOSHA said patients in mental distress “often display aggressive behavior” and defended the requirement based upon the number of times that staff was exposed to the risk of injury at VPCH. The requirement came in response to worker complaints about assaults at VPCH.

The Department of Mental Health is appealing the citation. Commissioner Melissa Bailey said she could not comment because of the appeal.

Psychiatric survivors across the state have reacted, objecting to the use of such equipment and the underlying assumptions in the language of the violations.

“What does it say to and about people in mental distress when they are regarded and treated as dangerous animals?” asked Marty Roberts, a longtime advocate who has served in numerous advisory capacities in the state and is board chair at Vermont Psychiatric Survivors.

The Vermont Department of Labor vigorously defended the finding of the violation. Stephen Monahan, the director of the Workers’ Compensation and Safety Division, termed it a “common” method for reducing the risk of workplace injury involving violence by patients in hospitals.

He initially said trainings from federal OSHA supported it but later clarified that it was only “discussed in webinars and training” and there were no training materials that suggested those specific measures.

After saying there were settlements he could cite from other states, Monahan sent copies of five. There was none in which the settlements included the use of “personal protective equipment,” or PPE, in a hospital.

Counterpoint was unable to locate any national organizations that suggest that the equipment described is an appropriate way to

(Continued on page 6)



MAD AS HELL—Vermont’s celebration of Mad Pride Day included a march down Main and State Streets in Montpelier followed by a rally on the steps of the capitol. Kate DeWolfe (left) and Jillian E. G. Grohmann hold their banner during the march. Story and more photos, pages 12-13. (Counterpoint Photo: Wilda White)



SAMHSA Censors Alternatives

By ANNE DONAHUE

Counterpoint

RUTLAND – Amid a controversy about its censorship of presentations at the annual Alternatives conference, the federal Substance Abuse and Mental Health Services Administration announced in June that it will no longer fund the four-day event which was established more than 30 years ago to “provide a forum for consumers from across the nation.”

“SAMHSA has increasingly put their thumb on the scale in regard to what topics and workshops could be presented at the Alternatives conference, and in the wording of workshop titles and descriptions – and even presenters’ bios,” said Susan Rogers of the National Mental Health Clearinghouse, a past organizer of the conference.

The censorship of programs for the conference came to light locally after two Vermont Psychiatric Survivor proposals for presentations were approved, but with titles

and descriptions significantly rewritten. Rogers and others said they believe the censorship was based on external pressure from criticism of SAMHSA for its support of the Alternatives conference and other consumer-based initiatives, both in Congress and in national media.

SAMHSA did not respond to a request for comments from *Counterpoint*.

The conference will continue next year under the leadership of two recovery-based private organizations, and it will seek other funding, according to Dan Fisher, a board member at the National Coalition for Mental Health Recovery, which will be one of the co-sponsors. It will team up with the Copeland Center for Wellness and Recovery.

“We’d be much freer to do it the way we want” if it is able to continue under separate resources, Fisher said.

An Alternatives conference that continued

(Continued on page 5)

World Hearing
Voices Congress

3

The Arts

14

Commentary

19



Meeting Dates and Membership Information for Boards, Committees and Conferences

Peer Organizations

VERMONT PSYCHIATRIC SURVIVORS BOARD

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

COUNTERPOINT EDITORIAL BOARD

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

—Currently Recruiting New Members—

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

DISABILITY RIGHTS VERMONT PAIMI COUNCIL

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

Hospital Advisory

VERMONT PSYCHIATRIC CARE HOSPITAL

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

RUTLAND REGIONAL MEDICAL CENTER

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

BRATTLEBORO RETREAT

Consumer Advisory Council, fourth Tuesdays, 12 - 1:30 p.m., contact Gwynn Yandow, Director of Patient Advocacy and Consumer Affairs at 802-258-6118 for meeting location.

UNIVERSITY OF VERMONT MEDICAL CENTER

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

State Committees

ADULT PROGRAM STANDING COMMITTEE

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

LOCAL PROGRAM STANDING COMMITTEES

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

How to Reach The Department of Mental Health:

802-241-0090

mentalhealth.vermont.gov

For DMH meetings go to web site and choose “more” at the bottom of the “Upcoming Events” column.

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

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WELLNESS WORKFORCE COALITION

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

MAD IN VERMONT

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

Advocacy Organizations

DISABILITY RIGHTS VERMONT

Advocacy in dealing with abuse, neglect or other rights violations by a hospital, care home, or community mental health agency. 141 Main St, Suite 7, Montpelier VT 05602; 800-834-7890.

MENTAL HEALTH LAW PROJECT

Representation for rights when facing commitment to a psychiatric hospital. 802-241-3222.

VERMONT CENTER FOR INDEPENDENT LIVING

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

VERMONT FAMILY NETWORK

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

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

VERMONT CLIENT ASSISTANCE PROGRAM

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

HEALTH CARE ADVOCATE To report problems with any health insurance or Medicaid/Medicare issues in Vermont 800-917-7787 or 802-241-1102.

VERMONT FEDERATION OF FAMILIES FOR CHILDREN'S MENTAL HEALTH

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

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FALL (September delivery; submission deadline July 29)
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World Hearing Voices Congress Airs And Welcomes Everyone's Perspective

By ANNE DONAHUE

Counterpoint

BOSTON – The ninth annual World Hearing Voices Congress would likely have surprised detractors of the hearing voices movement. They would say its universal message is that voices are a gift rather than a burden, and that those who hear them should abandon medical treatment.

There was a universal message.

It was to embrace all perspectives and to create spaces – including support groups around the world – where people can “sit with [their] experiences in a safe environment” without being labeled as mentally ill.

The key to the international hearing voices movement is “respecting the right of the person to define their own experiences.”

Participants from 33 countries shared their own stories, which included coping with voices that urged them to harm others, connecting to the spirit world as a calling, understanding voices as a response to trauma, finding medication to be a support in silencing voices, and learning that “instead of getting rid of our voices, [we should] change our relationship to our voices.”

A display in an exhibit room summarized the movement in this way:

“The International Hearing Voices Movement is founded on the premise that hearing voices is an understandable part of human experience that for some people causes distress and difficulty. In themselves, voices are not seen as a problem. Rather it is the difficulties some people have in coping with them, and the relationship that the person has with their voices that is the main issue.”

Both days of the congress were opened by three keynote speakers, each of whom took questions from the audience of nearly 300, followed by a broad array of workshops. Many in the audience identified themselves as voice hearers, and other participants included family members and mental health professionals.

Gogo Ekhaya Esima

Gogo Ekhaya Esima has a fulltime shamanic healing practice in Southern California and shared her journey from deep inside a “sinking hole” of depression.

“I wanted to drown the visions and voices [that were] directed to self-harm.”

Through rites of passage into her Zulu cultural identity from South Africa, a “passion in [her] soul began to emerge,” and she was initiated as a Sangoma traditional healer.

“The toxic voices are no longer present,” she said, and they have been replaced by “voices of how to heal.”

Not every person with voices has a shamanic calling, Esima said, but it should be recognized that for some, as for her, the experience of voices “wasn't a disease, but a gift.”

Marty Hadge

Marty Hadge shared his experiences with trying to get rid of voices with street drugs and then attempting traditional mental health services, with negative effects from antipsychotic medications and multiple hospitalizations.

The support of a Hearing Voices

He sees voices as “normal extreme responses” to today's world.

“When society is creating all sorts of stress, we can't blame it on the people” who experience those responses.

Akiko Hart

Akiko Hart is a board member of the English Hearing Voices Network and establishes support groups in prisons, secure hospital settings and immigration detention centers.

“Hope is not the best response to hopelessness,” she said. “Connection is.”

Institutions are “built on the premise that some of us are human and some of us are not” and exist because they have been built “in our image” in a world of inequality.

The HVN groups are about “being humanizing in dehumanizing spaces,” Hart said.

She talked about the challenges of ensuring that “the ethos is retained as more and more groups emerge” and risk becoming, themselves, a part of an institutional culture. “Our ethos is so radical it should be unsettling” to institutions.

Barry Floyd

Barry Floyd of New York City said he heard voices that told him, “We own you,” when he tried to object to their control. His voices are “very mean and nasty,” even once trying to direct him to kill members of his family.

“I don't like them,” he told the audience. He was arrested several times after becoming involved with street life and self-medication with drugs but was never convicted because of how he was controlled by his voices – apparently based on not being competent to face the charges.

He was able to disassociate from them after a nine-year effort.

“It's good to be part of my life” through no longer being controlled by his voices, Floyd said.

David Walker

David Walker, Ph.D., calls himself a “liberation psychologist” who began working among the Yakama Nation in Washington state after a personal experience with an external voice led him to his own Cherokee heritage.

His talk focused on the role of the “domination metaphor.”

Before the genocide of Native Americans became the universal strategy of European invaders, there was a movement among some of them that asserted that “heathens have a soul ... [and] must be saved rather than massacred.”

That is the same flawed approach of the mental health system, Walker said, and he strives to fight “the tyranny of this benevolence.”

In the same way, the eugenics movement sought to “breed out undesirable traits among groups of people,” which extended into the evolution of “mental hygiene” as a system that is now “embedded in various practices of coercion.”

(Continued on page 4)



SHARING – Art depicting thoughts of a person hearing voices: from an art workshop series in Bradford, Leeds and Durham, England first exhibited at Durham University. More about the project can be found at hearingvoicesdu.org.

Network group in the Western Massachusetts Recovery Learning Community led him to understand that his experience “is real, it's relevant, it's important” and that he could change his relationship to his voices by asking, “What are [they] trying to tell me?”

He now can look at why he is getting a negative message and rebut it, no longer needing medication to smother it.

Learning “how other people have made it through” was pivotal for him.

“Peer support did something that the medical model couldn't.”



VOICES • Continued from page 3

Val Resh

Val Resh of India, the final keynote speaker, is an artist and activist from India who centers her creative life around her diagnosis of schizophrenia.

“Everything that happens to us is a defensive mechanism” as a result of traumas, which means we must ask, “What can I do with this?”

She talked about the role of retelling the stories of our traumas in a different way, not to negate them but to “ease our suffering” and to allow ourselves to “move on.”

“Our psychoses are a projection of our own suffering,” she said.

If we deny that part of ourselves, it can project itself outside of ourselves, demanding to be heard, Resh said.

The Hearing Voices Movement is a call to action. It's a call to create a world where people can talk openly about their voices, visions and other sensory experiences without fear of the consequences. Where friends, family members and colleagues react with empathic curiosity, not fear.

Voices from Brazil

One of the breakout workshops featured a documentary from Brazil called “Hearing Voices,” which explored the lives of three people who were engaged with traditional treatment at a mental health center while also exploring their experiences at an HVN group.

The documentary explored the relationship between the strong religious culture of Brazil and its community-based approach to mental illness. Providers at the center ranged in



Overview of the Congress gathering at Boston University.

attitudes from a strong medication orientation to openness to what is unknown and uncertain about traditional medical views and diagnoses.

There is a “very fine line” between the spiritual and psychological, one commentator said. “God speaks to all of us, sometimes auditorily.” A voice hearer who may not believe in God might ask, “In what sense is your God more real than my voices?”

The documentary gave the voice hearers a microphone to comment as they went through their daily routines.

Renaldo said that “the voices talk to me when I’m most down on myself” and further attack him. He listened in silence as his identified family and community support network discussed his situation, with some members expressing concern and others condemning him for not trying hard enough to help himself.

A young woman, Emilda, was referred by her mother for treatment with medication although she had been a voice hearer all her life and did not use medication.

Emilda shared that she had “a voice telling me to do wrong and another one telling me not to do wrong.”

Marlene, the third person profiled, was a feisty older woman who sometimes got nasty with other members of the group. She found its value by discovering “there are a lot of people [besides herself] who hear voices.”

Near the conclusion, a staff member contemplated what the center had learned through exposure to the HVN: that there may be many causes of hearing voices.

“What right do we have to say [which] are true?”

It used to be that for any person who heard voices, the response was to order medication, she said.

Now her first thought is to say, “Tell me what you hear. What does it mean to you?”

Hearing Voices Network

Next year’s congress is proposed to be in Quebec, and the following year is tentatively scheduled to be in Brazil.

The United States branch of the network



EXPRESSIONS — One workshop gave participants the opportunity to make puppets to represent voices they live with, creating possibilities for expressing experiences that can be “difficult to live with and harder to talk about.” It was led by Kevin Healey of Canada.

can be contacted via its website, www.hearingvoicesusa.org. According to its website, “The Hearing Voices Network USA is one of over 20 nationally based networks around the world joined by shared goals and values, incorporating a fundamental belief that there are many ways to understand the experience of hearing voices and other unusual or extreme experiences. It is part of an international collaboration between professionals, people with lived experience, and their families to develop an alternative approach to coping with emotional distress that is empowering and useful to people, and does not start from the assumption that they have a chronic illness.” 🗨️

VermontABLE Accounts Empower Saving for the Future

MONTPELIER — The state is promoting a new savings initiative that allows eligible individuals with disabilities to save money without losing certain public benefits like Medicaid and SSI.

VermontABLE accounts provide individuals with disabilities the opportunity to invest up to \$14,000 per year without being removed from public benefit programs.

“One of my top priorities is to empower more Vermonters to save and prepare for a more secure financial future,” said Treasurer Beth

Pearce in a prepared statement.

“Since launching VermontABLE in February, 70 individuals are now depositing money in their ABLE accounts, with an average account balance of \$3,700. We expect increased enrollment as we kickoff our public awareness and outreach efforts this month.”

“Until now, some disability benefits were structured in a way that actually discouraged people living with disabilities from saving. By giving Vermonters with disabilities and their

families new tools to invest, we can provide a framework for more of our neighbors to prepare for the future,” said Governor Phil Scott in the joint news release.

A range of savings plans is available to eligible Vermonters. The plans have user-friendly functionality to allow online electronic funds transfers, easy withdrawals, and a loadable debit card. More information and instructions on how to sign up for a VermontABLE account are at VermontABLE.com. 🗨️

ALTERNATIVES • Continued from page 1

under different funding “would definitely have greater autonomy. And the goals of the conference would gain,” Rogers agreed.

Both would-be Vermont presenters – Wilda White, executive director, and Calvin Moen, a peer advocate – withdrew from the conference after receiving the revised descriptions.

The conference “has betrayed my trust,” Moen wrote to organizers. “To have my language edited so extremely without even a conversation about it does not create an environment where I am safe to talk about my very personal experiences in such a vulnerable way.”

According to the chief operating officer of this year’s conference organizer, the National Empowerment Center, White and Moen are “not alone.”

There are “people that are really upset,” said Oryx Cohen.

Impact of Murphy Bill

The Alternatives conference gained a national profile after U.S. Rep. Tim Murphy began to use it as an example of wasteful SAMHSA funding as he pushed for his legislation to create greater control over the federal agency, and to align federal policy and funding behind medical models of mental illness and treatment.

In one post on his website after a congressional hearing, he claimed that his work “has revealed that SAMHSA has wasted taxpayer money on conferences where ‘consumer-survivor’ and ‘patients’ rights’ organizations show persons with serious mental illness how to stop taking their physician-prescribed medication.”

At one hearing, he waved an Alternatives conference brochure as he questioned SAMHSA funding, Fisher said.

Fisher said that scrutiny has been increasing every year since at least 2010, but this year it was “more in response to the Murphy legislation than the change in administration.”

In 2010, a controversy erupted when the National Empowerment Center rescinded an invitation to speak to Robert Whitaker, author of *Anatomy of an Epidemic*, which had been published that year.

After public protests, Whitaker was re-invited, but only on the condition that a psychiatrist would present immediately after him to give a rebuttal to his criticisms of the psychiatric industry.

Murphy’s bill created a new assistant secretary position to oversee SAMHSA, who is required to be a psychiatrist, and pushed for priority for medical treatment over recovery models of care. It passed last year.

The new assistant secretary appointed by President Donald Trump, Dr. Elinore McCance-Katz, resigned from her position as chief medical officer for SAMHSA in 2015, objecting that it was “more focused on building recovery and wellness programs like the peer workforce, and neglected the treatment needs of people with serious mental illness,” according to an article in *Politico Pro*.

Scott Bryant-Comstock wrote in the *Huffington Post*, “Most of the articles written about McCance-Katz since the President’s announcement [of her nomination as assistant secretary] invariably include reference to her desire (along with some national mental health advocacy groups) to see SAMHSA move away from supporting alternative medicine and recovery-based programs.”

Fisher said he feared that “we can expect

there’ll be more in the way of shifting resources into the medical model” under the new legislation and the new assistant secretary.

Vermont Presenters Censored

The presentation proposal submitted by White was titled “Reconceptualizing Stigma: Toward an Anti-Oppression Paradigm” and included learning to recognize the “structural, political and power imbalances integral to the marginalization and disenfranchisement of those labeled by psychiatry.”

The acceptance letter she received eliminated the word “oppression” in favor of the title “Reconceptualizing Mental Health Awareness: Toward a New Paradigm,” and it referenced a “social change paradigm” that “recognizes that different types of prejudice and discrimination exist.”

Moen had proposed a workshop to “compare

The conference will continue next year under the leadership of two recovery-based private organizations and seek other funding, according to Dan Fisher, a board member at the National Coalition for Mental Health Recovery, which will be one of the co-sponsors. It will team up with the Copeland Center for Wellness and Recovery. “We’d be much freer to do it the way we want” if it is able to continue under separate resources, Fisher said.

and contrast the history of attitudes and beliefs about gender-nonconforming individuals and individuals with psychiatric labels.” It was titled, “Surviving Science, or: How I Learned to Stop Worrying and Love Being Mad and Queer.”

In the session description, he said he would speak about his personal experiences as a psychiatric survivor and a transgender person.

The approved session description said participants could “learn what it is like to be both a survivor of trauma and a transgender person,” how to cope, and how to advocate for mental health services and social supports.

In declining the invitation to speak, Moen said that his identity as a psychiatric survivor had a “profoundly different political significance” than being a trauma survivor, and that he had said nothing in his proposal about “‘coping’ or advocating for mental health ‘services.’”

“Most distressing to me,” he wrote, “is the suggestion that participants might ‘learn what it is like to be both a survivor of trauma and a transgender person.’ No one who hasn’t

had those experiences can ever say they know what it’s like, certainly not after a 45-minute workshop. My identities are not on display for the curious to come and learn about.”

Attacks from Outside

The SAMHSA grant agreement with conference organizers specifies that it holds final approval authority for the conference program. However, Fisher and Rogers both said they believed the censorship from SAMHSA was not internally driven.

Rogers said that although she could not confirm it, her feeling was that “staff members who had been assigned to ‘oversee’ the Alternatives conference were not performing this oversight because they wanted to, but because they were fearful of political repercussions if the Alternatives conference seemed too ‘alternative.’”

“It should be said that there are still people employed by the Center for Mental Health Services [under SAMHSA] who are supportive of the movement for social justice,” Rogers said. She added that “in some instances, when we pushed back, the Center for Mental Health Services backed down and allowed the original wording to stand.”

Matthew Federici, the executive director of the Copeland Center, said he also had the impression that the censorship was more “to protect the Alternatives conference from further attacks” than because SAMHSA itself objected to the content.

One of those attacks came in a 2014 *Wall Street Journal* editorial titled “The Definition of Insanity” written to endorse the Murphy bill. It said SAMHSA “is in the vanguard of the legal-advocacy and anti-psychiatry movement that sprang to life in the 1980s.”

