

Counterpoint

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From the Hills of Vermont

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Since 1985

Fall, 2016

Is 'Peer Support' Losing Its Roots?



MAD PRIDE MARCH — Dozens of psychiatric survivors head up the front entrance to the statehouse in Montpelier as part of international Mad Pride Day on July 14. Speeches followed. Story and more photos are on page 8. (Counterpoint Photo: Anne Donahue)

Some Are Uneasy As Formal System Gets More Involved

By ANNE DONAHUE

Counterpoint

MONTPELIER – The words “peer support” have become well established in mental health services jargon, and definitions are showing up more and more in state and federal laws, sometimes without even the input of peers themselves.

But what is peer support?

What makes someone qualify to be a “peer”?

As peer programs become more accepted, with more consistent standards and adopted within traditional agencies, do they lose authenticity?

Is peer support less about who is offering support, and more about how support is offered?

A state-funded coalition — the Wellness Workforce Coalition — has been struggling with those questions, and there are two definitions for “peer support” on its website.

One states that, “Peer support means sharing the power of your lived experience with others to achieve mutual goals, assess options, and discover new ways of thinking and doing. It means creating a connection between two people that does not place one in the role of the helper and the other in the role of helpee. When we do this, both parties benefit, and both learn from the process.”

The Coalition’s “core competency” definitions state that peer support is, “A values-driven approach that promotes alternative perspectives, advocates for human rights and dignity, and focuses on genuine, mutual relationships that enrich the lives of those involved.”

Across Vermont, there remain broad differences in how individuals who consider themselves in some way to be peers perceive the answers to those questions.

A common theme, however, is both hope and fear about the impact of the push towards greater professionalism: the hope that it makes peer support more accessible to more people, and the fear — in the words of two of those interviewed for this article — that it will lose its roots as “anti-oppression and social justice oriented” by “becoming part of the machine” of the system instead of an alternative to it.

In Vermont, the biggest leap forward in financial support for peer services came when the mental health system was reorganized after the Vermont State Hospital was forced to close after flooding from Tropical Storm Irene in 2011. The

Survivor Speaks Up, Proposes Police Ride-Along Program

by ANNE DONAHUE

Counterpoint

BURLINGTON – When Ward Nial heard news accounts about the death of 76-year-old Phil Grenon at the hands of police last spring, it bothered him enough to send a note to the police chief, asking why more couldn’t have been done to avoid the shooting.

It was not until he saw the body camera recordings of the interactions with police and attended a Police Commission meeting that he became determined to try to do something about it himself.

The video footage was “pretty disturbing,” he said. It struck him that “someday that could be you, or me. It’s personal.”

It led him, on August 23, to attend a second Police Commission meeting and pitch an idea to help break down barriers between police and individuals like Phil Grenon, who are labeled with a mental illness. Or like him.

“It was the first time I’ve ever stood in front of a group of people and said” he was a person who’s experienced mental illness, said the 58-year-old aerospace industry employee.

Nial reflected that one can go through life working at a job, doing the ordinary, and then all of a sudden, “you look at what’s happening and say, ‘this isn’t good,’ and try to get involved.”

Nial’s proposal is to have persons with lived

experience of a mental health diagnosis participate in the police ride-along program, in the hope that simple exposure and informal sharing will help to combat the stigma and other assumptions that block trust and may prevent the de-escalation of a mental health crisis.

Police said they had gone to Grenon’s apartment in response to a neighbor’s complaint about threatening behavior, after Grenon had received an eviction notice. He allegedly threatened police at his door with a knife, and police said they then attempted over the course of five hours to talk Grenon into surrendering.

When they entered the apartment, Grenon was hiding behind a shower curtain in his bathtub, they said. According to the police reports, several officers tried to disarm him by using a shield and pulling the curtain back. Police said Grenon pushed past the shield, so a Taser was fired at him, but it did not go off. They said he was still moving forward, and one officer then fired the shots that killed him.

The Police Commission has met three times to work on plans to help prevent such shootings, and Nial presented his concept at the third meeting.

They listened and asked questions, Nial said, and one of the Commissioners, Christine Kemp-Longmore, was assigned as the point person to

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Opportunities for Peer Leadership and Advocacy

Meeting Dates and Membership Information for Boards, Committees and Conferences

State Committees

Adult Program Standing Committee

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

Local Program Standing Committees

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

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.

Peer Organizations

Vermont Psychiatric Survivors

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

Counterpoint Editorial Board

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

Currently Recruiting New Members

Alyssum

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

Disability Rights Vermont PAIMI Council

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

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

Facebook and Web Sites

Wellness Workforce Coalition

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

Mad in Vermont

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

Advocacy Organizations

Disability Rights Vermont

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

Mental Health Law Project

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

Vermont Center for Independent Living Peer services and advocacy for persons with disabilities. 800-639-1522.

Vermont Family Network

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

Adult Protective Services

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

Vermont Client Assistance Program (Disability Law Project)

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

Health Care Advocate (problems with any health insurance or Medicaid/Medicare issues in Vermont)

800-917-7787 or 802-241-1102.

Counterpoint

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Mission Statement:

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

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How to Reach

The Department of Mental Health:
NEW NUMBER 802-241-0090

<http://mentalhealth.vermont.gov/>

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

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

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Back Issues can be accessed at www.vermontpsychiatricsurvivors.org

Police Ride-Along

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work with him on how it might be developed.

“I think they understand the concept,” he said, and they could tell he had been doing homework on thinking it through.

An idea had been discussed at one of the prior meetings to have mental health workers ride with police, and have police officers ride on mental health outreach, but that would have been costly for staffing and people were quick to point out that there would be significant objections to having police accompany mental health staff.

“I’m not trying to oversell what it’s going to accomplish” by having police ride-alongs with psychiatric survivors, Nial said. He thinks “it’s an opportunity” for dialogue and understanding, even if it isn’t a big step.

Despite the two prior meetings, Nial said there was a sense of a lot of talk but “nothing’s going to happen,” and this is about “actually standing up and trying to do something about it.”

He thinks there is a better chance at a push for change if it is coming from “us with more skin in the game.”

Nial has already reached out to various stakeholders to evaluate interest. His next step, he said, will be to reach out to the newly appointed contact person on the Commission. He thinks her role shouldn’t be difficult, acting as an “enabler” by helping to make the connections with the police.

Yet to be worked out are details such as how structured the program should be, ranging from “just do it,” to planning specific orientations and laying out expectations.

One advantage is that “it doesn’t really cost anything,” he said, whereas most ideas cost money and time.

“It could fall flat on its face,” Nial said. But “you get a lot of support when you step up. I feel optimistic. We’ll see what comes of this.”

Persons interested in finding out more or helping Ward Nial with developing the mental health police ride-along program can contact him at wlnial@comcast.net.

Retreat Revises Process For Discharge Planning After Ex-Patient’s Death

BRATTLEBORO — The Brattleboro Retreat revised its process for discharges after the suicide death of a patient within a day after leaving a voluntary hospitalization. A report from the state’s Division of Licensing and Protection in August cited several violations of federal standards for failing to communicate information about the discharge to the patient’s legal guardian and Pathways Vermont case manager.

According to the Division’s report, the individual requested an unplanned discharge over the Memorial Day weekend. The doctor on call determined that the patient did not meet criteria for an involuntary hold, and thus was entitled to be discharged. The report said that those involved in the discharge failed to review the case record and see that the patient — who had a developmental disability and opioid dependence along with the depression that led to the hospitalization — had a court-ordered public guardian. That might have affected the discharge plan, it said.

According to information in the report, the Retreat created an immediate internal task force that reviewed the communication gaps and created new documents to protect against missed information prior to a discharge. AD

Murphy Bill Passes House in 422-2 Vote; Senate Action Unsure

WASHINGTON — A bill to change federal oversight and the use of mental health funds passed the United States House of Representatives on a 422-2 vote in July. Senate action will be required this fall if it is to become law.

The House bill — known as the “Murphy bill,” based on the name of its lead sponsor, Rep. Tim Murphy (R-Pa.) — faced stiff opposition by mental health consumer advocates when first introduced because of provisions to push increased use of forced interventions, to cut off advocacy work by protection and advocacy programs, and to weaken privacy laws for mental health clients.

Although the most controversial elements were removed, the National Coalition for Mental Health Recovery, a group of survivor organizations, has continued to call for opposition to the House bill. Both Vermont Psychiatric Survivors and Alyssum are members of the Coalition.

The Coalition has urged support for a Senate version of mental health reform instead.

Mad in America, a webzine whose mission is to remake psychiatric care, called the House bill a “heinous piece of legislation.”

The Coalition said the House bill remains “hostile to programs and concepts of recovery.” It is calling upon “all people of like minds, who care about individuals who need mental health services,” to “call your Senator to insist that the Senate reject any amendments or changes to mental health legislation from the House.”

“Tell them to support S. 2680 as passed by the HELP Committee, without changes from HR 2646,” a Coalition statement said. The HELP Committee is the Senate’s Health, Education, Labor and Pensions Committee.

According to the Coalition, it is unclear whether the Senate will consider its own bill or not. However, “There is a significant danger that the bill will have amendments attached to it, or be changed when the conference process with the House takes place.”

Members of the Senate may have been convinced by proponents that the changes to the House bill mean that it “is now acceptable to all stakeholders. This is far from true. We must prevent any language from HR 2646 from bleeding into the Senate bill.”

Rep. Peter Welch of Vermont wrote a strong letter of concern about the House bill’s earlier drafts, but voted for it with the later changes.

The Coalition for Mental Health Reform is made up of disability, civil, and human rights organizations which identifies its mission as to “ensure that consumer/survivors have a major voice in the development and implementation of health care, mental health, and social policies at the state and national levels, empowering people to recover and lead a full life in the community.”

The Coalition identified the following elements as problems that remain in the revised version of the bill that passed the House, and encouraged survivors to use them as “talking points” in contacting their Senators:

▶ Nothing about us without us. HR 2646 excludes the voice of people who have lived experience with mental health issues in decisions that dramatically affect our lives.

▶ The bill expands grant funding for [involuntary] Assisted Outpatient Treatment. There is no evidence that AOT is more effective than voluntary care.

▶ HR 2646 significantly weakens the Substance Abuse and Mental Health Services Administration (SAMHSA).

▶ HR 2646 uses “anosognosia” (the premise that persons are “too sick to know they are sick”) as a rationale to relax confidentiality issues and promote forced treatment. There is no scientific basis for anosognosia in mental health.

▶ The bill is hostile to programs and concepts of recovery. Increased services in the community are needed; they cannot be replaced by hospitals. The Coalition identified these additional problems with HR 2646 from the viewpoint of other advocacy groups:

▶ The bill creates an additional grievance procedure within the PAIMI Act. No evidence has been provided that this already existing system is not working, and therefore there is no need for an additional process.

▶ HR 2646 removes an incentive for states to develop community-based services and avoid overreliance on long-term institutionalization.

▶ HR 2646 provides \$10,000,000 over a 5-year period for paraprofessional training and education programs. Given the crisis in community care, the funds should be re-directed to all states to expand a broad array of peer support services.

▶ The bill creates an Electronic Verification Visit (EVV) requirement for home health workers that would be harmful to individuals with disabilities, ineffective at addressing fraud and has the potential to increase state liability. AD

How To Advocate On Mental Health Bill Make Your Voice Heard on Senate 2680!

Sen. Patrick Leahy

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

Sen. Bernie Sanders

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

Is 'Peer Support' Losing Its Roots?

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legislature appropriated \$1 million as new investments in peer services, defining a peer as “an individual who has a personal experience of living with a mental health condition or psychiatric disability” and peer services as “support services provided by trained peers or peer-managed organizations focused on helping individuals with mental health and other co-occurring conditions to support recovery.”

Although there was input from psychiatric survivors in those definitions, not everyone agrees with them. Others point out that despite the excitement over the amount of new money, it remains less than one percent of the state’s mental health budget.

The Wellness Workforce Coalition

One of the legislature’s directives for spending the money was that the Department of Mental Health “improve the quality, infrastructure, and workforce development of peer services.”

That led to the creation of the Wellness Workforce Coalition, whose mission is “to create a statewide coalition of peer-run organizations which supports training and advocacy for Vermont’s peer workforce while preserving the autonomy, character, and contributions of each member organization.”

The Coalition has adopted a set of core competencies that it suggests should be the standards for members of a peer workforce.

Sarah Launderville is the Executive Director of the Vermont Center for Independent Living, which has the contract for operating the coalition.

She said that as someone who has been “20 years into this, taught as a rights perspective,” it



Sarah Launderville

has been a new experience to learn that others are not comfortable with limiting the definition of a peer to persons with a “lived experience” of a disability.

Her roots in the disability community bring a focus on peers as “other people I could relate to... somebody who has that lived experience

through the system, that we’re all kind of going through” and are working for change through a social movement.

She saw the psychiatric survivor movement emerge more narrowly because, instead of being cross-disability, it was tied to a specific diagnosis.

If the term “lived experience” becomes used as a noun, some are now seeing it as “just another label” and as something they do not want to identify with, she said.

There are also challenges in “remaining faithful to the authenticity of being a peer-to-peer worker” when training criteria and certification are increasingly seen as important and valued steps in making peer services sustainable.

“We have to recognize that we lose something,” in that process, Launderville said, because “there’s always going to be a little bit of power” that enters into the peer relationship, and the core of peer support is supposed to be about the mutuality of the relationship.

Perhaps the most extreme example of a risk to authenticity is the language (later withdrawn) in a bill in Congress introduced by a psychologist, Rep. Tim Murphy (R-Pa.)

His definition of a “peer-support specialist” included not just “skills learned in formal training,” but also work done under “the supervision of a licensed mental health or substance use treatment professional.” The peer must have been “an active participant in mental health or substance use treatment for at least the preceding two years.”

Counterpoint interviewed nine persons in the peer support services field in different parts of the state, including Launderville, to assess the breadth of different perspectives and experiences. They included persons working both within traditional mental health agencies in peer-identified positions and persons working for organizations identified as peer-directed.

These are the perspectives that were shared.

Rachel King

Rachel King works for the Howard Center, the designated mental health agency for Chittenden County, in its START program, which does crisis response and outreach to individuals “who have been kicked out of every [other] program.”

She said she sees strong support at Howard for peer support; it agreed to have the new program peer-staffed at its inception. Recently, when the program director position came open, the team “advocated hard for one of our own to take over,” and the Howard Center agreed.

King thinks it is important for a peer to “have acknowledged experience,” including hospitalization, in part to be able to relate closely to “the shame involved” in society.

“Self-definition is the key,” however, and the question in practice is, “how do you use that as your point of connection?”

King believes it is possible and necessary to standardize training while keeping “the room for flexibility” in the “sharing of yourself” that is essential to peer support. There has to be “free rein, in a certain sense,” yet all jobs “require standards”; “both things have to be true.”

“People think in dichotomy,” but “you can’t just do this in the abstract,” she said; there has to be a framework.

King believes there is more than one way to give authentic peer support, and bristles when others carry a “personal agenda” and make judgments that “you don’t know what peer support is” or “you shouldn’t [work in] a traditional agency.”

She thinks there is a lot of pressure on peers, and it is important to have “someone else to talk to” about the work – something of great value by being part of the START team.