“Known generally as the ‘consumer/survivor’ movement ... this movement largely opposes drug treatment, psychiatric care, civil-commitment laws or even the reality of mental illness. SAMHSA pushes the ‘recovery model,’ an approach that puts the patient in charge of crafting his own recovery plan and stresses ‘empowerment’ and coping rather than medical intervention.”

The commentary then pointed to SAMHSA’s funding of the Alternatives conference and cited examples of presentations it considered inappropriate.

Future of the Conference

Under SAMHSA, three peer-led technical assistance centers have alternated coordination of the annual conference as a component of their Technical Assistance Center grants: the Clearinghouse, the Copeland Center, and the National Empowerment Center.

Federici said that the Copeland Center had been scheduled to host it next year, and “we are proposing to do it anyway” with non-SAMHSA resources, also reaching out for co-sponsorship by the National Coalition for Mental Health Recovery.

That only brings it through 2018, however, and does not resolve the question, “What are we going to do with Alternatives here on out?” he said.

The Copeland Center is “ready to step up ... but not to take over,” Federici said.

Fisher agreed that there are challenges ahead. “We have to find the funds,” he said, and will need to “look around” for opportunities and to “try to do it less expensively.” ❗

VOSHA • Continued from page 1

protect health care workers. OSHA updated its detailed voluntary guidelines specific to preventing workplace violence for healthcare and social service workers in 2015 and made no reference to personal protective equipment.

Kate Purcell, a consumer member of the hospital's advisory committee, said she would be "aghast if this statement is suggesting that patients of VPCH are considered to be the 'hazards.'"

"These citations are insulting to an entire population of patients. I am embarrassed for VOSHA," she said.

Counterpoint found only three OSHA actions in the country that suggested a similar "abatement method." A North Carolina citation was overturned on appeal in 2015 as being contrary to the therapeutic needs of patients. The court said that "no other similar [psychiatric] hospital setting utilizes the recommended PPE" described by its OSHA agency.

The other two, both in the same county in Pennsylvania and both referencing only arm guards, are currently under appeal.

The Vermont Veterans' Home, a nursing home in Bennington, agreed to comply with a similar VOSHA finding last year because its administration felt it had no choice because of the lack of a budget to appeal or to pay the fine. Fines are reduced as part of settlements.

"Your back's against the wall. You pick the lesser of two evils," said the home's administrator, Melissa Jackson. There is no way for the padding to be unobtrusive, Jackson said, and she worries that if worn, it could trigger a post-traumatic stress reaction in a veteran.

Leadership at other Vermont hospitals with inpatient psychiatric units shared concerns about stigma, impracticality and damage to a therapeutic environment that would be caused by the use of the personal protective equipment cited in the second of three workplace safety violations.

Executive Director Steve Howard said, however, that the Vermont State Employees' Association "support[s] the implementation of the recommendations" including the use of PPE. The VOSHA investigation was conducted as a result of complaints filed by staff.

He said the primary issue for them was staffing, believing that "if they had adequate staff a lot of this [violence] would be prevented." However, "our members find [PPE] would be a tool [to use] in certain situations" and "may be our only choice" if staffing is not addressed.

The overall citation for failure to provide a safe workplace included three violations. The first violation and \$7,000 fine was for exposing workers to "physical assaults such as spitting, biting, kicking, punching, scratching and choking that resulted in minor to serious physical injury." VOSHA identified an acceptable abatement plan: development of a comprehensive workplace violence prevention plan with 17 components.

Item 2, with a second \$7,000 fine, was the failure to provide personal protective equipment, and item 2b was the failure to conduct a "determination as to PPE required if a patient turns violent."

'There Isn't Any Such Thing'

"I've been 40 years doing this," said Kevin Ann Huckshorn, Ph.D., a consultant on psychiatric hospital certification. "There isn't any such thing."

Huckshorn, who is currently consulting with the Bridgewater State forensic hospital

in Massachusetts, is a former head of mental health and substance abuse in Delaware and an international expert in reduction of the use of restraint and seclusion in psychiatric hospitals. Her research shows such procedures to be the leading cause of staff injuries in those settings.

"I can't think of a healthcare setting where it would be appropriate," she said. There are "all kinds of other ways to minimize violence."

A new enforcement procedure directive from OSHA, issued in January 2017, was referenced by VOSHA Manager Dan Whipple as part of the basis for increased attention to healthcare workplace violence.

The directive says, "OSHA believes that a well written and implemented workplace violence prevention program combined with engineering controls, administrative controls and training, can reduce the incidence of workplace violence."

It references the 2015 OSHA guidelines specific to healthcare, which state they were developed "based on industry best practices and feedback from stakeholders."

"I am not aware of any best practices or even recommended practices that have been published with respect [to] the routine use of PPE for use in hospital settings for the prevention of injury from physical assaults," said Jeff McKee, Psy.D., the vice president for community and behavioral health at Rutland Regional Medical Center.

The Joint Commission, the accreditation body for hospitals, also provides guidance on preventing workplace violence. None of the guidance suggests that staff wear protective equipment. VPCH is accredited by the Joint Commission.

In a review of more than a dozen articles by healthcare organizations addressing workplace violence, *Counterpoint* found none suggesting the use of personal protective equipment in a hospital.

Survivors React

"This is horrifying. I've never heard of these sorts of measures," said Chris Hansen, a Vermonter who works with Intentional Peer Support, a national training organization based in West Chesterfield, New Hampshire.

"In my opinion this sort of mentality exacerbates rather than protects," she said. "If I can see that people are afraid and protecting themselves from me, I am more likely to be reactive. ... It also seems a rather tacit permission to be violent."

Hansen noted that Huckshorn's research and work on reducing emergency involuntary procedures supports that premise.

Pamela Spiro Wagner, a Brattleboro survivor and artist whose work addresses violence against patients, said that while she appreciated the staff's need for safety and protection, "I believe that such measures would not only not help matters but run the risk of increasing the dangers of an assault occurring both by adding to a false sense of security – promoting an attitude of casual indifference and less compassion towards the person they are dealing with – and by assuming a dangerousness that is less real than it is feared, and in doing so provoking it."

"Shows of force, as I have experienced in person so very many times, always and only evoke fear and a reaction of protest and outrage on the part of the patient." She said that staff using protective gear "would only have made my terror and reactivity worse, not better."

Patients already experience trauma in the

hospital, said a former patient at VPCH who has worked with staff orientation both before and after her seven-month hospital stay in the first half of 2016. She described in vivid detail seeing a parade of the "biggest, strongest staff [with] the charge nurse leading the way, and they're all wearing their blue Nitro gloves."

It meant they were coming to hold down a patient to drug him, in front of the other watching patients, Kris Gowdy said. "You see them start putting on those gloves ..."

Patients are "being retraumatized by watching this unfold."

If staff came at patients with even more protective equipment than latex gloves, "you're creating an added level of anxiety," the Granville resident said. "You're breeding fear."

If protective gear is worn only to respond to an emergency, "the delay in the reaction is going to do more harm than good," she said. If it is worn all the time, it's telling patients you are afraid of them. "It's not doing any good if you're afraid."

Patients need to "feel heard, feel validated, feel understood, feel respected" if staff want to prevent violence, Gowdy said. "Dressing yourself like a GI" is not going to achieve that, she said.

"All this – do they [the staff] want this?" she wondered.

Xenia Williams, a longtime advocate from Barre who was also a provider in a crisis bed program for many years, said that training stresses that "the best protection [is] forming relationships."

"If people wanted to wear unobtrusive stuff – let them" if it makes them feel better, she said, but "if they fear [patients] then that isn't a good way to build relationships."

"I hope no bright person suggests the old-fashioned way of dealing with people who bite – they just used to take all our teeth out," Williams commented.

Hospitals Respond

The Brattleboro Retreat and Rutland Regional Medical Center are the two hospitals in Vermont that also have units for Level 1 psychiatric care, where higher levels of patient agitation are anticipated and where rates for emergency restraint and seclusion in response to safety emergencies are highest.

Neither have staff who wear the equipment described in the VPCH violations, although a Retreat spokesperson said that protective items such as sleeves or gloves are available for "extenuating circumstances to protect staff against the transfer of pathogens" on rare occasions when a patient "exhibits high-risk behavior during a code."

McKee said of one unique situation involving a patient who had bitten several staff, "We developed a plan to make use of folded blankets that we kept nearby that could be draped over the arms of staff during any type of physical hold."

Serious injuries do happen but are "represented by a very small number of patients during very limited portions of the patient's stay," he said.

"To treat all patients as if they were assaultive or dangerous, or even to treat a single patient that way across the entirety of their stay, would be therapeutically contraindicated at best. At worst, I think it adds tremendous stigmatization to psychiatric patients, promotes a negative patient self-concept, and increases the perception that all patients are dangerous."

(Continued on page 7)

VOSHA • Continued from page 6

McKee also cited similar points to those made by psychiatric survivors: “Wearing protective equipment could be seen by some patients as a provocation in and of itself.”

He cited the strategies developed by the federal Substance Abuse and Mental Health Services Administration for preventing emergency involuntary procedures – taught by Huckshorn – that “if we routinely treat our patients as though they are violent, aggressive, and unpredictable they will increasingly behave that way, resulting in much higher use of seclusion and restraint and staff injuries.”

SAMHSA publications stress the relationship between staff injuries and the use of emergency involuntary procedures, citing studies that show that 60 to 70 percent of injuries occur when using restraint or seclusion rather than from assaults.

VOSHA Contradictions

The 2017 federal OSHA instructions provide detailed examples of safety measures for hospitals and note that even actions such as “deep counters at nursing stations” and “secur[ing] furniture and other items that could be used as weapons” must include “an appropriate balance of creating [a] suitable atmosphere for the services being provided and the types of barriers put in place.”

OSHA gives trauma-informed care as an example of training in “therapeutic procedures that are sensitive to the cause and stimulus of violence.”

Other examples the directive gives for means to protect workers are to “establish areas for patients/clients to de-escalate” and to “divide waiting areas to limit the spreading of agitation among clients/visitors.”

National data identify the three highest-risk areas for violence as “emergency rooms, geriatrics, and behavioral health.” A 2014 survey reported that “almost 50 percent [of assaults] came from patients and family members who were drunk or on drugs.”

However, Whipple said, “Our recommendation is related to the level of expected contact” with patient violence at VPCH, referencing the protective equipment violation that resulted in a fine. “Some [responses] that are suggested ... may not be appropriate,” he said.

“Solutions can be very different depending on what you have,” he said, and protective gear might include items worn under clothing and not visible, for occasions when “dealing with a known perpetrator” of violence.

Monahan stressed the risk of blood-borne pathogens from bites and said he thought it was “bizarre” to tell someone they cannot “take action to protect themselves.”

No staff injury reported to OSHA by VPCH since its opening has resulted from a bite, OSHA reports show.

Whipple said that the language of the citation “might be a little confusing.” One violation that was identified and assessed for a fine was failure to make personal protective equipment available and to require its use “when dealing with patients engaging in assaultive behavior.”

He insisted, however, that despite the wording of that violation, there was still room for an “amicable solution” with DMH that would not necessarily require such equipment.

There was a PPE citation because evidence in the investigation indicated “it might be feasible” as a way to address worker safety, Whipple said.

Monahan said the basis of the citation was that VPCH did not have an overall program to

assess risk and address worker safety, and that part of such a program was to determine “when and where” to have PPE available.

“[The] citations issued ... refer to the failure to do the assessment, and because no assessment was done, the failure to have equipment available if an assessment demonstrated the need,” he said.

Monahan said Vermont had not yet adopted the 2017 instructions when VPCH was reviewed in February, and he highlighted the OSHA bulletin that was still in effect at that time.

It provides guidance to compliance officers for all industries and says officers should assess whether the employer has “a hierarchy of controls for worker protection against potential acts of workplace violence (e.g., engineering or administrative controls, work practices and personal protective equipment).”

That same bulletin later lists examples of abatements specific to hospital settings and does not reference any PPE.

Although Monahan acknowledged that the 2015 federal healthcare guidelines never identify PPE as an abatement method for workplace violence either, he said that it was an inherent component of the engineering and administrative controls – despite the fact that the federal guidelines spell out its version of those controls for hospitals in many pages of detail.

He said that de-escalation was a “major emphasis” in safety, but “this is where it has failed. The question is, what do you do then? You can’t leave a violent, aggressive patient [assaulting others], you have to protect them and you have to protect yourself.”

In reference to other hospitals, he said, “I know that federal OSHA has engaged in three settlements” that included PPE requirements.

Monahan later sent copies of five settlements. Only one made any reference to PPE, and it was a residential center for “individuals suffering from traumatic brain injury, significant neuro-developmental disorders and autism.” The PPE was explicitly limited to “use of Kevlar gloves and sleeves for direct care staff working with program participants who are known to have a risk of biting.”

Only one of the cases Monahan sent involved a hospital; others included outpatient settings or schools. He used highlighter on sections in several as if on point. Those sections referenced requirements such as “implementation of workplace controls and prevention strategies that maximize safety and minimize the likelihood of assaultive behavior on staff.”

He also referenced the citation at the Vermont Veterans’ Home, pointing to a settlement that included the use of PPE.

Jackson, the administrator there, made it clear that the home believed such equipment was neither useful nor appropriate.

She said she told VOSHA that if a resident becomes aggressive, it is a situation where “it’s the flip of a light switch” and there would be no time to put special equipment on before intervening.

Safety glasses, elbow and knee pads, and soft body guards are now available to staff, and they were told they could use it “if they felt they need it.” None have yet.

The equipment cost the home \$4,000, but the facility has a tight budget and it was “cheaper to buy” than to appeal the citation or to risk the full fine being levied, since a settlement meant the fine was reduced. However, that \$4,000 could

have been far better used for additional services for the residents, she said.

She anticipates the PPE “will never be used” and would be impractical as a response to a violent act.

In the North Carolina case, where a hospital successfully appealed, administrative law judge Monique Peebles ruled against the eye and head protections, body, knee and elbow pads and mouth guards that OSHA wanted in place.

She found that in a psychiatric hospital setting, use of those items “would be disruptive and provocative, would not create a safer workplace [and] would be more dangerous because it would give the message to the patients that it was not a safe place which would increase their anxiety and stress and cause increased aggression.”

VSEA Cites Assaults

A press release from the VSEA said that a public records request to determine “how many assaults took place on VPCH employees from January 2015 to June 2016” showed “more than 200 assaults on workers with an average of 11 per month. The assaults run the gamut, from a slap, punch or kick to being spit on to having furniture thrown at you. Some even end up with the worker having to be seen by a doctor.”

The DMH data tracking all “patient to employee incidents” from July 2016 to July 2017 provided to *Counterpoint* showed 131 incidents, with 42 resulting in no injury, 75 resulting in minor injury, and 14 resulting in moderate injury.

The DMH definitions state, “No injury means the event ... did not cause any harm. Minor injury means that the employee required no treatment or first aid (e.g. scratch). Moderate injury means the employee left VPCH and went to the emergency department for assessment and possible treatment.”

Workplace injuries must be reported to OSHA, and *Counterpoint* reviewed those data for 2014, 2015 and 2016. In 2014, there was one injury from a patient assault; it required 67 days away from work. In 2015, there was also one injury; it required six days away from work. In 2016, there were four injuries from patient assaults, two of them resulting in no time away, and two of them resulting in a total of 542 days away from work.

The four incidents were described as: “Patient choked employee with both hands”; “Resident attempted to assault employees with a raised chair and [staff] injured right shoulder”; “Patient grabbed employees hand and twisted – left hand strain”; and “Lower back pain – patient pushed door into her [employee’s] back.”

Howard, of the VSEA, said that the complaint was brought to VOSHA because of the belief that it was the only way to bring attention to the issue of inadequate staffing.

Howard said that under current staffing levels, staff are frequently mandated to work overtime shifts to cover gaps, meaning they are tired and stressed. He said that in addition, when staff from one unit need to respond to a crisis in another unit, the first unit is left with only one person covering, which is unsafe.

“It’s been a problem for so long [we] don’t believe staffing will ever be addressed.” He said that resistance about the cost of additional staff appeared to be the barrier to that solution.

Staff “understand they’re working in a therapeutic environment” but “want to see a reduction in the number of assaults,” Howard said. ❗

ED Plan Draft Has No Surprises

WATERBURY – The Agency of Human Services report on Vermont’s mental health system, including prolonged ED waits for psychiatric patients, that was due to the legislature by September 1 identifies no immediate actions or solutions that are significantly different from those that “we have been discussing for many years,” according to Department of Mental Health Commissioner Melissa Bailey.

Instead, the commissioner has concluded that decisions need to be made and “we need to move to the finish line on some of these things.” Most will take significant financial investments, she acknowledged, and “we obviously need to prioritize [them].”

The legislature directed DMH to develop an analysis and action plan by December 15, with a preliminary report due September 1. DMH held two public hearings to solicit information and ideas as well as compiled data and met with individual stakeholders.

The report identified five themes that emerged from the discussions on the “growing pressures on the mental health system of care from inpatient to community based” and the “most recent pressures in inpatient flow and the needs of individuals requiring that level of care and intensive community based plans.” They were:

- Best engagement strategies and access to care.
- Peer supports.
- Medicaid funding versus general funds.
- Court involvement, including voluntary versus involuntary treatment.
- Licensing requirements and restrictions that present as barriers.

Among the 13 “needed components” identified were increasing the secure residential program capacity from seven to 16; creating a forensic mental health unit; adding Level 1 inpatient beds, which are the most intensive involuntary beds; expanding mobile crisis outreach to communities; expanding supportive housing and peer services; and addressing geriatric support.

At the first of the public hearings, held in July, much of the focus was on the emergency room delays resulting in adults and children waiting many days for an inpatient bed.

Psychiatric survivors stressed the factors leading people to go to emergency rooms when it might be unnecessary.

Malaika Puffer said sometimes people just need someone to talk to, and if the only people they have access to are crisis services teams, “the only place for the conversation is the ED” because teams aren’t staffed to respond elsewhere.

Advocate A.J. Ruben from Disability Rights Vermont said that being brought to the emergency room to see the community mental health crisis team is “so wrong,” but those services have been shifted there because the staff “can’t be three places at once.”

It “could resolve a lot of the crises” if the teams could go to where the person is, he said, since the individuals “maybe don’t need to go to the hospital” and could access a different resource.

The executive director of Vermont Psychiatric Survivors, Wilda White, said that EDs are like schools: “Social problems show up there.” She said they are a safety net “if you don’t know where to go” to get basic needs met, including when homeless or simply lonely.

Crisis services are not always helpful, according to Cindy Tabor of the Vermont Federation of Families for Children’s Mental Health, saying that more and more parents are calling her to report being told they should call the police if their child exhibits certain behaviors.

“Calling the police is not a mental health plan,” she said.

Calvin Moen, another psychiatric survivor, said there needs to be more information about why people are going to the ED. “Is it something in the culture?” he asked. “Housing? Safety in the home? Lack of support for coming off psych drugs?”

Physicians from two hospitals commented on the same issue.

Dr. Justin Knapp, medical director of Central Vermont Medical

Center’s inpatient psychiatry unit, said that one problem is when people in residential programs have a “behavioral emergency” that lands them in the emergency room, but after a day or two, “the storm passes.”

“Their bad day” is just a bit worse than “our bad day,” but when they are rejected for inpatient care they have no place to be transferred. “Are there more therapeutic environments [that could be available]?” he asked.

Knapp also said he was deeply distressed about geriatric patients on inpatient units who do not need a nursing home but don’t have a discharge option.