“The world is watching,” she said. “We’re so marginalized.”

Kerry Skiffington

Kerry Skiffington has been a peer support worker at Counseling Services of Addison County (CSAC) for almost three years. The agency has a reputation for progressive approaches in the use of peers and “intentional peer support” models.

Skiffington is less complimentary.

“The thing that matters most to me is the aspect of mutuality, which they don’t endorse in our workplace,” she said.

The agency is “happy for us to share experiences where relevant,” such as using the statement, “when I was in the hospital...” as a non-threatening approach to support an individual.

However, when peer workers are trying to establish a sense of belonging in the community for other individuals, “belonging is predicated on two people being on the same playing field,” which has to include being able to receive, as well as give, support, she said.

“How can we help them with belonging unless we allow them to belong with us?” she asked.

She said that CSAC and others draw a line, saying that peer staff should not take it personally if they get negative feedback from a person they are helping.

“I would not be doing my job as a peer if I don’t take it personally,” she said. The bottom line for the role to function is to recognize that “I am a person and they are a person.”

Skiffington does think that people can use a “peer approach” without being a person with direct lived experience, and it doesn’t have to be only “one way or the other.”

On the other hand, those who are not directly a peer are “a different kind of fish.” There are places where a job function can only be filled by a person who can feel that a person with a shared experience “is the only one who gets it.”

Gloria van den Berg

Gloria van den Berg has been the Executive Director of Alyssum in Rochester since its beginning five years ago. The residence describes itself as “an alternative respite and peer-hosted approach to mental wellness.”

Despite a web site that states that “All of our staff are individuals with lived mental health experience,” van den Berg questions, “Do we need to put a label on it?”

It is “about being human,” she said. There are “not that many people who escape unscathed from some kind of trauma” in their lives.

What is most essential is to “be able to be mutual,” she said, “not better than or worse than” the other person, and to “come at it from an empathetic space.”

As a member of the Wellness Workforce Coalition, she helped develop the core competencies with the concept “in the ideal world that people would have these skills” and that training supported by the Coalition should deliver those competencies.

Professionalism is about a person’s ability “to be responsible and do the job they’re supposed to do,” and doesn’t have to interfere with being au-



Kerry Skiffington



Gloria van den Berg

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TIME FOR REJUVENATION — The Workforce Wellness Coalition provided an opportunity for peer support staff around the state to share time together and relax with a picnic in August at Branbury State Park. (Counterpoint Photo: Anne Donahue)

Peer Support

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thentic, she said. If peer support moves towards certification, it will make funding “more resilient, more stable,” van den Berg said, in contrast to funding today that only reflects one percent of mental health funding through non-traditional Medicaid money.

The downside is that those structures will make peers look “more like a [traditional] mental health person” in the system, she noted.

The risk of one-upmanship among peers exists whether there is certification or not, she said, just as there are those today who suggest that someone is not qualified to be a peer if they have not been hospitalized with a mental health diagnosis. Ultimately, there is a need for “the world to change and become more like what we do,” rather than have “a whole other world that’s a peer world.” It is “100 percent about systems change.”

“We have a screwed-up world,” van den Berg said, with a “hierarchy problem” that is highly judgmental of others, and changing that needs to be the focus.

Calvin Moen

Calvin Moen is someone who has worked both under a more formal agency structure and in one that is considered “peer-run.” His current employer, Vermont Psychiatric Survivors, is based in Rutland. He has done some form of peer-to-peer work since 2008, and believes that defining it needs to stress “having a mutually supportive relationship, working together side-by-side.”

“Being able to share from my own experience where it’s relevant” is a “part of that mutuality,” he said. He found his prior experience of being hired to provide services as a peer specialist in an agency “only a few steps away from being a case manager” in its job expectations. Now, the work he is able to do is “much more directed by the individual.”

In his position doing outreach in southern Vermont, he also sees how other organizations address peer support. He said he has seen Health Care and Rehabilitation Services of Southeastern Vermont “grow a little bit” with its peer staff being “more valued” and able to affect policy as they move higher into leadership positions.

In his own position, which is spread over a large area, “I feel sort of isolated,” Moen said.

The “peer team at HCRS is small, but it’s a team”; those staff are like colleagues to him.

“I’m so thirsty for that” kind of collaboration with other peers, he said. The Wellness Workforce trainings “have been fantastic” in helping to address that, he said. “It’s always so welcome [to be able to] bounce ideas off a colleague.”

However, he feels anxiety about peer support being co-opted by the mental health system as it becomes “professionalized.”

“I don’t want to become a tool of the state under the guise of ‘this is an alternative,’” he said. He believes there is some protection because the individuals doing peer work are “fierce about making sure they’re doing the work” in the way it is intended.

Lauren Sales

Lauren Sales worked in a peer staff capacity in Washington County until recently, and has felt the sting of being questioned over “whether I was a real peer.” It was strange to be “embracing a label” for the first time there, because “it never occurred to me to identify myself by my diagnosis.”

Sales believes being a peer does not require a “specific painful experience” – when it comes to struggling with hearing voices, for example, “I do not have that particular experience” – but rather having a “genuine appreciation of diversity” and a “genuine experience of injustice.” She likens it to being a “universal donor” as a peer.

She also hopes that both so-called professional peers, working in agencies, and those fostered as informal alternatives, can both exist. The professional part is important for funding, she said.

Sales thinks there is a “huge grassroots peer movement” that is “going to take off” and that “doesn’t decide what’s best for other people.” That movement can “make our [whole] culture more human and more respectful.”

Peer support is something that has “a unique, really distinct flavor,” and “it really needs to remain a unique, distinct flavor,” she said.

“I worry a lot about it being co-opted,” she said. She believes the Department of Mental Health is trying to avoid that – “they recognize it as a unique and incredibly valuable resource” – but they want to fund it, which requires measurement and other elements that can place it at risk.

Malaika Puffer

Malaika Puffer has worked in peer support at Health Care and Rehabilitation Services of

Southeastern Vermont since 2012, an agency she said is “very supportive” of peer work.

“It’s kind of a tricky balance,” though, for an agency, which has limitations required by law such as mandated abuse reporting.

There is a “degree of self-expression that wouldn’t be appropriate in our setting” in contrast to more informal programs, Puffer said. However, in many ways there may not be significant differences based on setting, because there can be creative ways to avoid using power over others, even in a more structured organization, she said.

Being within a mainstream organization means “reaching a population that... might not otherwise have any access to relating in a different way” to persons offering support.

When it comes to defining a “peer,” Puffer said, “I really don’t use that term.”

“The ‘peer’ is not about who is doing it,” but rather, whether “it is happening in a peer-to-peer way” in which the staff person is “not above the other person.” That may be “most likely to be happening” when the person has “some kind of life experience that allows them to relate” because it is “based on marginalization and oppression that is relatable to the people who use services,” she said. Although Puffer said she understands the “need for formalizing the role and definitions,” she does think it is “losing some of the roots” of it being “anti-oppression and social-justice-oriented,” particularly in trends she sees in other states.

In Vermont, “many people are working to protect” the core values, but losing them is “still a threat.”

Jackie Leman

Jackie Leman, like Rachel King, started working on the START team when it began four years ago. She has been involved in peer work for nine

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Malaika Puffer

Callers Urge That Beds Be Added To Address Emergency Room Waits

RUTLAND – Sixteen individuals who voted in *Counterpoint's* first telephone poll urged that more inpatient psychiatric beds be added in response to long waits in hospital waiting rooms. Only one person voted “no.”

“The results of the *Counterpoint* telephone poll were overwhelmingly and emphatically in favor of adding more psychiatric hospital beds,” said *Counterpoint* publisher Wilda L. White.

Eight callers left comments in addition to a “yes” vote, and at least two were calling from a hospital.

“As I was trying to get help for my anxiety and bipolar disorder, rapid cycling, last week... there was zero beds in the entire state of Vermont except for one at Brattleboro Retreat. So I’m pretty fortunate to be here,” said one caller.

Another said she was willing to speak out to help build support for more beds.

“I myself right now am [in the hospital in Burlington]. I am looking forward to getting out and I am willing to share whatever need be to get this ball rolling a little bit faster. I’m sick of it.”

She cited the need for “more beds or places” for persons with mental illness to stay, “wherever they are in this country, not just in Vermont.”

One caller directly noted the impact of bed shortages on emergency room delays.

“My answer is absolutely yes. As a consumer I’ve found that sometimes you need to spend too much time in that emergency room, and if the hospital doesn’t have an area for someone to go, in crisis, then they end up staying in the hospital emergency room exam room for the duration of the time with the hustle and bustle of the emergency room going on.”

Another said that “the same thing happened to me” when there were no beds available, except that, “I was incarcerated when I should have been in a hospital.”

Several referenced hope that the poll itself would have an impact.

“I’m pleased to see that this is something that you would take our vote on,” said a woman who had recently been hospitalized and waited in the emergency room for a bed. “I’m excited to think that you would actually be able to add more beds for the people who need them.”

“I hope something goes right with this” in terms of effecting change, another said.

The only person to call in and register a “no” vote was from Brattleboro.

According to the call location system, those voting “yes” included five calling from Rutland, four from Burlington, two from Middlebury, two from Bennington, and one each from Brattleboro, Arlington, out-of-state, and unknown.

Additional comments made included a reference to the need for policy improvements, and two compliments to the emergency care area developed last year at Southwestern Medical Center in Bennington.

The policy comment came from a recent inpatient at Rutland Regional Medical Center, who said she had been there and at the emergency care area in Bennington. The state needs more beds, she said, and “they also need to overhaul all of them, and a look at the old policies and probably install new policies.”

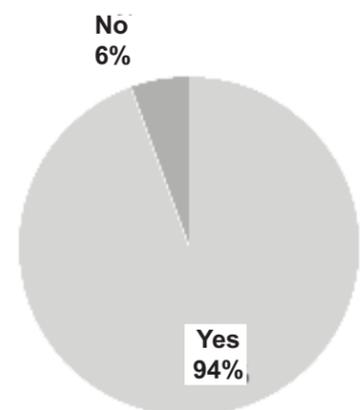
Where she was, “they [the policies] were pretty bad,” she said, and she had to leave the hospital early as a result.

The phone-in poll question was a first for *Counterpoint*. White said that it will be

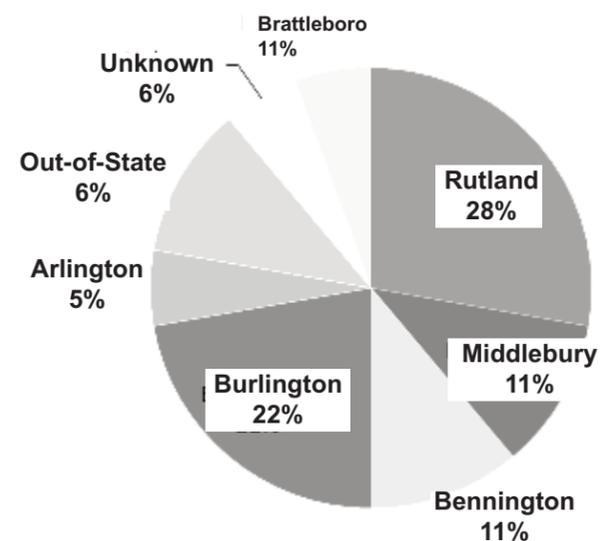
an ongoing feature, enabling psychiatric survivors to express their opinions on key issues in the state.

The new poll for this issue of *Counterpoint*, accessed through a toll-free number, asks about whether peer support services are available to survivors in Vermont. (See information at bottom of this page.) AD

Should Vermont add more psychiatric hospital beds as the solution to emergency room waits?



Origin of Calls



**New
Question!**

Counterpoint Telephone Poll



Issue: Peer Support

**Question: Do you have access
to peer support services in Vermont?**

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*.

Is 'Peer Support' Losing Its Roots?

(Continued from page 5)

years. "For me, [being a peer] has always meant someone who's had a lived experience," whether that be having received agency services or been hospitalized, "so they connect with other people who have been through similar things."

Working within an agency as a peer does mean relationships are "not as mutual as we would like them to be," Leman said. "I know there's a reason" that, for example, "notes have to be taken" for record-keeping, "but it does sort of contradict the idea that it's all mutual."

On the other hand, despite wishing she could "just talk" without the notes, "I don't feel that it makes me feel less of a peer."

"There has to be a natural empathy" that isn't something that can be trained, she said. Someone can't just say, "I've been through this... and therefore I'm qualified" – the person "has to know how to use what you've been through."

She sees progress in acceptance of the value of peer support. While the Howard Center has a



Jackie Leman

long track record, it took the University of Vermont Medical Center "a while to get used to."

Now, "they are really seeing, 'yeah, this really is helping,'" and staff on inpatient units will call and make direct referrals to her team.

Hilary Melton

Hilary Melton is the Executive Director of Pathways, a large nonprofit agency based in Burlington that runs programs in support of housing, a community center, and the statewide warm-line that is funded under the state's 2012 peer-run initiative legislation.

Melton said she has worked in peer services since the 1990's "without the language" of today.

She says her agency uses a "peer approach" rather than defining "peer," although 68 percent of staff who responded to a recent internal survey defined themselves as having a "lived experience" and "we value that experience in all of its forms."

"We don't put a label on the person who's providing the service," Melton said. "There's something that's troubling" about doing that.

"Everybody identifies their lived experience in a different way," she said, and there are "connection points about being a human person."

For example, one might "connect about being coerced" or about "losing your voice" – "there's a connect point [in] losing your human rights," and "it's not only about a diagnosis."

She said that "narrowing it down" is a "missed opportunity."

"I don't want to minimize that, if you've had your human rights violated," she added.

The difference is that traditional providers

don't have to make connections to their personal experiences when they work with others. A peer approach is when the persons "grow from each other" and form a relationship.

Melton's hope is that the approach will eventually "infiltrate all providers."

"It's about not 'othering' people," Melton said, where "I am the provider and you are over there."

"It's about empathy."

To see the Wellness Workforce Coalition documents on "Core Competencies and Core Values for Funded Peer Support Work," and its table on "Essential Functions and Core Competencies for Peer Support Workers," see: <http://wwcvt.org/resources/>

Antipsychotics Overprescribed, Study Reports

FALLS CHURCH, Va. – A national study has found that large numbers of individuals continue to be prescribed multiple antipsychotic medications contrary to recommended practice. Next year, an analysis ordered by the state legislature could help indicate where Vermont doctors stand in their prescription practices.

"A large number of individuals with serious mental illness, particularly with a diagnosis of schizophrenia, are being prescribed multiple antipsychotic medications" despite current best practices that "call for psychiatric patients to be discharged on as few antipsychotic medications as possible," the NRI said in an August press release.

NRI — the Research Institute of the National Association of State Mental Health Program Directors — said that its study reviewed practices in state psychiatric hospitals and found that the prescribing of multiple antipsychotic medications has continued "for reasons other than those with evidence to support the practice."

This past spring, the Vermont legislature directed the Vermont Medicaid Drug Utilization Review Board to analyze data from prescriptions dispensed to Medicaid beneficiaries to determine whether health care providers routinely follow the U.S. Food and Drug Administration's recommended dosage amounts. The law referenced "prescriptions written to treat mental health conditions" in particular.