“We’re not doing well by these folks,” he said, and he sees “so much unnecessary suffering” as they live for months in a hospital. “There needs to be urgency” in addressing their needs, he said.

Dr. David Clauss from the emergency department at the University

of Vermont Medical Center said that “we have to own the fact that people with the greatest psychiatric distress” are the ones left in the ED for long periods because hospitals see their needs as too acute to handle.

A case review study of “long-term stay” patients at UVMMC over 2 ½ years found that 38 percent stayed because they continued to need that level of care, not because of barriers to discharge, according to a report presented at the hearing by Dr. Isabelle

Desjardins. (Long-term patients were defined as those staying more than 30 days in contrast to the average stay of 15 days.)

The 15-day average is double what it was 10 years ago, she said, primarily due to increased severity of illness and medical nursing needs. That longer average alone reduces access to inpatient beds by half.

“There is something happening” that is causing this, but “we don’t know what,” she said.

She said that the biggest barrier to discharge is a “social safety net problem” – patients with no housing or support system to return to. Reducing barriers requires more investments in housing, Desjardins said.

But even if all “barrier days” were eliminated, it would only free up two inpatient beds, leading to her second conclusion that there is a critical need for increased inpatient capacity in the state.

White called that a “dangerous conclusion” because it doesn’t account for what is driving “such high-level needs.” There might be prevention or earlier intervention options, she said.

Desjardins responded that “if we take three years to find out why people are getting so sick,” it will delay addressing the emergency room crisis for far too long.

Discussing the interim DMH report, Bailey said it is not clear to her how severe the perceived emergency room crisis is because, despite the “increased anxiety coming out of the hospitals,” the department is not yet getting clear numbers from them to “confirm or deny how big of a problem” exists.

The legislature asked that the interim report indicate any actions taken by September 1 to address the crisis. Bailey acknowledged that, other than pushing for faster resolution from a “case-by-case perspective,” there were none.

DMH has concluded that there are enough data to make informed decisions about how to move ahead, she said. There was nothing “surprisingly new” in the information gathered over the summer, she said.

Bailey said she wanted to either move forward and develop specific proposals that have been discussed, or make decisions not to proceed with a given proposal. For proposed solutions that are not pursued, the state needs to decide from among the options “what are we going to do instead.”

For a copy of the September 1 report, go to http://mentalhealth.vermont.gov/sites/dmh/files/documents/news/Report_to_the_Legislature_on_the_Implementation_Act_82.pdf. 



DEBATING OPTIONS – Psychiatric survivors are urging an increase in peer alternatives such as Soteria House in Burlington as the state looks to address emergency room waits and access to mental health support. Others, however, are asserting the need for more institutional solutions such as increasing the number of high-acuity inpatient and secure residential beds. (Courtesy Photo)

Prison Seclusion Replay Raises Questions

By ANNE DONAHUE

Counterpoint

BERLIN – Within months of both new legislation on inadequate mental health care in prison and the settlement of his prior discrimination complaint before the Human Rights Commission, a Bennington man experienced “a completely bizarre replay” of a previous hold in a segregation cell while waiting for transfer to a hospital.

Miles Hall said his stay in the Southeastern Correctional Center’s Alpha Unit in Springfield “went a lot better than last time” but that he was incredulous that he was held there when “they knew all about my mental health condition” and “I shouldn’t have gone to Corrections at all.”

Department of Corrections Commissioner Lisa Menard said that although she could not comment on any specific case, the situation described surprises her because “[we] have made it a huge priority” to get away from the use of segregation for inmates. She said she would look into Hall’s report.

Hall spent five days in the seclusion unit in contrast to 14 days last year. That time, he had pepper spray canisters placed in his cell and was left without a shower or eyewash for decontamination.

“For someone going through a mental health crisis, isolation is the worst thing,” he said. He was left in a segregation cell the entire time other than a few escorts to a shower or a different cell, Hall said. There were no allegations of acts of violence in the psychiatric Emergency Examination paperwork.

In May, a new law, Act 78, expressed the intent of the legislature to limit the use of segregation for people with a mental illness and required that every inmate who is screened and found to be in need of inpatient care be referred for that care within 24 hours.

According to paperwork from the family court, where an application for involuntary treatment was filed, a psychiatrist at Vermont Psychiatric Care Hospital interviewed Hall in prison the day after he was taken into police custody, and again five days later shortly before he was sent to the hospital.

Both times, according to Dr. Alison Richards, he was “extremely disorganized and manic” and threatened to kill President Donald Trump and “every psychiatrist” other than her.

She wrote, “[H]e is so disorganized that he has been naked in his cell, standing in his toilet, getting toilet water on his food and unable to meet his own needs for safety.”

The new law also directed the Department of Corrections to open, or create access to, a “forensic mental health center” by July 2019. After that, if inpatient care is needed, it must be provided within 48 hours.

The term “forensic mental health center” is not defined, but according to advocates, the discussion was clear that an inpatient level of care was intended, whether provided by DOC or through the Department of Mental Health.

Hall said that he believes a forensic hospital run by DOC is exactly what is needed, and that VPCH should be converted to that specific use.

“We have [to] change systems in Vermont by changing this into a forensic hospital,” he said in an interview there. He believes it shouldn’t be run by DMH.

If there is a question of a person’s competency after a criminal charge is brought, “this [VPCH]

should be a competency restoration unit. You should not be in [a] Corrections [facility],” Hall said.

Act 78 also required DOC to establish an agreement with DMH by July 1 for consultation on treatment plans for inmates “requiring a level of care that cannot be adequately provided” by DOC. The plan for the forensic mental health center is due to the legislature by January of 2018.

That agreement also requires outlining the role of the DMH Care Management Team with inmates who come into the commissioner’s custody from DOC, or who are voluntarily seeking hospitalization and meet inpatient criteria.

According to A.J. Ruben of Disability Rights Vermont, there has been a “huge, drastic improvement” in the past two years since his agency and others like Miles Hall have begun bringing lawsuits and discrimination complaints to protect the rights of people with psychiatric disabilities.

There are now, on average, “only a couple of people locked up in cells by themselves,” compared to a previous average of 12 per day.

That does not change the fact that “there is no safety net for Corrections” when prisoners need an inpatient level of care, he said, and “the state has a duty to provide [that] care.”

Although hospitals like VPCH that are designated “Level 1” are not permitted to reject patients who need hospital care if they have space, there is a prejudice against people coming from prison, Ruben said. In addition, because of the lack of adequate community resources and the use of hospital beds as a result, there is “not enough capacity in the system” for “hospital level care for people who are in prison.”

Hall was first brought by police to the Marble Valley Corrections facility. He said a judge ordered that he be sent to the Brattleboro Retreat, but he didn’t want to go there. Hall’s attorney from his earlier discrimination complaint, Robert Appel, said it appeared from court paperwork that the Retreat refused to take him.

Menard said that the referrals for higher levels of care are happening within 24 hours, and that the average wait for a hospital bed has been reduced to about six or seven days. As for care while waiting, in July 2016 there were 20 inmates in segregation, and in July 2017 there were two.

In addition, she said measures were being taken to improve the “conditions of confinement.” The “first response is to engage” with the inmate and use segregation only when it is unavoidable for safety reasons, she said.

Annie Ramniceanu, the DOC mental health systems director, also described a new initiative to use peers for mental health support, a “promising practice” that is just beginning to be considered in other states.

Fifteen inmates who have “shown leadership and mentoring capacity” have just completed a two-week training, and DOC is now “beginning to use the inmates’ voices and perspectives” to shape the program, Ramniceanu said.

In the meantime, the work is underway to “further refine” assessments of what kind of facility might be needed as a forensic mental health center, including deciding whether it needs to be for an inpatient level of care or for addressing high-level treatment needs that do



DOC Commissioner, Lisa Menard

not meet hospitalization criteria, Menard said.

That review is part of a look at “capacity across the system” for state facilities being conducted by the secretary of the Agency of Human Services, she said. DOC, DMH and the Department for Children and Families are all part of that initiative, which includes determining whether there are enough psychiatric hospital beds in the state, Menard said.

“There will be stakeholder involvement” as the forensic center assessment continues this fall, she said, but “we are not yet far along enough” to begin broader outreach.

Appel said he is looking into what legal authority the state had to arrest Hall, when he was not being charged with any crime. Hall said he was met at the bus stop in Bennington by police when he arrived from out of state to get his car, which was parked at his stepfather’s house, also Hall’s legal home address.

Hall had a criminal charge pending when he was in DOC custody the previous time, but it was dismissed without prejudice – meaning it could be refiled in the future – because he was found not mentally competent to stand trial. However, court records confirm that the charges had not been reinstated at the time police took Hall into custody upon his arrival in Bennington.

Although Hall was sent to VPCH by the criminal division, the psychologist there, Jim Huitt, said in the EE paperwork that he feared Hall might be released, and Huitt believed he needed to be placed on court-ordered medication.

Huitt wrote that he was told, “The only way to expedite a hearing for non-emergency court-ordered medication is through the commitment process, which in turn can only happen via an EE, thus this application has been made.”

Both the application for the exam and the application for involuntary treatment made repeated reference to a prior history of violence but made no allegation that Hall had acted violently since his return to Vermont.

Huitt wrote that Hall was transferred from the secure admissions area to a seclusion room on the unit via a restraint bed “because of his inability to engage in any meaningful way, as well as his history of violent behaviors.”

When Hall arrived at VPCH he was naked and “unable to respond to questions in a coherent fashion” and initially refused to get out of the sheriff’s vehicle, Huitt said, but “after some coaxing from familiar staff, he agreed.”

Court Defends Patient Drug Choices

By ANNE DONAHUE

Counterpoint

BRATTLEBORO – The Vermont Supreme Court rejected a forced medication petition last year because, it said, the lower court failed to consider the person's express written desire not to take psychiatric drugs.

Isaac Graham was later discharged from the hospital to the transitional Meadowview program, without relying on any drugs. At the time of his interview with *Counterpoint* in August, he was in the process of moving to an apartment supported by Pathways Vermont.

Although his appeal was successful, Graham described being discriminated against at the Vermont Psychiatric Care Hospital in Berlin. His discharge was delayed as a result of refusing to take the drugs his psychiatrist was prescribing, he said.

The state is currently reviewing the law to determine whether to make it easier to get forced medication orders, based on a directive from the legislature to review the current system. The legislature asks whether the process contributes to long hospital stays and delays in emergency rooms for people waiting to be admitted to a psychiatric unit. (See related article, page 11.)

Graham's case was one of two in 2016 in which the court ruled on involuntary drugging issues. In the other, a patient's request to represent himself in a drug hearing was rejected, based in part on the major rights the court said are at stake in a court decision to force someone to take drugs.

Graham had written an advance directive to say that he did not want to be on psychiatric drugs but never had it properly witnessed. An advance directive must be followed under Vermont law, and the court said the law required any written wishes to be considered, even if they were not binding in all circumstances.

Graham said he was able to listen to the oral arguments in front of the court, even though he was not permitted to leave VPCH to be present. He said he was nervous about the outcome as he listened to the Supreme Court hearing, feeling that in some ways, the debate was "sort of promising," but he was "preparing for the worst."

Graham wondered why the appeal would be granted if the justices were saying, "He doesn't know what he's talking about."

"I guess it all kind of worked out," he said, adding, "It's a good system" in Vermont for protecting rights. He particularly praised his Legal Aid attorney, Rebecca Plummer, who "really went the extra mile."

Graham said Plummer told the court that he "clearly understands that he'll be hospitalized longer" when he considered the pros and cons of refusing medication.

That was, in fact, the outcome of winning his case, according to Graham. He said he watched other patients who were having "many episodes" of instability or even violence being "released because they were on medication," while he was still being held.

He was at VPCH in Berlin for more than 10 months; six months of that were after the Supreme Court decision that rejected the forced drug order.

He said he felt he was "held to a higher standard" because of "not taking medication."

In addition, transitional programs were refusing referrals. It was as though there was a "big red flag" for psychiatrists that Graham was the "bad guy" for not wanting drugs.

Graham, who is 34, said he had not been on psychotropic medication in the past but did his own research on the side effects.

"They inhibit nerve signals in the cerebral cortex," he learned. "That's where you get all these disorders from," like diabetes. "People get really messed up on them."

He also decided, "I don't really think it's going to help my mood."

"I guess people think it makes them feel good ... but they [the drugs] can kill you," Graham said. "For street drugs, people don't talk this way," as though there were pros and cons.

Graham is now in the process of writing an advance directive that will be completed in full and therefore be legally binding.

The one he started before – after a first hospitalization – did not have witnesses verifying that he understood what he had written. At the time,

he couldn't find someone who wanted to be a witness and didn't know he could get help from Disability Rights Vermont, he said.

"I just wanted to get it done" and sent in, he said. "I thought it would protect me in the future," even though he "wasn't expecting to be committed again."

The Supreme Court said that if the lower court "concludes that there are no [previous] medication preferences, or that the person's medication preferences have not led to a significant clinical improvement in the person's mental state in the past within an appropriate period of time," only then can it weigh the legal factors that support or do not support an order.

A person must be shown to be incompetent before an order can be considered but must be competent when an advance directive is written or, as in Graham's case, when medication preferences are put into writing in some other way.

The court ruled that there was enough evidence to show that Graham was incompetent when the drug hearing was held.

But the state needed to show that he was not competent at the time he wrote the document about his preferences.

The court pointed out that Graham wrote the document in July 2015, more than nine months before the hearing.

"Second, and more significantly, the record reflects that patient was discharged from the [hospital] in July 2015, after a court rejected a [previous] petition to involuntarily medicate him."

Graham said that for himself, the main lesson was not about the drug issues – it was about avoiding hospitalization in the first place.

He said he was "coerced into going into the mental hospital" after criminal charges were filed on a domestic abuse claim by a girlfriend. The attorney his parents hired convinced him that it was better than risking a possible 20-year prison sentence and said he would only represent him if he agreed to the hospital.

"I guess for starters," if anything happened in the future, "I would not accept any lawyers" who insisted on a hospitalization option, he said.

In the other forced drugging case last year, the Supreme Court decision discussed at length the serious nature of involuntary medication when it rejected a person's right to represent himself.

"The State has no recognized interest in injecting therapeutic medication into the bloodstream of a patient who is competent to refuse the medication, and the State's interest in not allowing mental health patients to proceed unrepresented flows directly from that fact: the State has a strong interest in not exercising the most profound governmental power – the power to invade the body of a citizen – when that exercise of power is unwarranted."

The court also cited the intention of the state legislature "to enact involuntary medication laws in accordance with the principle that involuntary medication 'should be avoided whenever possible because the distress and insult to human dignity that results from compelling a person to participate in medical treatment against his or her will are real.'"

The court also referenced United States Supreme Court decisions: "[W]here involuntary treatment is accompanied by compelled medication, the concerns about liberty are heightened because '[a]mong the historic liberties protected by the Due Process Clause is the right to be free from, and to obtain judicial relief for, unjustified intrusions on personal security.' *Vitek v. Jones*, 445 U.S. 480, 492 (1980)."

"This is especially true in the case of involuntary medication, where '[a] compelled surgical intrusion into an individual's body . . . implicates expectations of privacy and security of great magnitude,' and where the patient 'cannot undo [the] harm' of involuntary medication, even if he or she is adjudicated competent to refuse," the Court added, quoting from the same case. ❶

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[Assistance in writing an advance directive for health care can be provided by Disability Rights Vermont, www.disabilityrightsvt.org, 1-800-834-7890, and by Vermont Psychiatric Survivors, www.vermont-psychiatricsurvivors.org, (802) 775-6834.]

“The State has no recognized interest in injecting therapeutic medication into the bloodstream of a patient who is competent to refuse the medication, and the State’s interest in not allowing mental health patients to proceed unrepresented flows directly from that fact: the State has a strong interest in not exercising the most profound governmental power – the power to invade the body of a citizen – when that exercise of power is unwarranted.”

Forced Drugs Are Back Under Debate

WATERBURY – Under direction from the state legislature, the Department of Mental Health has begun a new review of the court process for getting forced psychiatric drugging orders for mental health patients. The department is looking at whether it should be faster or changed in other ways.

Karen Barber, the head attorney for DMH, said at a public hearing, “What we hope to put forward is a balance.”



That brought a strong reaction from Jack McCullough of Vermont Legal Aid, who complained that the issue has been debated “year after year after year,” even after the law was changed in 2014, simply because some people did not get fully “what they want[ed]” from those changes.

He said he felt the push was coming from those who believe that the decisions should be made by psychiatrists, not judges.

The review this year was tied to legislation addressing emergency department delays for people waiting for inpatient beds.

At one point during the hearing, Dr. Sandy Steingard, a psychiatrist with the Howard Center, said that she knew that “the bar is lower” for getting orders in other states but had herself shifted toward being more cautious, and wondered if there was any common ground.

Is there ever a time when those who say, “never,” would say it is justified, she asked? Do those who promote change in the law recognize any downsides?

Wilda White, Executive Director of Vermont Psychiatric Survivors, said she believes force is never justified.

She said she had undergone a “sea change” after years of being a guardian for medication decisions for her brother.

“Those drugs robbed him” of the things that mattered most to him in life, and after her own later personal experiences with psychiatric medications, she said she believes his point of view “should matter more than yours or mine.”

She also said she believes that more effort would be made by pharmaceutical companies to develop safer drugs if people could refuse them. We need to be “demanding a higher standard,” she said.

Marla Simpson, a consumer representative on the State Standing Committee for Adult Mental Health, called forced drugging “traumatic and ... overall terrifying” and said she is now “afraid to even step inside a hospital.”

However, Ed Paquin of Disability Rights

Vermont said his advocacy agency’s position was “not never,” but that there should be “time to establish a therapeutic relationship” before resorting to court-ordered drugs. An effort to move to faster drugging orders would remove that, he said.

Too often, “dollars [saved] for turning over beds” seems to be prioritized, he said.

Patient representative Michael Sabourin said there is value in the current time frames, which “allow people to understand what’s going on” and sometimes result in force being avoided. He also expressed worry about what he sees as “routine overdosing” compared to federal drug standards.

Another psychiatric survivor said that involuntary medication can cause unintended consequences in terms of public expectations, because of lack of knowledge about whether the drugs work and what the side effects are. “There’s forced medication, and there’s uninformed medication,” Ward Nial said.

Several hospital psychiatrists also commented at the hearing.



INPUT – Ron Coppola (top), a parent from Essex, makes a point to the Department of Mental Health; Drs. Sandy Steingard and Alisson Richards (center) share thoughts during the meeting; DMH staff does some multi-tasking. (Counterpoint Photos: Anne Donahue)

Dr. Justin Knapp from Central Vermont Medical Center in Berlin said there were “various definitions of freedom” and that there are “people spending an extended period in the hospital” when they could be treated with drugs and discharged.

Outpatient orders would keep people from “cycling back in,” he added.

If the choice is to give people more time, then “allow the space and the staff and the training of staff” to care for those individuals, he said. “It requires a certain commitment of resources.”

“There’s forced medication and there’s uninformed medication,” Ward Nial said.

Dr. Alisson Richards works at the Vermont Psychiatric Care Hospital in Berlin.

“I take pride in the culture of being patient centered” there, she said. “We have a very high standard for taking these rights ... and I respect that.”

But the length of time before a court order can be obtained “puts everyone at greater risk,” she

Is there ever a time when those who say “never” would say it is justified, she asked? Do those who promote change in the law recognize any downsides?

said, including “the safety of the person and the loss of their autonomy” while being held in the hospital.

One of the closing comments came from Calvin Moen, another VPS patient representative, who said that from his perspective there is “never a good time to force-drug anyone.”

Court-ordered drugs are used when “someone’s behavior is causing difficulty for others,” he said. The system takes into account what those others want, instead of the person themselves, when it is their “quality of life that is actively affected.”

The department has until December 15 to complete a report to the legislature on “the role that involuntary treatment and psychiatric medication play in inpatient emergency department wait times, including any concerns arising from judicial timelines and processes.”

The legislature included a list of elements the department is expected to review, including gaps in the mental health system, both involuntary medication and non-medication alterna-



tives available to address psychiatric crises, and “the interplay between the rights of staff and patients’ rights and the use of involuntary treatment and medication.”

It also directed an analysis of the legal implication and cost-benefit of legislation “to prioritize the restoration of competency” for forensic patients and to enable applications for commitment and for involuntary medication to be filed at the same time “or at any point that a psychiatrist believes joint filing is necessary for the restoration of the individual’s competency.”

The department was also directed to find out what it would cost to do a study “comparing the outcomes of patients who received court-ordered medications while hospitalized with those of patients who did not receive court-ordered medication while hospitalized, including both patients who voluntarily received medication and those who received no medication, for a period from 1998 to the present.”

Mad Pride Celebrated With March



TAKING A STAND – Participants in Mad Pride Day march down Main and State streets with posters (left) and then listen to speakers at the rally in front of the State House. (Counterpoint Photos: Anne Donahue, Wilda White)

MONTPELIER – Dr. Seth Farber, who describes himself as a “social critic and dissident psychologist,” said that the world of today is “not conducive to human flourishing” and told psychiatric survivors at this year’s Mad Pride march and rally they could become “a vital part of making this world whole.”

Farber, from New York, is the author of *The Spiritual Gift of Madness: The Failure of Psychiatry and the Rise of the Mad Pride Movement*. He was the keynote speaker at the rally on the Vermont State House steps, which followed a march down Main and State streets by 30 or more people holding signs and chanting demands for rights and justice.

Farber recounted a history of the psychiatric survivor movement and shared the work of early writers who challenged assumptions about what is labeled as mental illness.

Various psychiatric liberation movements lost power in the struggle against oppression when the psychiatric and pharmaceutical industries merged in the 1990s, he said, but new initiatives such as the Icarus Project in 2004 became the nucleus for Mad Pride.

Seeing what is labelled as mental illness as “mad gifts rather than diseases” is the idea that “the threads of madness could inspire and effect

change in an oppressed and damaged world.”

Farber quoted from a Scottish psychiatrist, R.D. Laing, who wrote in the book *The Politics of Experience* in 1967 that those who are labelled with schizophrenia are “exploring the inner space of the mind.” Laing said the survival of the human race may depend upon the recognition that these explorers are as important as past explorers of the physical world.

Farber told the audience that Laing believed “the perfectly adjusted bomber pilot [is] a greater threat than a hospitalized schizophrenic who believes a bomb is inside him.” The metaphor of a bomb inside oneself “made sense” in the world context of war, he said.

He also cited Julian Silverman of the National Institutes of Health, who wrote a journal article, also published in 1967, in which he pointed to primitive societies that validated the experiences that are now called schizophrenia and initiated those people into the role of shaman. (A shaman is defined as a person seen as having access to wisdom from the spiritual world.)

Silverman’s article “Shamans and Acute Schizophrenia” in *American Anthropologist* emphasized that the cultural acceptance of “a unique resolution of a basic life crisis” makes the experience beneficial to the individual, rather than intensifying suffering.

“Yesterday’s shaman is today’s chronic schizophrenic,” Farber said. In reality, those experiences can be an asset “to enable people, given the right guidance, to make changes” through individual or social transformation.

The rally and march were coordinated by Vermont activist Matti Salminen, who spoke at the gathering. “Being here [as the organizer] is a great source of pride for me,” he said.

Pamela Spiro Wagner performed a skit in which she escaped the bonds of hospitalization and forced drugging, read from her new book of poetry, and performed her Crazy Lady Mental Health Patient rap song, accompanied by Jordan Goldstein on keyboard.

Beyond its support for advocacy, the event succeeded in raising public awareness. Several observers along the route of the march and on the State House steps asked questions, such as one woman who inquired, “What are they protesting?”

When a marcher explained that it was about rights for people who are labeled with mental illness, she said, “Oh – like me, with depression” and then asked, “What are they doing to us?”

After hearing the rally was in response to discrimination, she gave a smile and said, “Well, great!”

After the rally, Dr. Seth Farber expanded on his presentation in writing for Counterpoint.



By Seth Farber, Ph.D.

The shaman is a different archetype from the messianic figure. The latter is “creatively maladjusted.” She burns with a vision of a new order and a mania to change the world as it is, as did Jesus.

The mad person as shaman, as healer, is one basis for mad pride. But the mad person as messiah, as religious transformer, is another basis for mad pride, rarely discussed – it interests me more because of the looming social catastrophe that confronts humanity.

Anton Boisen’s comment is straight to the point. Boisen was a psychiatric survivor who had had a “psychotic” break and became a chaplain in a psychiatric hospital in the 1930s.

Boisen wrote that the idea that one is going

to play an important role in resolving a world catastrophe “arises spontaneously in completely different historical eras in persons who are going through a profound inner struggle.”

It arises, Boisen says, in “psychotics” in hospitals and in men or women of “outstanding religious genius.”

Serine is a former mental patient and so-called psychotic. Eight years ago she wrote, “When I go into mania, I have conversations with God and He has told me how He plans to bring together the plan for the ages. Or how he is going to bring about global awareness.

“And of course it is something that I have to do ... I was being told to gather earth children, and that there were many people around who were in on the conversation, we were speaking telepathically, as they were in different countries, and spread all over North America. Jesus is coming to establish his kingdom, and I think there will be a huge awakening.”

The religious geniuses Boisen discusses take

up the task of imparting a new religious or spiritual vision to the masses. They are messiahs – they are creatively maladjusted.

The religious geniuses Boisen discussed – Jesus, St. Paul, George Fox – all had psychotic breakdowns; they all were psychotic by modern standards. They were mad persons. (St. Paul had a “hallucination” on the road to Damascus – his companions heard nothing.)

They were mad persons who had found and accepted their calling, were possessed by their vision and have become not just maladjusted but creatively maladjusted to society.

Serine was possessed by her vision – and a beautiful vision it was – of a world in harmony. “We will no longer feel pain, and no longer feel any evil thought, or disappointment, we will be able to speak to all things.

“The time will come, I tell you, we will be aware of the most prominent parts of ourselves, our spirit, and we will know God, the spirit that

(Continued on page 13)

and Rally



Above, Seraphine DeWolfe-Haig, age 5, of Brattleboro, below, Calvin Moen



CRAZY LIVES
MATTER TOO
STOP KILLING
PSYCHIATRIC SURVIVORS



Xenia Williams

Photos by
Anne Donahue,
Wilda White and
Paul Capcara



FREEDOM – Pamela Spiro Wagner plays the patient in a skit at the rally, hoping for her discharge from the hospital from the ward aide (Jordan Goldstein) and doctor (Jason Mott), only to have the doctor come after her with a needle. Finally, she throws out her pills and breaks her chains. (Counterpoint Photos: Anne Donahue)

(Continued from page 13)

flows through all things, our eyes and hearts will be opened, and we will see what is Love and our hearts will be filled with fire, to light the darkness.”

John Weir Perry, the author and Jungian psychiatrist, described the messianic vision: “Almost always within acute psychosis lies a messianic vision of a new world order.” This is characterized by a sense of unity, of oneness.

The vision of oneness is expressed in the messianic ideation, along with the recognition that the world is going to be marked by a style of living emphasizing equality and tolerance, harmony and love. This hope is almost universally seen in persons in the acute psychotic episode.

The mad person is told by the experts that her sense of mission is narcissistic and grandiose – severely pathological. So she gives up her burning desire to change the world and her messianic-utopian vision and seeks to become adjusted to the world.

What a tragedy!

I would like to see the sense of calling of mad people treated with honor. It is the very same sense of calling possessed by the religious genius.

Let the Mad Pride movement consecrate the

mad person’s vision and sense of calling, since psychiatry seeks to destroy them. And then watch how many of the mad – now so often internally conflicted, unsure of their identity – blossom into spiritual leaders.

The religious geniuses discussed by Boisen owned their sense of calling, but the mad person

They were mad persons who had found and accepted their calling, were possessed by their vision and have become not just maladjusted but creatively maladjusted to society.

under the repressive influence of psychiatry – a corrupted religious priesthood – disowns her calling as a symptom of pathology.

I repeat: Psychiatry is a corrupted priesthood because it tells people who and what they exist-

tentially are, and it seeks to augment its own social status and income by demeaning the mad and preventing them from fulfilling their potentialities as human beings with a spiritual calling.

The shaman’s role in the more spiritual society out of which shamanism grew is to help people to adjust to society by experiencing the supernatural realm.

The role of the geniuses to whom Boisen refers is to resolve the looming world catastrophe by imparting to the masses, to the collective mind of humanity, the vision of an entirely different society based on love, peace and equality.

Every mad man is a potential religious or spiritual genius.

I would like to see some or many of the mad solve their personal crises by honoring their sense of mission, not disowning it, and by taking on the role of helping to resolve the impending world catastrophe by promulgating a new spiritual vision.

This is the vocation of the messiahs, and in the coming transitional age we will need many, not just one. ❗

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Seth Farber was the keynote speaker at the Mad Pride rally in Montpelier.

The Arts 14

Reflections on Life's Purpose, and Art

By Alexis Kyriak

There is a purpose, hidden, to be discovered. It is ourselves, and the mission is to take what we have been dealt and given at our entry into life, and transform it to peace.

The darkness is very, very real.

But it is not what we are ... we are full of light ... made of light.

To see our purpose, just like outer space, as a constant transformation of darkness into light, and to see our challenge as exactly that – a challenge – a call to action on our part.

To tame and transform the thoughts and emotions that rip through us; take the darkness and turn it to light.

To see myself as light ... not as my illness.

When we are cut off from what we perceive as life that others have that we can never experience, that is when we realize that something is missing, that there is a purpose, very important to fulfill, that we sense as missing and impossible to ever have.

But the thing is, that if we can sense it, it is there! Within. Within my soul is the answer.

For me, it is the art.

I came down with the illness at seven years of age. At four, we knew what I was. My talent was plain to see.

But it took 26 years to even begin taking steps toward what I loved so deeply. Before that, hospital after hospital and being given wonderful professional art materials, and not going near them.

One day, I was called to Voc Rehab. I went in and said, "What did I do wrong?" They said, "Nothing. You're going to school for fine art." I was 26. I am now 67.

It was not smooth sailing all the way. I dropped out of school several times and still don't have a degree. But just as the illness taught me values that many people don't have any inkling of, I know my purpose.

I am myself. It is not in degrees or a car or social expertise. It is in me.



My family formed me. Four generations of women, my great grandmother, my grandmother, my mother and aunt, her sister, and myself.

When I was 31, my family threw me out of its home. They had to. I was raging, and had been raging all my life, against life, against my illness. It could have ended in my never coming out of that rage, and destruction, or at best, a life without accomplishment, or anything to show for it.

The family that gave me the disposition to illness also gave me the way out of it: the example of my aunt, who had every reason to hate my grandmother, in my grandmother's old age, my aunt on the floor, before my grandmother, helping with her healing hands, relieving and tending to her feet.

In a culture that won't take responsibility for itself, my family taught me radical forgiveness. How to own myself. How to forgive. That is the factor that made my recovery possible.

Pride was the next battle. Knowing the Mind of the universe, and how deeply I myself was forgiven and loved, how immersed I am in its life, and how safe I am because of its strength, I could rest.

Not threatened by my illness, and not coming out of that illness, but out of the strength and wholeness within me through and with life, and wanting health. Identifying with the maturity of forgiveness.

Forgiving, totally, and forgiving myself: wellness was the result.

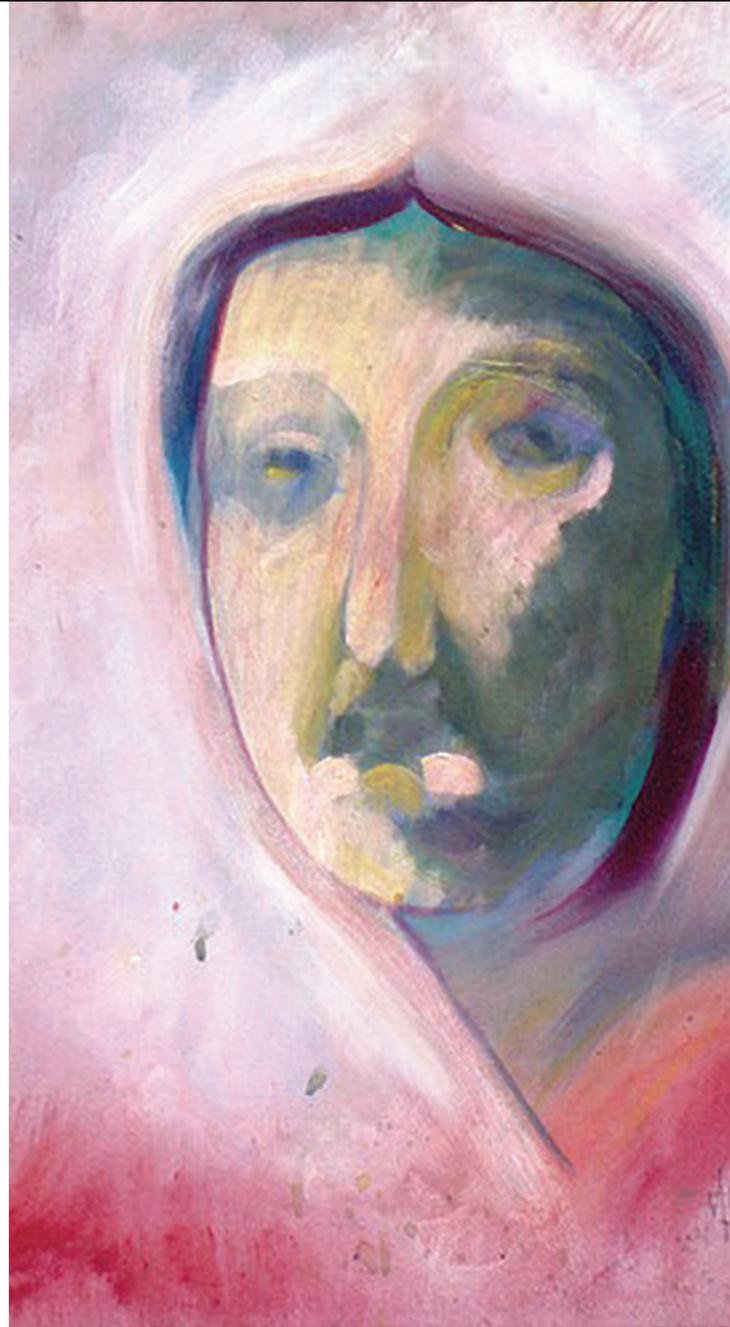
I am now 67 and am just beginning to live, in the power of forgiveness, both for myself and for the wrongs suffered. The freedom of true adulthood, and taking responsibility for my own happiness. Of forgiving.

I love to paint, and sculpt, and write. I was equipped, with the answer to the void.

I lose myself and find wellness! I risk! I go toward a dream, and find reality.

If we are breathing, it is because it is important that we are here.

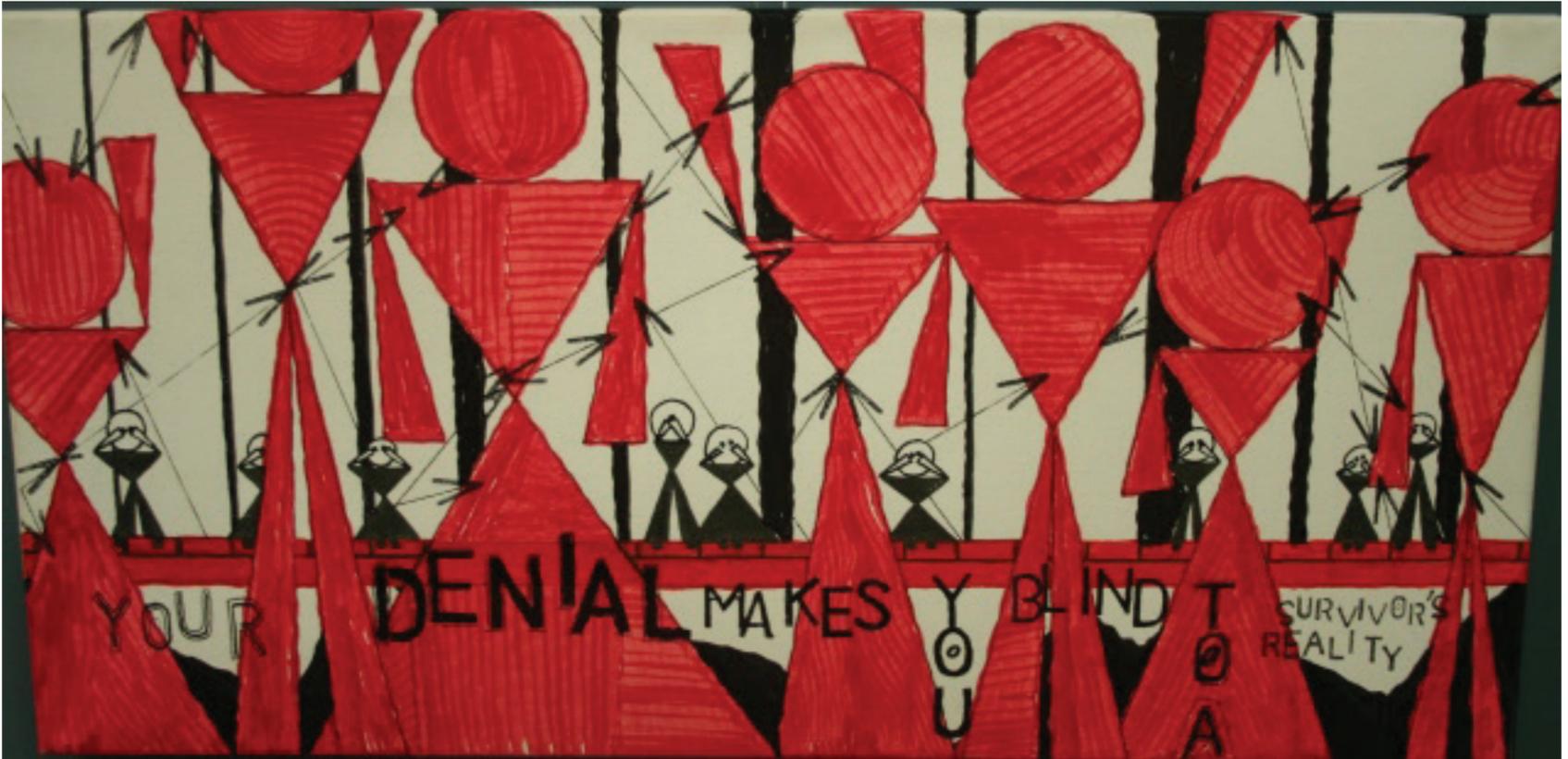
Our purpose is deep, and strong. Like novas and black holes in space, an incredible happening beyond our fathoming is taking place – constant transformation, from darkness to light.