The practice reviewed by NRI, known as antipsychotic polypharmacy, affects nearly 10,000 persons with a diagnosis of schizophrenia each year just within state psychiatric hospitals, its report said. The study recommended more analysis of the patients involved and their symptoms to try to identify what factors may be "contributing to practices outside the best-practice guideline."

The full study can be found in the July issue of the Journal of Psychiatric Practice or through the NRI website at http://media.wix.com/ugd/186708_994ac63baf6e407398e941d0e0de92e7.pdf

COMMENTARY

What Is Peer Support?

by JONATHAN JERMONE

My friend had wanted to become a social worker ever since I first met her.

Every September, when she started grad school she would be hospitalized for several months. Finally, after several years, a psych nurse came up to her and said shit or get off the pot, meaning make a decision, stick to it, and follow through.

We can argue the point, but I believe this nurse was practicing positive peer support.

Peer support is about self-determination offering non-judgmental, mutually beneficial, relationship focused support, without blame, condemnation, or pre-conceived notion.

The purpose of developing the relationship is to learn and grow about and with each other on a totally equal playing field where all participants benefit from the exchange. The usual power dynamics are disengaged because one person is not there to fix or make better.

This is achieved by learning and growing together where it becomes about the relationship and understanding each other's perspective and experience of the situation; being mutually respectful and beneficial for all parties.

The focus of the relationship has now shifted to become about what happened to you rather than what's wrong with you. Nobody feels judged, manipulated, shamed, or less than.

Both individuals come away from the relationship feeling a sense of empowerment.

When I am in a peer relationship my focus becomes about learning what the outcome they are

looking for are. I am present, as a mutually supportive person, who helps identify and empowers them to identify how they choose to use self-determination, by asking where do you want to end up, what would you like it to look like.

They gain a sense of mastery, control, and pride in themselves that they have never experienced before. I find myself moving toward the relationship, building the bond between each of us, and understanding other people's experiences and perspectives.

There is a commonality that I find between each of us that creates an unbreakable connection. We all walk away with the shared knowledge and sense of accomplishment. We have explored how we came to know and not know our own experiences that are valued, valid, and significant.

The possibility of creating something different will hopefully make a difference in the lives of the people we interact with. It is in the tolerating of the discomfort and unfamiliarity of the unknown that I have changed and become a peer supporter rather than a clinician who pathologizes what is wrong with you and retraumatizes the experience.

It must work for everyone in the relationship to be mutually beneficial. I am no longer the clinician who sets himself up as the expert and when wrong is blamed for what goes wrong in the person's life.

Jonathan Jerome is Vice President of the Vermont Psychiatric Survivors Board of Directors. He lives in Winooski.

Mad Pride March Celebrates Our ‘Creative Maladjustment’

MONTPELIER — Mad Pride Day on July 14 was celebrated in Vermont with a march down Main and State Streets from the Another Way center to the state capital steps. Chants such as, “We’re

here, we are loud, we are mad, we are proud,” echoed on the streets as the marchers made their way down the sidewalks.

Mad Pride Day occurred during the first-ever Creative Maladjustment Week celebrated July 7 through 14, established by the activist organization MindFreedom to “celebrate mad pride and creative maladjustment” to “honor the madly maladjusted among us,” echoing the words of Martin Luther King, Jr., who said that “the salvation of the world lies in the hands of the creatively maladjusted.”

“[T]here are some things in our society, some things in our world, to which we should never be adjusted. There are some things concerning which we must always be maladjusted if we are to be people of good will,” he said. Although King is best known for his fight for racial equality, he spoke on all injustice in the world. (See sidebar article, below.)

On the steps of the Capital building, Malaika Puffer of Brattleboro led a rally and addressed the marchers. She shared that she had always been told that her symptoms came under two options: broken brain or bad person.

It is important to tell people that “their thoughts and feelings are within the spectrum of human experience, and they are not alone,” she said to those at the rally.

Labels of unacceptable behavior differ by culture, time periods and belief systems, and she added that this “says more about the belief systems of the society than about you.”

To take “people’s actions out of context” and then to mandate treatment “is a violent, oppressive thing to do.”

“Instead of nets under bridges,” why aren’t we asking, “I wonder what is wrong in Vermont that people want to die?” Puffer asked.

The event was organized by Matti Salminen of Another Way. AD



SHOWING PRIDE — The Mad Pride March in July ended on the Capitol steps in Montpelier, where Malaika Puffer (top photo) was the lead speaker. Organizer Matti Salminen is on her left. Marchers constructed mobiles with slogans (bottom photo) to highlight the theme.

(Counterpoint Photos: Anne Donahue)

Psychiatric Survivors Pick Up on a Concept First Coined by Martin Luther King, Jr.

What is “creative maladjustment” and where did the term come from? Martin Luther King, Jr. is credited with creating the term when he first challenged psychologists in 1963 about their use of the term “maladjusted” as something that needed to be fixed. He agreed that there can be “destructive maladjustment.”

“But on the other hand, I am sure that we will recognize that there are some things in our society, some things in our world, to which we should never be adjusted. There are some things concerning which we must always be maladjusted if we are to be people of good will,” he said in a speech at the annual convention



Martin Luther King, Jr.

of the American Psychological Association in 1967.

He repeatedly said he was “proud to be maladjusted” and “never intend[ed] to become adjusted to” such things as segregation and discrimination, religious bigotry, the “self-defeating effects of physical violence” and “to economic conditions that will take necessities from the many to give luxuries to the few.”

“Thus, it may well be that our world is in dire need of a new organization, The International Association for the Advancement of Creative Maladjustment,” King concluded in his 1967 speech.

“[T]hrough such creative maladjustment, we may be able to emerge from the bleak and desolate midnight of man’s inhumanity to man, into the bright and glittering daybreak of freedom and justice,” he said. He was assassinated seven months later, on April 4, 1968.

The activist organization MindFreedom proclaimed the first Creative Maladjustment Week this year “in celebration of the founder of the In-

ternational Association for the Advancement of Creative Maladjustment.”

“MindFreedom echoes the famous words of Martin Luther King, Jr. in saying that ‘the salvation of the world lies in the hands of the creatively maladjusted,’” its website said.

The week is a “special time to honor the madly maladjusted among us.” It expanded upon the traditional celebration of Mad Pride Day on July 14.

“The celebration in July will include themes for each day of the week as we celebrate mad pride and creative maladjustment across the US and around the world with parades, street theater, activism, and more!”

In Vermont, events to mark Creative Maladjustment Week included a day of workshops and an evening of celebration organized by The Hive, a mutual support network in Brattleboro, and a Mad Pride march in Montpelier organized by members of Another Way, a peer-run drop-in center. AD

Is Adjustment Needed?

Rethinking When To Call the Police

BRATTLEBORO – Sometimes, it seems like the only solution to a major, life-threatening crisis is to call for police help. Yet that creates the real possibility of a bad outcome, even death.

Are there alternatives?

That was the focus of a visioning session this summer at The Hive, a community support network that held a day of workshops in honor of Creative Maladjustment Week.

The event was open to the public.

The theme that emerged in the discussion was the need to build neighborhoods of compassionate friends who can engage in “mutual aid” and organize in advance to address crises.

The Hive’s workshop happened in the midst of national public reaction to racism in police responses and the deaths of young black men shot by police. Persons with psychiatric labels have not received attention in relationship to those issues; three persons labelled with a psychiatric illness have died in Vermont over the past several years after being shot by police.

Calvin Moen, who introduced the workshop by summarizing earlier brainstorming at a meeting of The Hive, said there may be times when there are benefits to calling police, but “we’re in this conversation” based upon “coming from a place of seeing [the] damage.”

Voices from the Discussion

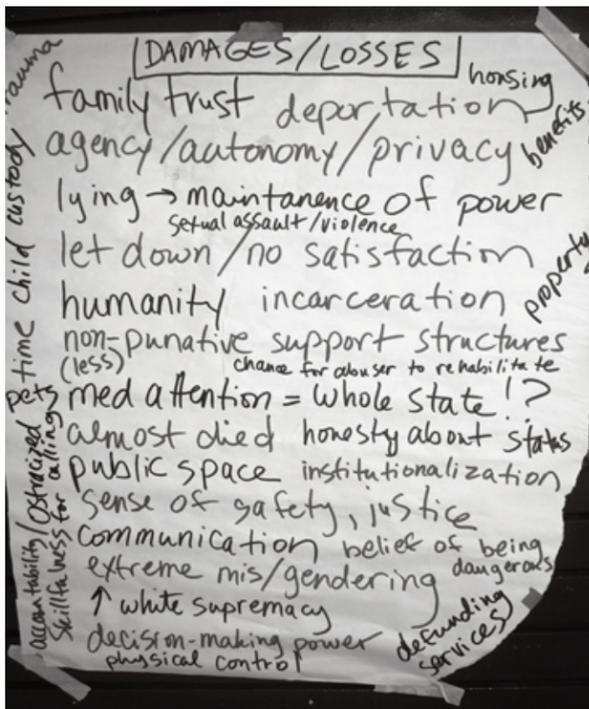
The workshop visioning discussion was intended to “lift up and highlight examples” of how to address situations that may currently result in a perception that police need to be called, said cofacilitator Wyatt Andrews (*Counterpoint maintains confidentiality when covering such discussions in order to prevent interference with participant emotional safety in fully sharing thoughts and feelings.*)

Ideas that participants shared included:

- ▶ Remember the concept of “wildness survival” – the concept that “you can be lost and be fine,” so the fact that someone is struggling does not automatically require others to intervene.

- ▶ Friends and helping professionals need to take accountability for skill-sharing when they learn what works.

- ▶ “It’s OK to disengage” and recognize that “this is beyond what I can respond to,” and to recognize that your response may be more about



your own needs to feel that you can help.

- ▶ “Don’t get tired and burned out.”

Be determined that “I’m not going to send violent and coercive people” as the alternative, “walking away” if necessary instead of calling police.

- ▶ Remember that “I don’t have to do this by myself” and people can build a network to relieve one another while supporting someone in crisis, knowing that “if I need you, you’ll come in 30 minutes” to take over.

- ▶ Minimizing the risk of harm includes “not adding information that makes violence more likely,” such as calling for an ambulance and saying that it is “a mentally ill person” that needs help.

- ▶ Our national “ethic of individuality” sometimes creates a reliance on the state to intervene because we don’t have strong communities; people think that watching out for one another invades privacy.

- ▶ “Creating community” is a way of “stitching together people” to be able to help one another.

- ▶ When thinking about community, we can “whittle that down to neighborhood” and about “organizing in advance” for how a crisis can be addressed.

- ▶ “Get to know your neighbors.”

Before discussing alternatives, the participants added to a list of the kind of damage that they have experienced when police are called, and reflected on times they had used police as resources – and when and why it was perceived to be necessary.

Among the items in the list of losses or impacts of calling the police were: deportation, incarceration, institutionalization, being misgendered, the weakening of community-based supports, trauma, loss of trust, loss of autonomy and decision-making power, loss of sense of safety and justice, loss of employment, housing, child custody, pets, property and public benefits, and, “ultimately... loss of life.”

Several individuals shared their detailed life experiences of why they called for police help.

A parent said her daughter was out-of-state, so she couldn’t go to her, and “I thought she was going to kill herself.” The positive result was that “in the short term, she is alive.”

But “then this other whole can of worms

opened up” as the daughter was sucked into the system. She was glad that she knew enough to fight back for her daughter, but “I was so worried I would lose her trust.”

Another parent shared that, “I don’t feel safe being there with my son” when he becomes agitated, and called it a “huge gender issue” because of the lack of male support responses.

Her experiences with calling have ranged widely. On one occasion in Vermont, the “police response was excellent,” but only a few months later while visiting relatives in Kentucky, her son was cuffed and mistreated.

She also called the sheriff in California when she said he was experiencing manic behavior, “destroying the home” while others were hiding in the house for safety. She said she realized later that destruction of one’s own property should not be a basis for calling police.

A woman who was working in a group home recounted an instance when, despite a culture of avoiding calling, staff were dealing with a “woman in an altered state” who was increasing threatening behaviors with the situation lasting a “long period of time.”

As the crisis continued, the “waning tolerance of staff” was what resulted in calling the crisis team, who called police.

The police worked to avoid restraint, waiting some 45 minutes despite worrying about the time they were spending; the outcome was that the woman was “able to walk out on her own” to be brought to the hospital.

However, the outcome there turned very negative: she was held in the emergency department for 10 days and repeatedly held in restraints.

“I wish I didn’t seek help” with that first call, and that staff had had more perseverance, she said.

The group then brainstormed some of the “why” that police are called, and the perceived needs. That led to the later, final discussion about what the alternatives can be. The list of “why” was varied:

- ▶ “The best interest of my family from my perspective,” such as when a child was lost.

- ▶ “Personal safety and, unfortunately, property safety.”

- ▶ “Exhaustion”

- ▶ “Witnessing a domestic assault,” where “I did not feel prepared to do the violence” that would be required in order to intervene.

- ▶ “If you can’t get there.”

- ▶ Lack of medical training, tools, knowledge of the place.

- ▶ When the person “will respond to a person in uniform” and not to you.

- ▶ “Because you care.”

- ▶ “They [the person calling] think they know what is better.”

- ▶ “To reduce one’s own anxiety.”

- ▶ Out of “denial of what the community can do” to help.

- ▶ “Fear and not practicing skills”; it can be “easier and less scary” to call others to intervene.

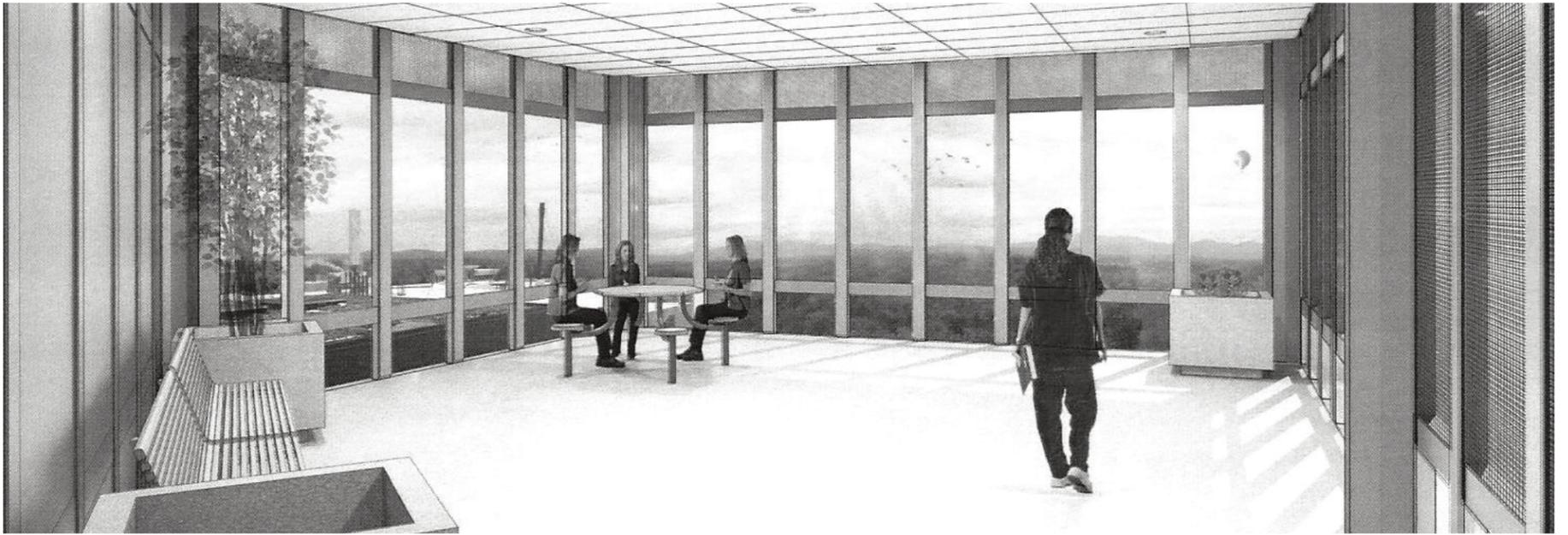
- ▶ “Reflex” because it is the way we are programmed and taught; “everything flies out of my head” in a crisis.