Alexis Kyriak has lived with a label of mental illness since she was 7, and of schizophrenia since she was first hospitalized in New York at 18. Thirteen years later in 1981, she "broke the cycle" of therapy, medication and hospitalization when she went AWOL from a state hospital. She moved to Vermont in 1991. Kyriak credits government subsidies, community mental health services, and medication for her recovery, as well as "the dedication and gift of the therapists and friends I have lived among for the past 30 years."

She now lives independently in Northfield and has a working studio in her home.

Kyriak first went to school for fine art study through Vocational Rehabilitation in New York in 1976, and has shown extensively in Vermont, including at Helen Day, Studio Place arts, and presently at the Saint Johnsbury Athenaeum. She received a grant from the Vermont Arts Council in 2009, and is currently pursuing another grant. Her work is accessible at alexiskyriak.com.



YOUR DENIAL by Patricia Harrington Randolph

CELEBRATING CREATIVITY – Patricia Harrington’s art piece, “Your Denial,” was one of the works displayed last winter in the Clara Martin Center’s first annual art and poetry show. This year’s show entitled “From Green to Fall: Celebrating Creativity in Mental Health, Wellness and Recovery” will open with a reception on Friday, Sept. 29, from 4 to 7 p.m. at the Chandler Art Gallery in Randolph. The exhibit will be open to the public from September 15 through November 5. Art for the show is solicited from “friends of mental health.” The Clara Martin Center is the designated agency providing mental health and substance abuse services to Orange County and greater Upper Valley communities. (Counterpoint Photo: Anne Donahue)



ORANGE WINGS 2017 • inks and paint on paper by Caroline Tavelli-Abar Rochester

Share Your Art!

Express Yourself in Drawing, Prose and Poetry... Counterpoint Is About Peers Sharing With Peers

Email to counterpoint@vermontpsychiatricsurvivors.org or mail to Counterpoint, The Service Building, 128 Merchants Row, Room 606, Rutland, VT 05701 Please include name and town

Quieter

Why is it never quiet?
 Be quiet please, please
 be still. Learn how, if you don't
 know how
 to be quiet. This goes
 for everyone –
 Everyone on the streets
 and everyone else who
 doesn't remember
 silence. Doesn't remember,
 or forgot that they ever
 even knew. Ever knew
 silence and how to listen
 to silence 'til it turns
 into a quiet and invisible
 substance and people
 can hear themselves
 think and people can
 remember.

by Dennis Rivard
White River Junction

Michelle Obama Tribute

by Susan King Saunders Burlington (2013)

Michelle Obama Sasha and Malia's momma First Lady 2008 – 2016 is her fate. the fashion queen brings class to any thing whether Vera Wang K-Mart Marshalls or Ralph Lauren Essence Ellen People The View Vanity Fair to name a few. Enlightened/ Elegant	and so refined assertively she speaks her mind her smile lights dark eyes diamond sparks her body tight her posture right so full of grace a gorgeous face there by her side a famous man who won our votes with YES WE CAN but this is not	a poem about the president won't leave him out but it's a poem about his wife who he would give his precious life to fight for the little girl from Chicago who followed bro to Princeton's row then onto Harvard Law school back to hometown then organic foods	her aim to cease childhood obesity and to support military families this list can go on and on I hope you Sing it Into song Michelle Obama Sasha and Malia's momma you don't see her in any drama she's a true queen in every way I pray I meet her At the White House one day.
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MEDS

*Somebody's calling to me here
When they come here
I'm going to leave
Here goes nothing
No matter what you hear
I'm gone*

by **Carmen White**
Westford

Labelled and Bullied

I try to live a normal life.
I pay my bills, I clean my house and take care
of myself.
I get called names and labelled insane
And get the blame.
I go to mental health I get bullied and ha-
rassed.
I was traumatized growing up by others, no
fault of my own.
I suffer from PTSD
'cause of what someone has done to me.
So why do you taunt me?
I do my best to make the most of every day,
all I want is to live in peace, I say.
I wish I was deaf so I couldn't hear
What you say.
Maybe you need help too
But won't admit it or get it.
I'm an easy target.
And you'll just say I'm lying and
I'm crazy and they won't believe me
'Cause I'm labelled crazy.
I get kicked out, driven out of the place
I live. I'm stressed out and sick of the BS.
I don't bother you, so why are you bother-
ing me? Being nosy. Causing me problems.
I don't even talk to you and I don't want to
know you. So just shut your mouth.
Are you trying to piss me off? You trigger me
every chance you get.
All the injustices I've endured
All my life.
But I've survived and I haven't
Given up the fight.
I'm shamed for an illness I have no
Control over, I deal with it every day.
I wasn't given that choice, one I was born
with. The other I was given.

by **Tiffany Kangas**
Springfield

Depressive Line Art

(Still Here Despite It All)

Staring in the mirror over furrowed brows,
Tears taint the corners of bloodshot cobalt eyes.
I will my fists against striking down the glass,
Longing to break seals on my pressure-cooker skull, I
Loose blows onto my face instead, free the rancid anger.
Heavy footfalls fill my ears as I run, raging.
Eyes envy pavement, it's been run over a thousand times,
Rebuilt after endless snowplows scrape it raw.
Each time laying down anew every trivial byway.
Darkness covers me: rancid, malignant, muddy memories,
Echoing every naysaying nag: "social retard," "bastard," "Big Fat Ben,"
Searing self-bigoted brands into my scorched psyche.
Poisoned, bitter words roll down my throat like alum-coated ipecac.
Imbibing to silence sentences, judgments of a brutish brain,
Tequila coats the passages winding from Hell to Delirium.
Erlenmeyer flasks form within my veins, swizzling cocktails of nihilism.
In tunnels, a match turns to a torch.
The sullen cycles inevitably turn.
Arcing across chasms of helpless hate, I remind thee:
Leaping sparks sputter engines of hope to life.
Look your mirrored glare in the eye and grin.

by **Benjamin Wurmfeld**
Bennington

What Decency Is

Decency is never having to say sorry
about anything you have done
except for honest mistakes.
Conscientiousness is always trying
to keep honest mistakes to a minimum.
Compassion is admitting you could have
made the same error
or done the same wrong
as your neighbor.
and even if you didn't, or wouldn't,
that you may need, at some point in your life,
to be forgiven, too,
and that the price of being forgiven
for anything
is being willing to forgive
anything.

Faith is knowing that there is a God
and that He is able to love and forgive us
according to our need
and according to the love and forgiveness
we give to others
for His sake.

There is a God.
His grace is sufficient
for every need.

by **Eleanor Newton**
Burlington



**Enter the 2018
Louise Wahl
Memorial
Writing Contest
Total Prizes Up to
\$250!**

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:
March 15, 2018**

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.



Anna Guzman, "Amazing Grace"



Peter Burns, "Purple Polo Shirt" story



Jody Lane, song



Carole Perkins and Ivan Crus, merengue dance



Isaac Sage, "Lionel Ritchie"

29th Annual Evening of the Arts

Westview House in Burlington, a program of the Howard Center, held its Evening of the Arts this summer at Burlington City Hall. The annual event combines an art display and talent show. It was dedicated this year to the memory of Marilyn Ragsdale, Richard Medina and Marc Beaudin. (Counterpoint Photos: Anne Donahue)



Line sketches, Paula Preavy



Richard Love, leading all in "World Is Black"



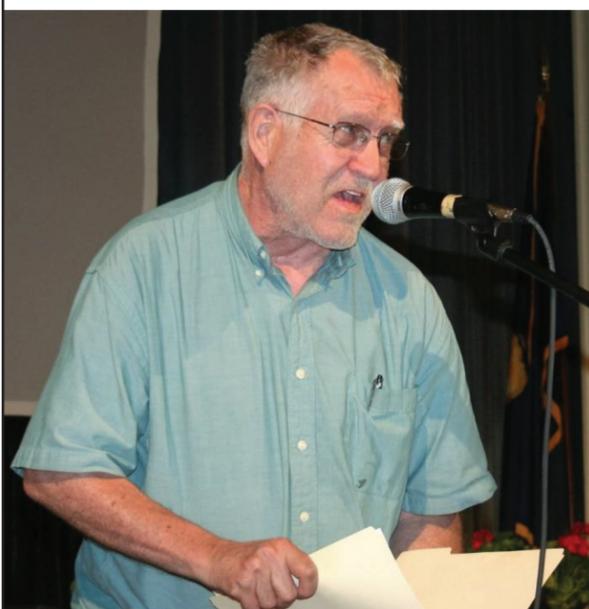
Sarah Robinson "The Color of Vowels"



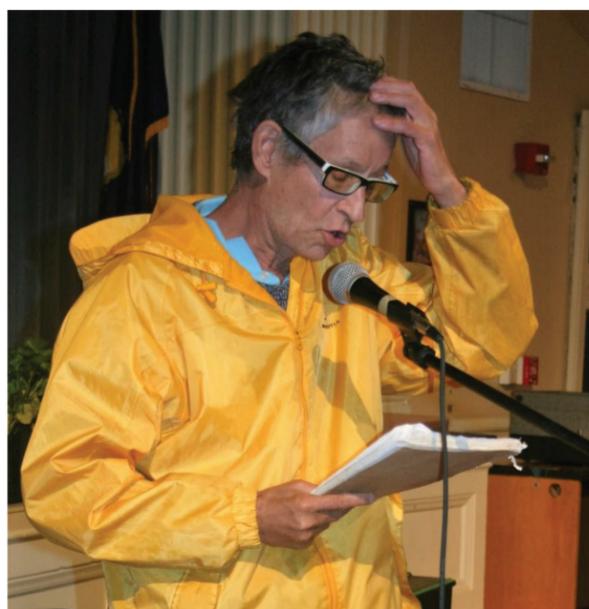
Adam Forguites



Jon Stoneman (L), Andre Vidal-Kaufman (C), Stephen Tall (R)



Jim Patterson



Chris Hall, impersonations (doing Paul Newman)



Anthony Parshall, jazz

The first inaugural and possibly last ever...

Special Writing Contest for Humor

Insiders know there were humorous things that happened at the Vermont State Hospital in Waterbury. Maybe you are one of them...

Announcing — The Chili Day Prize for Humor \$500 Prize!

Guidelines: This contest is seeking humorous stories from the Vermont State Hospital in Waterbury post-1980 through its closure by the flood in 2011. Stories do not need to be completely factual, but must have “truthiness” in it: based at least in part on some real event, but then — humorously — converted into felt or perceived truth. Word limit 1,500. There will be a 3-person panel of judges; judges reserve the right to reject all entries if none meet the criteria.

**DEADLINE FOR ENTRIES IS
DECEMBER 15, 2017**

Send entries marked “Chili Day Contest” to Counterpoint at Vermont Psychiatric Survivors, 128 Merchants Row, Suite 606, Rutland VT 05701 or by email to counterpoint@vermontpsychiatricsurvivors.org
Sponsored by an anonymous “Patient Benevolent Fund” donor.

(Runner-Up, 2017 Louise Wahl Writing Contest)

A Sledding Story

One day, when it was Nicholas’s and my first winter in Vermont and with fresh snow on the ground, my brother asked if we could go outside to play.

Nicholas and I were sitting at the table eating breakfast and, as usual, my little brother was at the table pestering me and begging to go outside and play.

Yet again I had to tell him no because I wasn’t up early enough to ask. Saturdays are usually boring because our parents were at work; Kansas was at either a birthday party or at a friend’s house, which meant I was babysitting my little brother and getting ready for school at the same time. So, which meant I was also in charge.

After three weekends of him asking and begging, I finally got up early enough to ask my mother and stepfather if it was OK to go outside and play for the day in the snow. They thought about it, and just before they left they gave us the ok, but there were a few rules that we had to follow.

They told me that I would have to come in at a certain time, do not leave my brother out there all alone, and to come inside when my brother got cold or when I felt he needed to warm up. I agreed to those rules.

So that morning I got my brother up for breakfast and told the good news — that we were allowed to go outside to play and go sledding. My brother was very excited and could not wait to try out his new bobsled that he got for Christmas. I blew up the bobsled and went to play outdoors.

We were outside for about three hours straight. After we sledded 10 times down the hill and built two snowmen, I noticed my brother getting cold and tired so I said to him, “Nicholas, we need to go inside to warm up and I’ll make us some hot cocoa.”

“No, I don’t want to go inside, I want to stay outside and slide down the hill and play. Please,” my brother begged.

“Well alright,” I said uneasily.

“But only 20 minutes more, then we really need to go inside to warm up. Then, I’ll go put some hot water on the stove so that we can have some hot cocoa.”

So, he and I went up the hill and sledded down it two more times, and I looked at my watch and the 20 minutes was up. I said to my brother, “Nicholas, time is up now; we really need to put our stuff away and go inside and warm up.”

“Oh, but can we go down the hill one more time please?” my brother begged, with his teeth chattering because he was so cold.

“Well, OK, but then we really, really need to go inside and warm up.”

So we climbed up the hill that last time. I pointed the sled towards the house so that it would be easier to go in through the sliding glass door.

But, being five years old and being a little impatient, he decided to knock me into the sled and gave a running start. Before I could stop him, he ran up and jumped onto the sled behind me and then we were heading right towards the neighbor’s pond!

I said to Nicholas, because we were going so fast, “Nicholas, let go of the sled.”

I dug my foot underneath the sled to try and slow it down. But, instead of the sled slowing down, we were doing flips. It knocked me out of the sled but my brother was still in it!

I sprang into action, ran into the barn, grabbed my bobsled and the blankets that were in the barn (because I would go in there and sleep), came back to the pond and told my brother to stay still.

But when you tell a five-year-old to stay still, their minds are curious and they move around and do the opposite of what you tell them.

With the ice cracking around him, I jumped into the pond and my brother fell in. I dove my head under the icy water and grabbed my brother before he went down any farther beneath the surface.

Then I pulled him to shore, grabbed him, put him into the sled, and wrapped the blankets and my jacket around him. I dragged him across the street and into the Ashmens’ house and told them to call 911, and then I called my parents right after.

My parents asked us, as the paramedics came into the house, “Did you guys learn a valuable lesson today?” and I answered, “Yes. Not to let your brother talk you into doing something that is dangerous because you don’t know when this mistake will be your last.”

By Tiara Mendala
Derby

VSA, Flynn Center Seek Art

VSA Vermont and the Flynn Center for the Performing Arts have announced an exhibition showcasing works of art by Vermont artists with various disabilities. The deadline for submissions is September 29.

The exhibition — called FLOURISH — “will offer participating artists opportunities to be featured in statewide publicity [and] build larger audiences for their work,” a news release said.

Application materials and more information are available at www.vsavt.org/flourish.

The exhibition is to be held at the Amy E. Tarrant Gallery at the Flynn Center for the Performing Arts, April 7 – June 30, 2018.

Vermont artists with various disabilities, regardless of experience or formal training, who are 18 years of age or older are eligible to apply.

“We encourage participation by artists who have lifelong disabilities as well as artists applying with artwork completed after the onset of their disability. A disability, as defined in the Americans with Disabilities Act, substantially limits one or more major life activity,” the news release said.

Eligible artwork includes but is not limited to painting and drawing in oil, acrylic, watercolor, pencil and charcoal, digital art, photographs, collage, fiber art or computer-generated prints.

Works of art must be completed during the past five years, art must be able to be hung on a wall, and must be original or numbered fine art prints in limited editions of 50 or less.

vsa The State
Organization on
Arts and Disability
VERMONT

Five More Reasons to Question Your Diagnosis

(SECOND IN A TWO-PART SERIES)

By MALAIKA PUFFER

Author's disclaimer: This series is critical of psychiatry. This is not the same as criticism of people's individual choices or of the reality of people's struggles.

1 ■ There are actual illnesses that could cause similar symptoms to "mental illness"

When someone is hearing voices, feeling incredibly sad, or any of the other things that get labeled as symptoms of "mental illness," this likely has to do primarily with what has happened or is happening in their life or the world around them.

In other words, there is usually a social meaning to experiences like these. It is a mistake to assume that any unwanted feelings or behaviors are due to problems in the brain.

However, it is true that if the brain is not working correctly it can impact our feelings, thoughts and actions.

For example, Alzheimer's is a disease affecting the brain that causes problems with mood and memory.

Not getting enough of certain vitamins can also cause the brain not to work well. A high fever or a urinary tract infection might cause hallucinations.

Are these mental illnesses?

No! They are real, physical illnesses that can be tested for and confirmed using science, as opposed to "mental illness," which cannot be scientifically tested for and does not exist except as a concept.

Ironically, even though your doctor may insist that your feelings, thoughts, or actions are because of a problem in your brain, this is not tested for and other real underlying medical conditions might go undetected.

2 ■ "Mental illnesses" were invented, not discovered

Psychiatric diagnoses came about through a group of people discussing and voting on what different mental illnesses they thought should exist and how we should define them, not through scientific research or identification of any biological problem.

There are a few major problems with this.

The first and most obvious is that this means psych diagnoses are not based on scientific evidence. This is a problem because psychiatry has repeatedly claimed to be based on science and most patients and family members trust this.

The other problem with diagnoses being invented is that the people who did the inventing were people with a great deal of power and privilege (the great majority being white, wealthy, straight, cisgender men) and the diagnoses they

came up with are applied for the most part to people with much less power and privilege.

They defined what kinds of thoughts, feelings and behaviors are "sick."

If we did this through a more democratic process, perhaps we would name greed, corruption, racism and police brutality as "sick" behavior.

As it is now, those in power have decided that being "too sad" or "too anxious" or having beliefs outside of consensus reality – all things that could get in the way of our ability to participate in the workforce – are what makes us sick.

3 ■ Psychiatric diagnoses have historically been used to oppress people

In 1851 black slaves who attempted to run away were diagnosed with "drapetomania," a "mental illness" that made them want to flee slavery, and "dysaesthesia aethiopica," which was thought to be the cause of "laziness" among slaves.¹

The "treatment" for both of these conditions was whipping and other forms of torture framed as being "for their own good."

During the 1960s, many African American people were diagnosed with schizophrenia because of their ideas about equality and civil rights.

Because racism was and is so much a part of our society, it was assumed that a black person must be insane to defy the power structures of white supremacy.

Of course we can look back on this history and see clearly that people were responding to their environment and injustices in their world, not suffering from a "mental illness."

There are enough examples of psychiatry being used to oppress people to fill this entire newspaper: Homosexuality was a "mental illness" until 1973, women with any number of experiences were thought to have hysteria, and political dissidents are held in mental hospitals, etc.

4 ■ Psychiatric diagnoses are still used to oppress people

Having a psychiatric label may mean the difference between whether you have your medical concerns taken seriously, whether you lose a custody battle, whether you get locked up, whether you are subjected to forced drugging, and more.

There is much talk in the mental health community about stigma, but the problem is actually even bigger than the judgment that many people hold toward mad folks – there is real discrimination happening on a daily basis, even legally.

If you were given a diagnosis of cancer or diabetes or pneumonia, you still get to decide what kind of treatment you receive and you have

the right to refuse treatment. Sadly, this is often not the case for people who get labelled as mentally ill.

This discrimination may increase if you have another marginalized identity, such as being poor, non-white, transgender, or having other disabilities.

Even if you are not experiencing discrimination, it is still possible to be oppressed by a diagnosis.

For example, if your struggle is related to something bad that happened to you (or maybe something bad that is happening around you all the time, like capitalism or misogyny), a diagnosis will locate the problem within you – your brain, your personality – rather than locating the problem outside of you, which would be much more appropriate.

The result is that our struggles are often taken out of context and therefore lose their meaning.

5 ■ Some people report doing much better after rejecting their diagnoses

I have heard countless stories of people who started feeling much better once they realized that, while their struggles may be valid, the label they were given was not.

If you are told some of the things that many people with psych labels are told – "You can't handle it," "You can't trust yourself," "You need to lower your expectations," "You can't cure it, but you can manage the symptoms" – you might not feel so good about your ability to handle life and therefore might not take the necessary risks to learn and grow and heal.

Additionally, when you let go of one explanation for something, you make room for different explanations.

Online sites like MadInAmerica.com, TheIcarusProject.net and MindFreedom.org, you can read many, many stories of people who have rejected their diagnoses and gone on to understand themselves in their lives in ways that work for them. 🗨️

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

Sources: ¹ J.D.B. De Bow, De Bow's Review Southern and Western States, Volume XI. (New Orleans: AMS Press, Inc., 1851; New York, 1967).



Have an Issue to Discuss with Other Survivors?

COUNTERPOINT IS THE PLACE FOR YOUR VOICE. 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 with letter or commentary. Please identify your town. Letters or commentaries do not represent the opinion of the publisher, and may be edited for length or content.



Opinions

Editorial

DMH Failing To Ask Essential Questions

Despite the good energy and the inclusion of survivor and peer voices, the Department of Mental Health's review of the causes of the backlog in emergency rooms continues to lack the most critical information of all.

Information is being gathered on why people are admitted to hospital psych units to see whether increased diversion options, such as crisis beds, could help.

Information is being gathered on why some people get "stuck" in the hospital after they are admitted, to see what kind of discharge options could help. (If people stay only for as long as they need to, more inpatient beds are available, which could reduce the emergency department waits.)

There is brainstorming on what sorts of added resources in the community might be needed to help people avoid getting to the point of crisis that brings them to the emergency room.

But at least one hospital has reported that the length of inpatient stays has doubled in the past 10 years and that a lot of the extended time is coming from "more severe illness" among those being admitted – and the staff don't know why. Double the length of stay means losing access to half of the number of beds!

This is a very separate problem from the issue of people coming to the emergency room for the "wrong reasons" – for reasons such as not knowing other options.

If people are arriving in emergency rooms in more extreme states, then diversion options aren't going to help, because screeners and doctors will determine that they aren't eligible for them.

Is this accurate? If it is, why is it happening?

Is there less access to outpatient care, so more people are in worse shape by the time they come to the hospital?

Do people not want the non-hospital support so they avoid getting help and are in greater crisis when they end up in the emergency room?

Are there things in society that are causing greater levels of more extreme crisis? More homelessness? More drug use issues? More domestic abuse?

If we brainstorm on these questions, we are only guessing at what might help.

The only way to learn more is to look at the specific situations of people at the point that they enter the emergency room. This information has never been gathered in the past, and there are no plans to start gathering it now.

The Department of Mental Health fears that trying to gather new information will delay creating an action plan to address the crisis. No one wants delay. But information could still be gleaned by reviewing the emergency room records from, for example, the most recent past year.

No one wants delay.

But not having the right information – not having information that helps to identify the actual causes of the problem – will mean that the solutions might be completely wrong.

And that would create a far greater delay in getting the right help at the right place to people who need it. **❶**

Publisher's Commentary

To Fix Mental Health System, End Discrimination

By Wilda L. White



Each time I talk publicly or privately about discrimination against people perceived as having a mental illness, someone will invariably challenge me, denying that people with mental illnesses suffer any societal discrimination. I then recite research studies and surveys: 68 percent of Americans do not want someone with a mental illness marrying into their family; 58 percent do not want people with mental illness in their workplaces; half of U.S. employers are reluctant to hire someone with a past psychiatric history; approximately 70 percent are reluctant to hire someone currently taking antipsychotic medication; 25 percent would fire someone who had not disclosed a mental illness. One-third of Americans say they do not want to live next door to a person with a mental illness.

If that doesn't convince them, I move on to how people with mental illnesses are portrayed or discussed in the media. Lately, I've drawn their attention to a tweet by President Trump that used the terms "Crazy Mika" and "Psycho Joe" or the interview given by President Trump's short-lived Communications Director who referred to the White House Chief of Staff as a "f-king paranoid schizophrenic." My point is not that these terms were used; my point is that these terms were used with impunity. No one criticized their use. The media characterized Trump's tweet as "sexist" and the Communications Director's comment as "profane."

When I share these observations, people do acknowledge that the comments disparage people with mental illnesses. However, they also admit that it had not occurred to them until I pointed it out. I then suggest that the discrimination and prejudice towards people with mental

illnesses are so pervasive that it's normalized. People don't even notice it.

I recently completed a review of national research about the prolonged waits experienced by people presenting at emergency departments for psychiatric complaints. The research disclosed that people with



psychiatric problems wait significantly longer at emergency departments than people who present with non-psychiatric problems, and not minutes longer but hours longer. The research also disclosed that among people presenting with psychiatric complaints, those with certain characteristics wait even longer. The characteristics include age (people less than 18 years old and greater than 65 years old wait longer); diagnosis (people diagnosed with personality disorders, autism, and developmental and intellectual disabilities wait longer); presenting problem (people with suicidal or homicidal ideation wait longer); residence (people experiencing homelessness wait longer); insurance (people with no insurance or public insurance wait longer); and visit characteristics (people who require sitters or restraints or have a history of violence wait longer). It appears that when it comes to psychiatric patients, the more need you have for services, the longer you wait.

During a recent public meeting hosted by the Department of Mental Health, someone observed that this research might suggest that psychiatric patients were being subjected to discrimination when it comes to timely treatment. Once again there was pushback. More than one hospital representative attributed the problem to a lack of inpatient beds, rather than discrimination. There was also the stereotypical and perfunctory reference to the potential for violence among psychiatric patients that hospitals say make it difficult to accommodate certain patients.

This pushback, however, revealed yet more discrimination. If Vermont hospitals have determined that there are not enough inpatient beds for psychiatric patients, why have they not increased their capacity? Why do hospitals expand their capacity to accommodate the needs of non-psychiatric patients but expect the state to use taxpayer dollars for psychiatric patients? All resources, public and private, should be just as available to psychiatric patients as they are for non-psychiatric patients.

I recently heard a DMH staffer say that a nursing home's reluctance to accept psychiatric patients wasn't based on discrimination, but rather fear. Fear of potential violence; fear of adversely affecting the facility's license. It reminded me of the time when I was in fifth grade, and none of my all-white classmates would sit next to me because they feared turning black like me. Discrimination often masquerades as fear, whether we are talking about race or mental illness.

Vermont will not solve the problem of prolonged waits for psychiatric patients at emergency departments without recognizing, acknowledging, confronting, and ending the discrimination against people with mental illnesses in all realms. A good first step would be to put the question to hospitals: why, if they feel that Vermont needs more inpatient beds for psychiatric patients, have they not increased their capacity as they would for non-psychiatric patients? **❷**

Letters

Vital Advocacy Opportunity

To the Editor:

The Vermont Adult Program Standing Committee needs new members, please! Do you have health topics, advocacy issues, professional or lived experience with mental health? Would you like your voice to be really heard?

Then please feel free to attend a couple of meetings of the Adult Program Standing Committee. We meet the second Monday of each month, from noon to 3 p.m. at the Department of Mental Health offices in Waterbury.

This is an excellent professional opportunity. Whether you identify as someone with lived experience, as a professional, a family member – or if you wear multiple hats – we kindly invite you to join us.

The committee has the very important advisory role of reviewing all designated agencies in the state. Designated agencies are the community mental health centers that serve each region.

The commissioner or deputy commissioner, as well as other leadership staff at the department, meet with us monthly.

If you'd like to be at the cutting edge of the latest developments in mental health in Vermont, the Standing Committee is the place to be! (By the way, although it is called "Standing Committee," we do sit down for the meeting.)

There is always time for public comment as well.

I have been attending these meetings for many years, and they have really enriched my life as a person as well as a professional. Some members give presentations on topics that are very important to them.

If you enjoy collaboration, leadership and advocacy, we invite you to reach out, connect and learn more.

We are seeking members with a wide variety of goals, not simply one subject or interest area. If you feel you have experience and good knowledge to share, please attend. We are searching for new members from all parts of the state.

Prospective members are asked to attend two meetings,

apply with the committee and provide two or three solid references. Appointment is by the governor.

Members are expected to attend regularly in person or by phone. There is a stipend and mileage reimbursement for members who are not reimbursed by their employer for attendance.

It truly is an honor to serve on the committee and also to serve Vermont. It is an exciting and intelligent committee to participate on!

If you'd like more information, please email me at marla.simpson@gmail.com or Clare Munat at claremunat@msn.com. Clare and I look forward to hearing from you.

M.S. SIMPSON, M.A.

Member of the Vermont Adult Program Standing Committee

Chairperson of the Mental Health Block Grant Planning Council

Giving Recognition to a Psychiatrist

To the Editor:

I am writing to give recognition to a great man and a great psychiatrist! Newly retired Bill Cody of private practice and Northeast Kingdom Human Services is a very well-known psychiatrist. I'd like to see high recognition for Bill and my sister-in-law, who is also a great counsellor, Deborah Lee, both of Lyndonville. Both work together quite often.

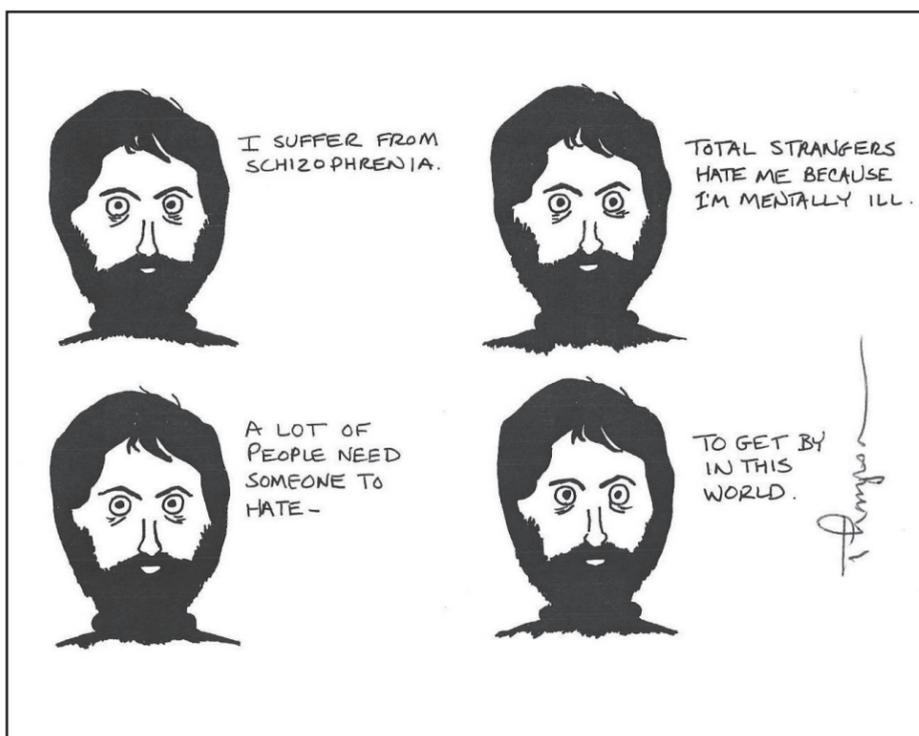
Ten years ago I reached the bottom of my life – stress, alcohol, drugs. I hit bottom at 3 a.m. Christmas morning, ready for a nervous breakdown. I called on my great friend Deb Lee, and she helped me through the night. She and Bill Cody and his dog Woody saved my life.

From that day on, I don't drink, swear very little, and just do my two mild prescriptions. Mental health is there for you and your family at Northeast Kingdom Human Services – very confidential, supportive and friendly.

From that day on, I don't drink, swear very little, and just do my two mild prescriptions.

Mental health is there for you and your family at Northeast Kingdom Human Services – very confidential, supportive and friendly.

PATRICK W. LEE
Lyndonville



By Jean Thompson, South Burlington

Wellness Tips from *Counterpoint* Readers

Nancy's Steps to Recovery

1. Make a commitment to your own recovery process.
2. Evaluate the areas of yourself/life that you want to improve or change and those areas that you are pleased with and do not want to change.
3. Do not make unreasonable expectations of yourself: Allow yourself to make mistakes, but don't let your mistakes overcome any gains that you have made.
4. Remember that we always have choices. You don't have to be a victim forever. We cannot control the past, but we can affect the future.
5. Take responsibility for your own feelings, not others'. We cannot control what others do or say.
6. Do not take on guilt that is not yours. Guilt is counterproductive and only slows down the process of growth and productivity.
7. Weigh the pros and cons of a situation. Attempt to make the best choice at the time, given the situation at hand.
8. Attempt to change a negative feeling, thought, situation, etc., into a positive one, when possible. Focus on your strengths, not your weaknesses. Replace negative thoughts with positive ones.
9. Strive toward excellence, not perfection. We are human, not perfect.
10. Set small daily goals. Take each day as it comes; don't attempt to conquer everything at once. Change takes time. Growth is a gradual process, and occurs with time, patience and perseverance.
11. Make deliberate efforts to help yourself feel better as a person. (Make daily lists, if necessary or helpful.) Remind yourself that you are worthy of good things and deserve to be happy.
12. Never quit. Strive to be all that you can be. It's up to you.
13. Always remember that you are a unique and special individual who has a right to be yourself, express your feelings, and to be happy.

—Nancy Balconis, Bennington

Richard's Six Tips for Happiness

- Free your heart of hate.
- Free your mind of worry.
- Stay away from things that make you unhappy.
- Give more.
- Expect less.
- Live simply.

—Richard A. Williams, Bennington

Ross' Six Coping Skills

- Walk away.
- Take a shower and pray.
- Be grateful.
- Pace, pushups/exercise.
- Take a PRN [medication].
- Reach out for support.

—Ross Jakubowski, Brattleboro

These lists of tips for wellness were submitted independently to *Counterpoint* by their authors.

A Noncompliant Patient's Story



By KATE DEWOLFE

One of the peers I have been working with is a current involuntary psychiatric patient. She has asked me many times to write about her story and publish it. To protect confidences, I will refer to her as Jane, though this is not her real name.

When I first met Jane, she was in the milieu on a locked adult unit at the Brattleboro Retreat. I introduced myself to her. “Hi, my name is Kate DeWolfe. I’m a patient representative with Vermont Psychiatric Survivors —”

She cut me off. “I don’t need an advocate, I know my rights. I’m fine. But you should talk to the guy in the ALSA. The staff provoked him! I saw it. He’s a nice boy, he shouldn’t be stuck in there.” (The ALSA is the adult low stimulation area. This closed section of each inpatient unit has fewer people, no throwable objects, and fewer privileges and activities than the milieu.)

During this first brief conversation with Jane, I was heartened to meet a patient looking out for her peers on the unit. I remembered my own inpatient experience, and how some of the other patients had seemed at times more supportive to me than my treatment team.

Jane was discharged soon after this first conversation, only to find herself back at the Retreat a week later. The next time I talked to her she was sitting at the computer on the unit, surrounded by books and papers. She was awaiting a court date for involuntary hospitalization and was frantically reading up on mental health law.

She was focused and determined. She gave me copies of Supreme Court decisions, peer reviewed journal articles, printed pages of legislation, and clipped news reports to read.

She knew her rights, and she was preparing for a fight. She did not believe herself to be mentally ill and did not want to take any medications. She didn’t trust the clinicians. She was the expert on her own experience and was highly critical of anyone else who claimed to be.

I was impressed with this sharp-witted, fast-talking, legal-savvy, cynical, sarcastic, strong-willed person with fascinating stories. During my visits to the unit, we had lively conversations about international politics and critical theory.

I was a little concerned, though, early on, that some of the hospital staff did not seem to appreciate Jane’s presence as much as I did. She had a one-on-one staff person following her around one day. This level of supervision is usually reserved for patients who are perceived to be at imminent risk to themselves or others, or for patients who pose a risk of falling and getting hurt.

Jane did not seem violent. She gave no indication she wanted to hurt herself or anyone else. She informed me she had been given a one-on-one because she kept advocating for other patients’ rights.

During Jane’s stay in that unit, many patients started requesting copies of the “green book,” “Your Rights as a Vermonter Diagnosed as Having a Mental Illness.”

I brought in six copies one day, and they disappeared fast. I noticed more patients than usual were reaching out to me to talk about their rights

and their experience at the hospital. I talked to a few who had advocated for themselves, actively making shared decisions with their treatment providers.

While I could see this positive influence, I also witnessed staff members and a few patients comment on Jane’s disruptive presence. “She won’t stop arguing with everyone!” “I wish she would just be quiet.” People said these things about Jane, sometimes in her presence.

One day Jane called me while I was in my office. She sounded distressed and asked for my help. She told me she had been planning with her treatment team on being discharged from the hospital before her court date, and everything had been all set.

All that was needed was a consult with her prescriber, to sign some paperwork, and get a ride out. She was alone in an interview with her prescriber who began to say, “It is my medical opinion —”

“— I don’t give a f--- about your medical opinion.” Jane had a lot to say about how little she cared about his medical opinion. She gave him a piece of her mind, criticizing his education and expertise.

That was when Jane made a huge mistake. She wasn’t out of there yet, and this man had the power to release her or keep her confined on the unit. He chose the latter. She had given him a piece of her mind, and he exerted his authority to diagnose that mind as mentally ill and dangerous.

In the days leading up to her hearing she was rapidly filling out subpoenas for witnesses, writing up motions to file, and looking up court decisions relevant to her case. She had tried to fire her lawyer so she could represent herself. But the judge had denied that request.

Currently Vermont does not allow involuntary patients to represent themselves, not even on a case-by-case basis. There are no hearings to determine whether psychiatric patients are competent to present their own cases to the court.

Jane needed her lawyer to be doing this work. The court would not accept anything unless it came from her assigned public defender from the Mental Health Law Project.

I didn’t know at the time that all the work she had been doing would be pointless. Jane asked if I could go to court with her. She asked if I could testify as a witness in her defense, and I agreed to.

Unfortunately, I was not allowed to testify in court that day. Jane’s lawyer had not notified the court that I would be testifying. I waited outside the courtroom for two hours while the state and hospital presented their case.

Then there was a brief recess, and I learned that the hospital’s attorney would object to me being called as a witness. The state and hospital hadn’t finished presenting all their evidence, so I waited a while longer. Then I was called in and told I could support my peer, but I would not be testifying.

Jane was called to the stand to testify, and the judge kept cutting her off before she could answer the questions fully. Despite having heard two hours of testimony against her and having a hostile interaction with the judge, Jane kept her cool through most of the questioning.

She accepted being redirected. She stopped talking and listened when interrupted. The only time she spoke out of turn was at the end of her testimony, after the judge made comments that denied the validity of her experiences prior to being hospitalized.

The state rested its case, and Jane’s lawyer again asked if I could be a witness to her defense. The judge denied the request due to the “late admittance, lack of expertise, and limited, brief contact with the defendant.”

I had accepted not being allowed to testify, but hearing this made my jaw drop. Limited contact? Psychiatrists can assess and diagnose someone in 15 minutes. Jane and I had built a mutual relationship as peers over many conversations over the course of several weeks.

During the judge’s decision, Jane turned to look at me a few times. I was, after all, present only to support the defendant. She shook her head in disbelief while hearing the judge talk about her “serious mental illness.”

Three times the bailiff asked her to turn and look at the judge, not at me. After the third time, I was asked to leave the courtroom because my presence was “distracting the defendant.”