The discussion will continue in future meetings at The Hive. Information about The Hive is available at hivemutualsupport.net/ AD



WHY DO WE CALL POLICE? — Wyatt Andrews records comments from a brainstorming session during the workshop.

Hospital Updates



An architect's rendering of the screened deck planned for Shepardson 6 at the University of Vermont Medical Center.

(Courtesy of Lavalley/Brensinger)

Outdoor Decks Coming on Line at 2 Sites

Two Vermont hospitals have projects underway to create screened decks that allow patient access to fresh air.

Central Vermont Medical Center in Berlin was the last inpatient facility in the state that had no available outdoor access for patients who were not permitted to leave the unit.

Construction is now underway for a balcony on the same level as the third floor unit and is “three quarters of the way completed,” a spokesperson said. According to CVMC staff, because it is attached directly and is a part of the unit, patients will be able to use the deck freely, without an escort.

At the University of Vermont Medical Center in Burlington, final design plans are under completion for a large outdoor deck on a rooftop adjacent to Shepardson 6, with planned construction this fall and winter.

A stakeholder team, including former patients, is reviewing furniture and decor. That deck, which is an expansion of a small existing balcony, will

also allow for open access as an integrated part of the unit. The deck is about 800 square feet, and faces Mount Mansfield and Camel's Hump. It is expected to be used for some group activities, such as yoga, along with individual use.

Work on the deck is expected to begin after current construction on Shepardson 6 is completed in October. That construction is moving staff offices and meeting rooms to the floor below in order to create more patient space on the unit, including an exercise room and a quiet room.

Currently, patients on the locked sixth floor can access the psychiatric inpatient garden only under limited circumstances and accompanied by designated staff, if available. The ground level garden is more routinely used for Shepardson 3, which is primarily a voluntary unit.

Vermont's other four hospitals that serve inpatient psychiatry have outdoor access, but are limited to staff-escorted use.

The Brattleboro Retreat, Rutland Regional Medical Center, and the Vermont Psychiatric

Care Hospital all developed outdoor air access areas as part of construction or renovation after flooding from Tropical Storm Irene resulted in closure of the Vermont State Hospital.

The Retreat and VPCH spaces are enclosed yards, while RRMC is a rooftop deck. The UVMMC deck plan was initiated and modeled after Rutland's deck after a peer member of UVMMC's advisory group described the way it was constructed in Rutland.

The Windham Center enclosed yard has existed for many years. As of 2003, it and the former Vermont State Hospital in Waterbury were the only facilities with any outdoor spaces.

In 2002, a state regulatory board reviewing plans for the UVMMC (then Fletcher Allen) new psychiatric units in the Shepardson buildings heard psychiatric survivor testimony about the importance of outdoor access. It made the garden a condition of a permit to construct the units. Since then, outdoor access has come to be seen by state regulators as part of the standard of care. AD

Restraint, Seclusion Data Show Decrease

WATERBURY — A year-and-a-half into an effort to reduce the use of emergency involuntary procedures — restraint, seclusion, and drugs — trends of use are down at most of Vermont's psychiatric inpatient units. The data are tracked only for persons being held involuntarily.

Most of the focus is on Level 1 units that admit persons considered most volatile, and those units have shown the steadiest decline, on average, according to the data shared at the August quarterly meeting of the emergency involuntary procedure (EIP) review committee.

Central Vermont Medical Center announced that it believed it was “well on our way to elimination of seclusion and restraint.” CVMC is not a Level 1 unit, but about a quarter of its average census of 12 are persons being held involuntarily, according to nurse manager Paul Capcara.

Capcara said that in the past five months, there was only a single instance of an EIP involving a brief manual restraint, and that the hospital has gone from “not being the lowest, to being the lowest” for use of all restraint or seclusion.

The EIP committee hears presentations from one or more hospitals at each meeting, and seeks to encourage the other hospitals to adopt practices that are succeeding.

Capcara said that CVMC identified staff fears about safety as a key trigger for EIPs. It then targeted training and creating a safer environment in order to reduce the need to be “hypervigilant” about risks. “We constantly say out loud, ‘Are you safe? Is the patient safe? Are the other patients safe? Then don't intervene... just ride this out.’”

In response to a question about whether CVMC simply has less challenging patients, Linda Cramer, from Disability Rights Vermont, said that she could vouch that “they are definitely

not cherry-picking.” She said that there was a noticeable change in culture at the hospital.

Cramer said she witnessed an incident with a person who was throwing chairs and acting out in other violent ways. “I saw them working with her very patiently,” she said.

The data do not include instances of restraint or emergency drugs in emergency rooms. According to DMH, the hospitals have not been willing to do the work to track that data because they are not legally required to do so. AD

New Policy Welcomes Visitors at All Hours

BURLINGTON — Patients can have visitors without restriction on hours, including for overnight stays, under a policy that went into effect hospital-wide at the University of Vermont Medical Center this summer.

The hospital said that its new “welcoming policy” recognizes the importance of family and support persons in patient recovery.

Katharine Monje, the interim nurse manager for the psychiatric units, said staff were nervous at first about whether the policy would work on their units. “It's been really positive,” she said at the August meeting of a statewide advisory com-

mittee on emergency involuntary procedures. Psychiatry has had several instances already where an overnight stay was an appropriate support for a patient, and the guest was able to spend the night on the unit, she said. There are recliner chairs on the unit for that purpose.

Paul Capcara, a member of the committee representing Central Vermont Medical Center, called the new UVMMC policy “really awesome.”

“We're revisiting our policy” for visitors based on the UVMMC experience, he said. “You're having a positive impact on others,” he told Monje. AD

Candidates for Governor

Mental Health Views Explored

by ANNE DONAHUE

Counterpoint

MONTPELIER – For Phil Scott, for almost every issue, “It keeps going back to the economy.” In his interview with *Counterpoint*, the Republican candidate for governor said he believes the ability of the state to meet the needs of its citizens, including addressing mental health services, depends upon the ability to attract businesses and create jobs so that the tax base can increase.

Even with “challenges ahead for the budget,” he said the state has a responsibility to be “taking



Phil Scott

care of its citizens.” For mental health, he said the priority should be on funding preventive services in the community, rather than waiting for people to reach a crisis point.

Although his direct experience is “on the practical

side” – when he was in the legislature, he was chair of the committee that decided on money for construction projects such as the state hospital – he said he believes the mental health system needs to recognize that people get helped in many different ways.

That was his response to *Counterpoint*’s question about increasing funding for peer services.

“Everyone is truly different,” he said. He “would try to add as much flexibility as we can” in the help that is offered, including with peer services that show beneficial outcomes.

“Any investment we can make from a preventive standpoint” saves money and is better for individuals, he said.

In addition to peer services, he responded to these questions in the interview:

What is the status of parity for mental health within the health care system?