Jane is still at the Brattleboro Retreat and is just as defiant as ever. She filed motions for an appeal and for a stay of involuntary medication. She has been frantically hitting the books, just like before.

When I last spoke to her, though, I hardly recognized her. She has a black eye and a large bump on her head from falling after an involuntary medication procedure. She refused medical treatment, then requested treatment, and then refused it again.

The stay of medication was granted pending an appeal, and she believes being briefly on the meds and then abruptly stopping them may have caused some damage.

She admitted she hasn’t been herself lately. She’s been screaming at the staff, throwing things, making threats. Jane never seemed violent or dangerous to me before, but now I can’t help but see a raging madwoman and terrified mental health workers.

But I know that inside that bruised and angry person is my friend, my peer, my ally. I cannot fully understand what she’s going through now, because I am not her. I am an expert on my own experience, and no one else’s. I will do my best to support, listen and advocate for a better experience.

Jane’s story is unique in a way. Not many patients order law books and comb through Lexis-Nexis. But in many ways, Jane’s story is a common one of noncompliant psychiatric patients everywhere.

I have met many others who disagree with their diagnosis and who refused medication. I’ve seen multiple power struggles with psychiatrists, and realistically, the psychiatrist inevitably has more power.

People I talk to who have been committed by the court often say the same thing — they never really stood a chance; the game is rigged. The courts overwhelmingly rule in the hospital’s favor, time and time again. Every week there are newly issued orders of involuntary hospitalization, orders of involuntary treatment, and orders of nonhospitalization (in which patients leaving the hospital have court-ordered aftercare).

I frequently talk to patients who understand that they must be med compliant, otherwise the hospital has permission from the court to give forced injections of Haldol or other sedating drugs. These orders allowing forced drugging are not typically obligatory, but once they’re issued the hospital will choose to execute them on noncompliant patients.

(Continued on page 23)

What Do We Want? When Do We Want It?



By CALVIN MOEN

On a Friday afternoon in July, 40 or so of us marched along Montpelier's Main Street toward the State House in our matching orange t-shirts with hand-painted signs. We chanted in call-and-response up and down the line of

bodies: "What do we got? Mad pride! When do we got it? Now!"

In thinking about the concept of pride, I am inspired by the gay and lesbian movement, which gained momentum in this country during the 60s and 70s, when gender-nonconforming people of color began to fight back against brutal raids by police on their spaces. My queer ancestors took to the streets to declare pride in something that society said we should be ashamed of.

Their fight is far from over. Though many gains have been won over the past few decades, LGBTQ folks around the world still face grave threats to our material and physical safety.

Despite our outward unity, I discovered by talking to my fellow mad pride marchers that there were several different ideas about why we were marching and what we were marching for.

For some, it was an end to psychiatric torture – electroconvulsive treatment, forced drugging, incarceration in locked hospital wards. For others, it was the right to exist outside the narrow margins of "sane." For some, it was increased access to services that help them survive and navigate the world. For others, it was raising awareness that, although invisibilized, shamed, and silenced, "We're here, we're weird, get used to it!"

The LGBTQ community has its share of differences, too. How do you think we got all those letters? While our diversity is a source of strength, it also means disagreements about which are the most important issues we face and how to address them.

Historically, those privileged by race, class, and gender inequalities have set the agenda and left people of color, poor people, women, trans people, immigrants, and others to fend for themselves while securing safety and benefits for just a few.

Although Black and Latina trans women like Marsha P. Johnson and Sylvia Rivera were the frontline leaders in the days of the Stonewall riots (which are the origin of today's gay pride

celebrations), their contributions have been largely co-opted and redirected by the more mainstream movement.

For example, in recent years, large nonprofits campaigned hard and at great expense for marriage equality. This allows gay and lesbian couples to be recognized by the state for purposes of taxation, healthcare, citizenship, and other legal rights. It does nothing to secure those same rights and benefits for anyone outside the nuclear family structure. It does nothing for homeless queer youth or poor trans women of color, who struggle to meet their basic needs.

During the mad pride march, I was struck by how many viewpoints were represented, and a little worried. With so many perspectives, how do we agree on what needs to change?

I saw a bumper sticker the other day that read, "We can't win until we are one." If that's true, I'm afraid we're in trouble. If we don't agree on what madness even means or whether we're proud of it, how will we be able to focus our efforts on making the world a better place for ourselves and our communities?

My suggestion: We can prioritize the urgent needs of those members of our community who are hit the hardest, who are pushed farthest into the margins, whose voices are silenced and discounted most often.

Just as I am inspired by LGBTQ pride, I see some parallels between conflicts that community faces and those within mad pride. The leaders of the psychiatric survivor movement, which also gained momentum in the 70s, were recently liberated from state hospitals. Many were homeless and/or low-income, and many were women.

Over the decades, the influence of mainstream funding and groups that speak "for" patients waned down that early militancy.

Psych survivors can learn from the LGBTQ movement's successes and failures in setting our priorities. We can make sure everyone has a seat on the bus, rather than throwing the most vulnerable underneath the wheels.

Our community members locked in psych units or hidden away in secure residential facilities are "out of sight, out of mind" and don't get to participate in our marches, our meetings, our trainings, or our conferences. Those whom the state, via court order, forces to take drugs on an outpatient basis are often too sick from the adverse effects of those drugs to join us, as well.

In order to build power, we need all of us participating in the struggle. I propose that we pledge to free people who are locked behind heavy doors, or incarcerated within the walls of heavy sedatives and other drugs they don't want to take.

If we can agree that no human being is disposable, that no one can take away our right to autonomy and participation in decisions about what happens to our bodies, then we can unite in our demand to end involuntary commitment and treatment.

Through my research and what I've observed visiting psychiatric hospitals in Vermont, I've learned that people with low incomes, people of color, and women are especially subject to rights violations and discrimination in the mental health system.

I'm sure that being white and college educated played a part in my ability to talk my way out of a locked ward when I decided there was nothing there that was going to help me.

Privilege is sometimes difficult to recognize. It's like the air we breathe: We don't think about it unless we are suddenly deprived of it.

When I didn't feel I had been personally hurt by mental health treatment, it was easier to think of it as benign, even sometimes helpful. As I had more and more scary and unfair experiences with providers, and met others who had been treated with even less respect, I began to think more critically, and I was more able to believe others when they said they'd been mistreated.

Until you or someone you love has been harmed by a particular system or institution, you might not perceive it as harmful. You might be tempted to dismiss others' experiences as misunderstandings, or their fault, and defend the status quo.

Survivors are a diverse group, and I don't believe we need to be homogeneous in order to move forward together. I don't think we need to be "one," as the bumper sticker suggests.

I want a movement that is broad and deep enough to encompass all of our dreams, identities, needs, and abilities. We don't need to agree on what it means to be mad – we don't even need to claim that identity. We just need to practice solidarity with one another and with those who are continuously left out of the conversation.

Whether or not you are calling for the complete abolition of psychiatry, whether or not you find value in DSM diagnoses, I hope you can agree that only those who want treatment should receive treatment.

Let's focus our energy and resources on ending coercion. Let's not let our privilege set the agenda. 🗣️

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Calvin Moen is a peer advocate for Vermont Psychiatric Survivors and does grassroots organizing for mutual support in Brattleboro.

(A Noncompliant Patient's Story • Continued from page 22)

I want to be clear: I am not opposed to psychiatric medications in general. I myself have been on and off medication.

At times, I have found meds to be quite helpful. I meet peers who feel that medication saved their lives. I am more than willing to work as an advocate for peers who are seeking out medications to help them cope with their struggles.

Conversely, though, I've also been on medications that I felt were disabling and harmful to me, and this is also a common experience of the folks I work with.

Every week I meet peers who want to get off the drugs they have been prescribed, for a variety of reasons. Adverse reactions, multiple drug interactions, disabling side effects and long-term health risks are all serious issues that should be considered whenever medication is prescribed.

Given these common complications, given the restrictive nature of hospital settings and the power dynamics therein, and given our shared

values in our society of freedom and personal liberty, I cannot say that I see the value of forcing a noncompliant patient to be treated against their will. Psychiatrists all take an oath to do no harm, and I can't help but see forced treatment as inherently harmful.

The hospital psychiatrists and administration will stress the necessity of involuntary treatment, but I believe strongly that there are other ways. There are many paths to recovery (what constitutes "recovery" will mean something different to each person).

The literal translation of the Latin word "psychiatry" is "soul healing." There are so many things in life that can be healing to the soul. Talk therapy, safe and secure housing, exercise and physical activity, spirituality, art, music, dance, supportive relationships, community building, gardening, reading ...

So many options are actually possible if we allow them to be. 🗣️

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Kate DeWolfe is the southern Vermont patient representative for Vermont Psychiatric Survivors and lives in Brattleboro.

Suicide Prevention Reviewed at Quechee Gorge

QUECHEE – Signs and call buttons have been placed at a bridge over the Quechee Gorge that has been the site of 15 suicide deaths since 2003.

A full scope and design study is also being conducted to determine the cost of either a barrier wall or a safety net. The estimated \$2 million price tag more than meets federal criteria for the cost-benefit analysis of “the value of saving a human life,” a report by the Department of Transportation said.

Both the immediate measures and the study were required by the state legislature in 2016 based on testimony that well-known bridges can become a draw for persons who want to die by suicide, and that barriers can prevent deaths.

The report, also required by the legislature, said that in the past two years there have been two deaths each year. Data were not collected prior to 2003.

“There is no other place in Vermont that is so associated with suicide and so readily accessible,” the report said.

The call button that was installed connects to a 24/7 counselling service in nearby Lebanon, New Hampshire. The signs read “You Matter” and provide a crisis hotline number. However, the report noted that no research exists showing that such access helps to prevent suicide attempts.

The report said, in contrast, research on the effectiveness of barriers or nets on bridges

shows that suicides can be prevented, and “there is no evidence that they lead distraught people in crisis to instead use other means of suicide.”

It cited research that demonstrated that such an effort to turn to another means of suicide “is rare to nonexistent” because the level of desperation that leads to an attempt is often brief, and measures that can “delay or deter their action give these people more time to get through their period of deep pain safely.”

Vermont’s rate of suicide deaths is above the national average. The report said that the Quechee bridge has become associated with a long record of suicide deaths, and “this reputation, combined with a relatively low and easily climbable barrier, may draw people to the bridge during times of crisis.”

The legislature required the department to review both pros and cons of creating safety precautions, and the report said, “Quechee Gorge State Park is by far the most visited state park in Vermont, and many additional visitors enjoy the spectacular views from the historic Quechee Gorge Bridge.”

It said that “impacts of means restriction include impacts to historic and natural resources, and visual impacts that would affect the enjoyment of the park and potentially the area economy.”

“Based on a conceptual design assessment, means restriction options including barriers

or nets would each cost about \$2 million for construction, and would also impose additional maintenance costs.”

It also said, however, “While jumping suicides are a relatively small percentage among all Vermont suicides, they may be among the most readily preventable, and worthy of investing in prevention, considering the young ages of many who have jumped from the bridge.”

The report included a cost-benefit analysis required by the legislature. It reviewed the national Department of Transportation guidance on “how to determine the value of saving a human life.”

A range of values has been listed as between \$5.2 million and \$13 million, the report said, but “states are permitted to use their own numbers for cost-benefit analysis, which are typically somewhat lower, and average at \$3.3 million.”

It said that although Vermont has not adopted its own value, “Based on research and past experience elsewhere, it can be expected that the investment in means restriction on the Quechee Gorge Bridge would have a positive cost-benefit analysis, even if much lower alternative life valuation numbers are used.”

No psychiatric survivors were invited to be a part of the working group for the review, and none were listed as participating in its development, although at least one testified at a planning meeting and several gave email input. ❗

Cats Get Support Status

MONTPELIER – Another ruling of discrimination against a person with a psychiatric disability has been issued by the Human Services Board, this time on behalf of a person with cats that function as her support animals.

Xenia Williams won her case after filing a complaint that the food stamp program, 3SquaresVT, wrongly denied counting her expenses for food and veterinarian care for her two cats from her income in determining eligibility. Such expenses for service animal care are usually deducted from income.

At issue in the case was whether her cats were responding to her with affection, thereby providing emotional support, as a result of being “specially trained to serve the needs” of a person with a disability.

The board split on the decision in a 4-3 vote. According to the decision, Williams provided testimony that she used behavioral modification techniques to train the cats to “do specific things when she needs relief from post-traumatic stress.”

The legal distinction, the decision noted, is whether an animal has been “specifically trained to help [a person] compensate for her disability or to perform a function that [the person] cannot readily perform on her own.”

The board said the rules do not require professional training of an animal, but rather, the animal can be considered a service animal “when a behavior by its owner dependably elicits a trained response that satisfies a defined medical need of its owner.”

The dissent argued that the decision of the Department for Children and Families that the cats “were simply responding as most cats do when petted” should be upheld.

The decision was specific to the 3SquaresVT program’s income eligibility test, not to general public accommodations rules on discrimination. Only dogs and miniature ponies are covered under public accommodations law, the Human Rights Commission notes in its public information materials.

It was the second ruling on service animals for people with psychiatric disabilities this year. Earlier, the board ruled that a deli owner discriminated when she asked a man for evidence of his dog’s training and what the nature of his disability was.

The board said that only two questions are permitted by businesses under the public accommodations requirements if it is not clear that the animal is a service animal: whether the animal is required because of a disability, and what specific tasks the animal has been trained to do.

The Human Rights Commission is currently running public service announcements to help educate people about the law. ❗



Warm Line to Expand



BURLINGTON – Pathways Vermont is developing expanded hours for the Vermont Support Line after a state budget grant of an additional \$200,000 as part of the legislature’s effort to address mental health crises.

The funding for the peer warm line was the only budget increase for services outside of the designated mental health agencies in response to the acknowledged shortfall in meeting the needs of people coming to emergency rooms and waiting for days for hospital admissions.

Designated agencies received money to increase salaries to help recruit and keep staff, especially in crisis service positions. The Department of Mental Health was also directed to conduct a full analysis of what other resources need to be added for mental health support in the state.

“I think [the added support line hours] will decrease emergency services use, as it has already demonstrated that it is doing so,” said Hilary Melton, executive director of Pathways. Responses from those who use the line have indicated that many might have gone to the hospital if they had not been able to talk to someone at the warm line, she has said.

“We still have to work on the staffing pattern and supervisory support,” she said, but the warm line should be able to be operational for up to 16 hours per day, in contrast to the current daily hours of 3-11 p.m.

The statewide warm line was created in legislation in 2012 as a “nonemergency telephone response line operated by trained peers for the purpose of active listening and assistance with problem-solving for persons in need of such support,” and Pathways Vermont received the grant to operate it.

The Vermont Support Line can be reached toll free at 888-604-6412.

Local warm lines operate in Chittenden and Washington counties. ❗

Clinician and Veteran Shares Story Of His Suicide Attempt in Air Force

KILLINGTON – Eric Astleford is a crisis clinician with Northwestern Counseling and Support Services.

He also is a psychiatric survivor and a United States Air Force veteran who shared his story this past summer on military culture and its relationship to suicide – including to his own suicide attempt in 2003.

Astleford spoke at the annual conference of the Vermont Suicide Prevention Center, where more than 200 people, mostly clinicians, gathered to hear speakers address state and national efforts to reduce deaths by suicide. Vermont's rate of suicide is well above the national average, and continues to increase at a faster pace than the rest of the country.

Veteran deaths from suicide have drawn broader attention, and according to Astleford, despite official policies against demeaning actions, harassment and bullying, the “warrior code” is deeply embedded in military culture and helps to account for those deaths.

He compared the rate of 22 veteran deaths per day in the United States to the number of people in front of him at the conference: in 10 days, “the entire room would be wiped out.”

When he became depressed during his time in the service, he felt he had nowhere to turn for support among those in his squad. He said he recognized he “already knew what they think” about people with depression, because he had, himself, participated in ostracizing and harassing others in his shoes.

Instead of getting support, he became the victim of “military bullying and active and passive hazing.”

He said the warrior code dates to Alexander the Great in the 300s B.C. (Astleford is a history

buff) when the Greek king faced his rebellious troops, showed them his own wounds, and told them, “If I can do it, why can't you?”

The warrior code tells soldiers that they are members of a team where the mission comes first, they can never quit, they must be physically and mentally tough and they are the guardians of freedom and the American way of life.

The military only functions when “everyone's doing their job ... pulling their weight.”

If someone is depressed, others think, “I don't know if I can count on him.” That leads the platoon to try to “get [the soldier] back into the fold” by shaming the person.

Within the platoon, a death by suicide prompts comments like “I guess he couldn't hack it” and “He failed,” Astleford said, “all in the name of the warrior code.”

That permeates how veterans see themselves, he said.

When he became seriously depressed, he turned to drinking and then pills and finally to the day that he took a large quantity of both. His girlfriend found him and got him to the emergency room, saving his life.

The next day in the hospital he felt so much shame that he was feeling “worse than the day I tried to kill myself.”

His turning point came through the words of a doctor who told him, “Eric, this is not your fault.”

Astleford said that a number of factors led to the point where he “started living again,” including doing a lot of walking, the birth of a daughter, and support from occasional therapy. He joked with the conference audience that he still wasn't one to respond well to therapy; he was better at providing it than receiving it.



Eric Astleford

Since leaving the military, Astleford has received his master's degree in clinical psychology from Saint Michael's College in Colchester, and is a member of the American Psychological Association and the Vermont Association of Psychoanalytic Studies.

Having opened his comments by putting on a military jacket and asking the audience what words came to mind when they saw him, he closed by challenging the attendees to put aside biases about the armed services.

The next time someone sees a person in uniform “crying because they can no longer get through the day,” they should remember, “That person's your neighbor; that person's your relative.”

It is the attitude of others that can change “how veterans view themselves,” he said, when they are experiencing the kind of shame that he once faced and ultimately survived. **!**

Alyssum Challenges Policy For Marijuana at Crisis Beds

ROCHESTER – Alyssum, the peer-run crisis respite program, is objecting to a model policy by the state's mental health agency network that prohibits the legal use of marijuana for health reasons on the grounds of their crisis programs.

The policy is not binding and would not apply to Alyssum, but Executive Director Gloria van den Berg said, “It's a big deal for someone who has finally managed to get a card.”

She told Dillon Burns of Vermont Care Partners – the network of designated agencies – that “individuals who have one have usually tried everything else and it has not worked.”

Vermont law allows individuals not to be prosecuted for marijuana possession if they have a card verifying that they are on a Department of Public Safety approval list as having a health provider's certification of specific illnesses.

The law was amended this year to add post-traumatic stress disorder to the list of illnesses that are recognized as benefitting from marijuana for symptom relief, as long as the person is also receiving care for PTSD.

When she first read the policy, van den Berg told Burns in an email, “I was offended, and felt



put down and shut down as an individual with lived experience ... It will upset and hurt people who are already hurting.”

Burns said that the model policy was developed based on federal funding standards that “require us to be drug free” and don't recognize exceptions for medical marijuana. She said that

the organization asked for guidance from the Department of Mental Health and the Department of Disabilities, Aging and Independent Living, and “didn't get any.”

Alyssum does not permit use of marijuana in the residence, and state law does not provide an exemption for use in a public place, so van den Berg said Alyssum permits clients to use the smoking gazebo, but no other guests or staff may be present.

“I realize that it is difficult to monitor and to create spaces for people to smoke,” she said, but, “It is very clear that this policy [by Vermont Care Partners] is set up to accommodate the system.”

“I think the biggest stumbling block is a smoking area which is managed for this purpose,” she acknowledged. “Unlike cigarettes, which can be taken to the street corner for a smoke, marijuana needs a smoking area which can be monitored so that there is no sharing.” However, she added, “We have had no problems at Alyssum so far.”

Burns disagreed in a reply to van den Berg, telling her, “From my seat at the table when agencies discussed this policy, I heard very sincere discussion in which agency staff tried to balance the real and valid needs of those with medical marijuana cards who use DA crisis beds and the federal policies on controlled substances that dictate licensing rules for Medicaid-funded settings.

“It seemed like a no-win situation.” **!**

'Beyond Silence' Takes on a Local Voice

BURLINGTON – Four Vermonters added their voices in a panel presentation after a screening of “Beyond Silence” – a new documentary that presents the stories of three people who describe experiences of being diagnosed with mental illness.

The local survivors offered some views that contrasted with and complemented some of the more conventional viewpoints of those in the movie. The half-hour film is part of a “Be Vocal: Speak Up for Mental Health” initiative of four national groups and a pharmaceutical company. It can be seen at www.bevocalspeakup.com/documentary.html.

Panelist Responses to Symptoms

Ericka Reil of Barre, who coordinates the Wellness Workforce Coalition, tried traditional responses to her challenges – medication, hospitalization and talk therapy – but “none of it worked for me.”

She has found that peer support “is the best support ever.” The movie screening and discussion were sponsored by the coalition.

Others on the panel described using a combination of different supports.

Abby Levinsohn of Burlington, who heads the Pathways Vermont Community Center, has found medication helpful but “definitely not a stand-alone thing.”

“Hospitalization was a really, really terrible time in my life. I think there must be a better way.”

Marty Roberts of Montpelier has found therapy helpful but cites her involvement in teaching WRAP (the Wellness Recovery Action Plan) as a key part of her wellness.

Toby MacNutt of Burlington has been “in and out of all [the] options,” including “medication that’s been a terrible experience” and “medication that’s been a great experience.”

Art is his mainstay, and “peer support has been monumental.”

MacNutt also had his service dog-trainee, Jax, with him, and described support from that relationship that echoed the experience of one of the speakers on the video.

Viewpoints from the Video

Jeff Fink described himself in the film as having “severe and persistent anxiety and depression” that was not fully responding to traditional treatment. He began training a golden retriever named Earl to be his mental health service dog, adding to what he described as his “whole-person approach” to wellness.

Fink later launched Go Fetch Wellness, an organization dedicated to introducing others to how the human-animal bond can support their journey.

Lauren Burke said in the documentary that she found her diagnosis of bipolar disorder to be a tremendous relief because it helped explain her symptoms. She described working closely with her medical provider as she continues in her job as director of a nonprofit organization she founded.

Lloyd Hale is a certified peer specialist who started RIDE 4 S.P.M.I. (Ride for Serious and Persistent Mental Illness), a 210-mile bike ride across South Carolina to raise awareness about mental illness. He is also raising two children.

Hale said that, “as someone living well with schizophrenia,” he shares his story in the hopes that others will seek treatment and receive the help and support they need. He spent many

years institutionalized as a young teen after being found not competent to stand trial for a murder.

The film’s executive producer, singer Demi Lovato, said, “I’m bipolar and proud, and I live well with it.” The documentary was directed by Shaul Schwarz.

The three people in the film all spoke to their reasons for becoming a part of



A LOCAL VOICE – The Wellness Workforce Coalition of Montpelier sponsored a screening of “Beyond Silence” this past summer, along with a panel of local survivors who shared their personal experiences with treatment, discrimination, and what makes them want to speak publicly. From left are Toby MacNutt, Marty Roberts, Abby Levinsohn, Ericka Reil, and moderator Sarah Launderville. (Counterpoint Photo: Anne Donahue)

the Speak Up for Mental Illness initiative, a collaboration between Lovato and the Depression and Bipolar Support Alliance (DBSA), the National Alliance on Mental Illness (NAMI), Mental Health America, the National Council for Behavioral Health, the JED Foundation and Sunovion Pharmaceuticals Inc.

“I know what it’s like to have lost your voice, and I want to be the voice for those that can’t speak up for themselves so others will see that they’re not alone,” Fink said.

Burke said one of her goals since her diagnosis has been to show that living with a mental health condition may be challenging, but dreams can still be achieved.

Local Panelist on Going Public

Moderator Sarah Launderville asked the local panelists at the presentation how they had gotten to the place where they could speak publicly about their experiences with mental health treatment. Launderville is executive director of the Vermont Center for Independent Living.

MacNutt said he had simply disappeared from his high school after an “indefinite medical leave” was forced on him as a result of symptoms he was experiencing. Years later, he reached out to reconnect with old friends and discovered that many of them had similar experiences but had simply been able to hide them better.

It made him realize how important it was to speak out.

Levinsohn said she wants people to know that the experiences are not all negative. She realizes that instead of making her feel “fragile and weak” they are “adding to the complexity of who I am.”

Reil said she had a condition that was going to lead to her death – because of wanting to die – “but nobody talked about it.”

For her, it is important for her son, who has been identified as having autism, to learn that it

is okay to talk about it. “I don’t want anyone to be ashamed of who they are.”

Crucial Value of Working

The presenters also discussed the value of employment and volunteer work.

For Levinsohn, it is “probably the number one thing ... [in] overcoming some of my challenges, where I can feel purposeful and feel I can give something useful.”

Volunteer work “brings meaning and some structure” to life, Roberts said. “It makes you get up in the morning.”

Facing Discrimination

All of them have experienced discrimination as a result of the labels of mental illness.

“It baffles me how people can believe what they read in the papers,” Reil said as she described the way people assume she must be violent when her diagnosis is disclosed.

They ask, “Why aren’t you on medication?” and “How can you be out in public?”

Levinsohn said the biggest example in her life came when a boyfriend broke up with her because his parents found her medication.

They told their son they felt sorry for her, but that she would “just be disabled [for life] and have a really hard life.” MacNutt, who uses a wheelchair, said that because his physical disability is obvious, he often experiences discrimination in that context first, and has to be “choosy” about disclosing his mental disability.

For Roberts, the single most painful discrimination came when members of her singing group at church told her she couldn’t continue with the group because she would be “too volatile and too fragile.” She was able to seek out the specific individuals involved and later rejoin.

What she fears most in disclosing her experiences, however, is the sense of separation that others create: “being seen as ‘other’ or ‘different.’” ❗

Parent Urges Community Supports

NAME WITHHELD

I'd like to read an excerpt written by a Norwegian woman, Arnhild Lauveng, who later conquered her schizophrenia and became a successful psychologist in her own right.

"It started carefully and gradually, and I almost didn't notice. It was like a nice summer day when the fog slowly creeps over the sky. First as a thin veil over the sun, then gradually more, but the sun is still shining, and not until it stops, when it suddenly gets cold and the birds have stopped chirping, do you realize what's happening.

"But by then the fog is already there, the sun is gone, landmarks are starting to disappear, and you don't have time to find your way home because the fog is so heavy that all the roads are gone.

"And then the fear hits you. Because you don't know what's happened, or why, or how long it will last, but you understand that you are alone and that you are lost and you are scared that you may never find the way back home."

My involvement [with the mental health system] started with dealing out tough love to my son soon after he squandered one opportunity after another. And the only thing he could tell me was that he was trying the best he could ... I was faced with a steep learning curve of having a child diagnosed with a severe mental illness and my own humility and heartache that my son indeed had been trying the best he could ...

I've learned that mental health is very much a Rubik's Cube with successful treatment being more an intuitive skill than just the mechanics of medicine ... As my son struggles with the physical and mental health care system, I'm confronted with one inescapable question.

If we know that evidence is telling us that some of our policies are ineffective and potentially dangerous to consumers, why are we continuing to do them?

Hospital beds and lockdown facilities are not the answer. Using long-term neuroleptic drugs only creates more dependency and permanent side-effect related conditions to be dealt with by an already overburdened system.

Identifying "undesirable" attributes is stigmatizing. Treating undesirable attributes from a standpoint of righteousness borders on medical tyranny...

This is why I urge the House to expand and fully fund the Howard Center mobile intervention program and Soteria House initiative ...

My "ask" is that these teams are made up of psychiatrists, social workers and peers and not just used for crisis situations, but become the primary care for clients during weeks and months, if not years, of follow-up treatment ...

My son's question is this: "Is the system making the best choices it can?"

My question is, "Do you have the willingness and the courage to change the way you fund and treat ill people, so the people that you treat change for the better?" ❗

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These excerpts are from comments provided to the legislature this spring. The author requested anonymity because he does not have the consent of his son to share information about him publicly.

Poll Shows 'Behavioral Health' Seen as Blaming

RUTLAND – All 14 people responding to *Counterpoint's* summer issue telephone poll said they objected to the term "behavioral health," which, several said, labels mental health issues as bad behavior.

"It's wholly inappropriate but very revealing of the ideology of the medical system's thinking about mental health," said one caller.

One person described being traumatized at the age of 3½ by a gang attack – "This is not my fault of my behavior."

"It's horrific that people who are supposed to be educated and trained in mental health ... do things like this. I don't think the education of mental health professionals – this shows it's not very realistic or good."

Another person who responded said the term supports stigma.

"As soon as somebody sees the word "behavioral," they automatically think, bad behavior. People see that [term] in the hospital, they know exactly what's down the hall."

"I have always disliked and felt insulted by that term," said another. "It makes it sound like we are misbehaving on our own."

The term says that "it's our fault that we experience mental health challenges because we have behaved badly," added another person who responded.

"The cure for this seems to be, as my mother used to say, to 'straighten up and fly right.' If we behaved appropriately, we wouldn't have this problem."

"It's horribly blaming and stigmatizing."

One comment was very brief: "It's short-sighted, and it's stupid."

The telephone poll allows for automatically registering a "yes" or "no" response to the question, with the option to add comments. Six people added comments explaining why they objected as they answered the question, "Do you object to the use of the term 'behavioral health?'"

The new question in this issue is, "Are there ever times when a person should be forced to take drugs by a court order?"

Readers can call the toll-free number, 888-507-0721, and dial extension 12 to vote yes, or extension 13 to vote no. ❗

Counterpoint Telephone Poll



QUESTION:

Are there ever times when a person should be forced to take drugs by a court order?

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*.

SURVIVOR PEER SERVICES

Vermont Psychiatric Survivors Peer Support Groups

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

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

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

RUTLAND: Wellness Group, VPS Office, 128 Merchants Row, Suite 606; every Wednesday, 5-7 p.m. Call Beth at 802-353-4365

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

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

www.vermontpsychiatricsurvivors.org

Peer Support

WARM LINES

VERMONT SUPPORT LINE (STATEWIDE):
888-604-6412; every day, 3-11 p.m.

PEER ACCESS CONNECTIONS: 802.662.1280
Friday, Saturday and Sunday 7:00 p.m. to 9:00 p.m.;

WASHINGTON COUNTY MENTAL HEALTH PEER LINE:
802-229-8015; 7 days/wk, 6-11 p.m.

MUTUAL SUPPORT NETWORK

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

CRISIS RESPITE

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

VERMONT PSYCHIATRIC SURVIVORS OUTREACH AND PATIENT REPRESENTATIVES

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

HOSPITALIZATION ALTERNATIVE

Soteria House, information and online application at www.pathwaysvermont.org/what-we-do/our-programs/soteria/ or call Pathways Vermont Intake Line, 888-492-8212, ext. 140

Peer Centers & Employment Support

ANOTHER WAY, 125 Barre St, Montpelier, 802-229-0920; info@anotherwayvt.org; www.anotherwayvt.org; see website for events calendar.

PATHWAYS VERMONT COMMUNITY CENTER (formerly The Wellness Co-Op), 279 North Winooski Avenue, Burlington, 888-492-8218 ext 300; www.pathwaysvermont.org/what-we-do/our-programs/pvcc; www.facebook.com/PathwaysVTCommunityCenter

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; 802-442-9700; turningpointbennington@comcast.net

BRATTLEBORO, Turning Point Center of Windham County, 39 Elm St.; 802-257-5600; tpwc.1@hotmail.com

BURLINGTON, Turning Point Center of Chittenden County, 191 Bank St, 2nd floor; 802-861-3150; GaryD@turningpointcentervt.org or www.turningpointcenter-vt.org

MIDDLEBURY, Turning Point Center of Addison County, 228 Maple St, Space 31B; 802-388-4249; teacvt@yahoo.com

MORRISVILLE, North Central Vermont Recovery Center, 275 Brooklyn St., 802-851-8120; recovery@ncvrc.com

RUTLAND, Turning Point Center, 141 State St; 802-773-6010 turningpointcenterrutland@yahoo.com

SPRINGFIELD, Turning Point Recovery Center of Springfield, 7 Morgan St., 802-885-4668; spfldturningpoint@gmail.com

ST. ALBANS, Turning Point of Franklin County, 182 Lake St; 802-782-8454; tpfcdirection@gmail.com

ST. JOHNSBURY, Kingdom Recovery Center, 297 Summer St; 802-751-8520; c.boyd@stjkr.org; j.keough@stjkr.org; www.kingdomrecoverycenter.com

WHITE RIVER JUNCTION, Upper Valley Turning Point, 200 Olcott Dr; 802-295-5206; mhelijas@secondwindfound.org; secondwindfound.org

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

Vermont Federation of Families for Children's Mental Health

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

Women's Holistic Outreach Learning Environment

(W.H.O.L.E.) peer support groups in Springfield for "women who struggle with mental, emotional, and behavioral health issues." Tuesdays from 7 to 8:30 p.m. at the Calvary Baptist Church, 156 Main St. Entrance at back on right side of building. More info at www.wholevweb.com

Pride Center of Vermont

LGBTQ Individuals with Disabilities Social and Support Groups: Connections and support around coming out, socializing, employment challenges, safe sex, self-advocacy, and anything else! Burlington, Wednesdays, 4:30 p.m. at Pride Center, 255 S. Champlain St.

Brain Injury Association

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

DBT Peer Group

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

Trans Crisis Hotline

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

Crisis Text Line

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

LGBTQ Youth Crisis Hotline:

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

NAMI Connections Support Groups

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

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

MONTPELIER: Every Friday 2-3:30 pm; Another Way, 125 Barre St.

NEWPORT: Every Wednesday 6-7:30 pm; St. Mark's Episcopal Church, 44 Second St.

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

ST. JOHNSBURY: Thursdays 6:30-8 pm; Universalist Unitarian Church, 47 Cherry St.

NATIONAL ALLIANCE ON MENTAL ILLNESS-VT (NAMI-VT) 802-876-7949 x101, 600 Blair Park Road, Suite 301, Williston, VT 05495; www.namivt.org; info@namivt.org

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



NATIONAL SUICIDE PREVENTION LIFELINE

1-800-273-TALK (8255)

24/7 confidential support

Public Community Mental Health

COUNSELING SERVICE OF ADDISON COUNTY, 89 Main St., Middlebury, 05753; 802-388-6751

UNITED COUNSELING SERVICE OF BENNINGTON COUNTY; PO Box 588, Ledge Hill Dr., Bennington, 05201; 802-442-5491

CHITTENDEN COUNTY: HOWARD CENTER, 300 Flynn Ave., Burlington, 05401; 802-488-6200

FRANKLIN & GRAND ISLE: NORTHWESTERN COUNSELING AND SUPPORT SERVICES, 107 Fisher Pond Road, St. Albans, 05478; 802-524-6554

LAMOILLE COUNTY MENTAL HEALTH SERVICES, 72 Harrel Street, Morrisville, 05661; 802-888-5026

NORTHEAST KINGDOM HUMAN SERVICES, 181 Crawford Road, Derby; 802-334-6744; 800-696-4979, 2225 Portland St., St. Johnsbury; 802-748-3181; 800-649-0118

ORANGE COUNTY: CLARA MARTIN CENTER, 11 Main St., Randolph, 05060-0167; 802-728-4466

RUTLAND MENTAL HEALTH SERVICES, 78 So. Main St., Rutland, 05701; 802-775-2381

WASHINGTON COUNTY MENTAL HEALTH SERVICES, 9 Heaton St., Montpelier, 05601; 802-229-6328

WINDHAM AND WINDSOR COUNTIES: HEALTH CARE AND REHABILITATION SERVICES OF SOUTHEASTERN VERMONT, 390 River Street, Springfield, 05156; 886-4500; 51 Fairview St., Brattleboro, 05301, 802-254-6028; 49 School St., Hartford, 05047, 802-295-3031

24-Hour Crisis Lines:

Involuntary Custody Screening

ADDISON COUNTY: Counseling Services of Addison County 802-388-7641

BENNINGTON COUNTY: United Counseling Service, 802-442-5491; (Manchester) 802-362-3950

CHITTENDEN COUNTY: Howard Center (adults) 802-488-6400; First Call: (child/adolescents) 802-488-7777

FRANKLIN AND GRAND ISLE COUNTIES: Northwestern Counseling and Support Services, 802-524-6554; 800-834-7793

LAMOILLE COUNTY: Lamoille County Mental Health, Weekdays 8 a.m.-4 p.m. 802-888-4914; Nights and weekends 802-888-4231

ESSEX, CALEDONIA AND ORLEANS: Northeast Kingdom Human Services 800-696-4979

ORANGE COUNTY: Clara Martin, 800-639-6360

RUTLAND Mental Health Services, 802-775-1000

WASHINGTON COUNTY Mental Health Services, 802-229-0591

WINDHAM, WINDSOR COUNTIES: Health Care and Rehabilitation Services, 800-622-4235

Veterans' Services

WWW.VERMONTVETERANSSERVICES.ORG

HOMELESS PROGRAM COORDINATOR: 802-742-3291

BRATTLEBORO: Morningside 802-257-0066

RUTLAND: Open Door Mission 802-775-5661; Transitional Residence: Dodge House, 802-775-6772

BURLINGTON: Waystation/Wilson 802-864-7402

FREE TRANSPORTATION: Disabled American Veterans: Toll Free: 1-866-687-8387 X5394

Homeless?

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



www.MakeTheConnection.net

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

Vermont Veterans Outreach

BENNINGTON AREA: 802-442-2980; cell: 802-310-5391

BERLIN AREA: 802-224-7108; cell: 802-399-6135

BRADFORD AREA: 802-222-4824; cell: 802-734-2282

COLCHESTER AREA: 802-338-3078; cell: 802-310-5743

ENOSBURG AREA: 802-933-2166; cell: 802-399-6068

JERICHO AREA: 802-899-5291; cell: 802-310-0631

NEWPORT AREA: 802-338-4162; cell: 802-399-6250

RUTLAND AREA: 802-775-0195; cell: 802-310-5334

VERGENNES AREA: 802-877-2356; cell: 802-881-6680

WHITE RIVER AREA: 802-295-7921; cell: 802-881-6232

WILLISTON AREA: 802-879-1385; cell: 802-734-2123

OUTREACH TEAM LEADER: 802-338-3022; cell: 802-881-5057

TOLL-FREE HOTLINE (24/7) 1-888-607-8773

VA Mental Health Services

VA HOSPITAL: Toll Free 1-866-687-8387

MENTAL HEALTH CLINIC: Toll Free 1-866-687-8387 Ext 6132

OUTPATIENT CLINICS: Bennington: 802-447-6913; Brattleboro: 802-251-2200; Burlington Lakeside Clinic: 802-657-7000; Newport: 802-334-9777; Rutland: 802-772-2300

VET CENTERS: (Burlington) 802-862-1806; (White River Jct) 802-295-2908

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