“I think we’ve come a long way,” he responded, but there is “further to go.” He said that health care reform shouldn’t just be about saving money, but about the care of people as well, and “we want it to be all-inclusive.”

Will peers and survivors have input in the selection of the Commissioner of Mental Health?

“Yes, absolutely.”

“I want to find talent” in all areas of leadership, Scott said, and that means getting input from the people who know the subject.

“I want to be transparent,” Scott added, saying that getting input doesn’t mean he would necessarily choose a person with stakeholder support. However, “I want to hear from them.”

What should be done to address the crisis of those left in emergency rooms for days, until a psychiatric bed becomes available?

Scott again stressed the need to “keep investing in the community,” and “front load” the system, before a crisis that results in someone needing an inpatient bed.

“We need to keep patients first,” he said, and

that goes “across the whole health care field.”

Forced treatment, and specifically, the forced use of psychiatric drugs: Two years after Vermont revised its laws to allow the process for court drug orders to go faster, Governor Peter Shumlin proposed changing it again, eliminating many legal protections, with a claim that it would save \$5 million. Would Scott support such an initiative?

“I don’t think we should be changing policy” for the sake of money, Scott said. “We lose sight of the fact that it has to be [the right thing] for the patient,” not just about savings.

“I wouldn’t pursue [any] change” at this point, he added, until seeing what the effect is of the revisions to the law passed in 2014.

How can the state enforce its policy on “least restrictive” transportation of patients, when the law was passed more than 10 years ago and yet shackling is still used routinely by some sheriff’s departments?

“We’re such a small state,” Scott said. “We have to bring them [law enforcement and stakeholders] together” and “put [the policies] into practice.”

It is about “getting the proper education,” and having the procedures in place, for law enforcement, he said.

“I can’t believe we can’t resolve it” by getting the right people together to work it through.

Should additional gun laws be passed that are specific to persons with a diagnosis of a mental illness?

“Not everybody that has mental health issues should be precluded from having a gun for hunting,” Scott said.

Laws proposed to address gun violence need to assess “What is the balancing” that is taking place?

“I wouldn’t want to expand” from what was done last year, when Vermont agreed to send the names of persons banned from possessing a gun, based upon a court commitment, to the federal database, he said.

What can you point to as any specific things you have done to help address mental health issues in Vermont?

Scott said that in his role on the Institutions Committee when he was in the Senate, he helped shape the state’s budget for state facilities.

At the time, many people believed the old Vermont State Hospital in Waterbury needed to be replaced, and he agreed. However, the governor at the time didn’t want any money invested in the meantime in the old facility.

He insisted on money for interim repairs and improvements, “whatever it [needed] to improve the lives of those in the hospital” right then, Scott said.

Scott said he was told it was “money thrown away.”

He responded, “Not for those who are there now.”

“We went down there [as a committee] every year,” to see the situation first-hand, he said. It was “something never done before,” but he felt it was essential.

Do you have any personal experiences that have impacted your perspective on mental health issues?

“We all have, in our lives,” people close to us, family and friends, who have been affected, or who have lost their lives to suicide.

“It’s become more and more serious.”

Scott said he feels mental health needs to be treated the same way as any other health needs, and it is by “talking about it” that people can understand that “it isn’t something to be ashamed of.”

DISCLOSURE: Counterpoint News Editor Anne Donahue is also a Republican State Representative and is running for re-election.

Candidate Sue Minter

There are two major party candidates running for governor: Democrat Sue Minter and Republican Phil Scott. Both candidates were contacted by *Counterpoint* at the same time to request an interview, and they were sent the same questions in advance of the interview time.

Minter’s staff said she would send written responses in advance as well as scheduling the interview. The morning of her interview, Minter’s staff sent this email to *Counterpoint*:

“Due to a last minute scheduling conflict, we will not be able to do the interview today, and unfortunately I don’t believe we will be able to make something work prior to your deadline. We do feel bad about this, and would like to get you a written statement from Sue regarding her position on mental health treatment in Vermont.”

No written responses from the Minter campaign to the *Counterpoint* questions were submitted.

Advisory Groups Seek New Members Across the State

At least three statewide committees are actively recruiting to fill membership slots.

Emergency Involuntary Procedures

Membership of the Emergency Involuntary Procedures Review Committee has recently been established officially, and it is recruiting for two required members: a “peer” and a “person with lived experience.”

Neither term is defined, but leadership from the Department of Mental Health said that ideally “lived experience” would mean a person who has experienced restraint or seclusion. Other members include representatives of hospitals, agencies, and DMH staff.

Meetings are quarterly. Contact Emma Harrigan at emma.harrigan@vermont.gov.

Counterpoint Editorial Board

Counterpoint is also recruiting to rebuild its advisory editorial board. The board edits drafts of each issue and makes recommendations on policy and news coverage.

Meetings are quarterly. Peer, survivor and family representation is needed. Contact Anne Donahue at counterpoint@vermontpsychiatricsurvivors.org.

Adult Mental Health

The State Standing Committee on Adult Mental Health is required to include representation by consumers, family members, and professionals. Current consumer members are recruiting to fill additional family and professional slots.

Meetings are monthly. Contact Marla Simpson at marla.simpson@ymail.com.

Court Says Caretakers Sometimes

by ANNE DONAHUE

Counterpoint

MONTPELIER – Patients who are judged to be dangerous may be more likely to have hospitals or mental health agencies give confidential information about them to caretakers, after a Vermont Supreme Court decision this year that makes it possible for hospitals and mental health agencies to be sued if a patient later injures someone.

Although the case, *Kuligoski vs. Brattleboro Retreat*, applied to a set of specific facts, hospitals and community mental health agencies say they have already begun to change the standards they consider in deciding whether they need to provide a warning, and to whom.

The court decided for the first time that mental health providers have the duty to educate a caretaker about the potential for violence and how to protect the public from that person's conduct, when a situation warrants it.

Under prior legal standards in Vermont, a duty to warn others about a danger applied only to persons who were identifiable as a specific potential victim. When there is a legal duty and a person fails to uphold that duty, if someone is harmed as a result, the victim can sue for the harm.

Some fear that the impact of the court decision could be that hospitals are more reluctant to discharge patients. Others are concerned about the loss of confidentiality.

The Chief Justice of the Supreme Court, Paul Reiber, wrote an opinion disagreeing with the majority, 3-2 ruling, saying that the court decision goes contrary to "the significant societal concern that patients not be unnecessarily hospitalized as a means to avoid liability."

It "questions what is the priority: protecting my rights and my HIPAA [privacy law] rights," or breaking that protection in order to protect mental health provider organizations, said Kate Purcell. She is a consumer member of the stakeholder advisory committee at the University of Vermont Medical Center.

Provider institutions "most certainly will react strongly by reporting widely for fear of being sued," Purcell said. The court ruling is "a poor decision affecting those receiving mental health services negatively."

Purcell said that what was being overlooked was whether or not the patient should have been released when he was.

"Upon reading this Court's decision and supporting documentation, as a peer or consumer, not as a professional provider or lawyer, in all likelihood, he should not have been released at the time that he was, thus potentially avoiding the tragedy for all."

Lawsuit Filed After Assault

The case involved a young adult, Evan Rapoza, who was hospitalized in 2010 with a diagnosis of a psychotic disorder. Two-and-a-half months after his discharge to live with his parents, he seriously injured a furnace repairman, Michael Kuligoski. The victim was in intensive care for a month and spent 14 months at four rehabilitation centers.

Criminal charges were dropped after Rapoza was found to have been insane at the time of the attack. (The Supreme Court decision referred to Rapoza only by the initials E.R., but the criminal court case was public, thus resulting in his public identification.)

Kuligoski sued Rapoza, his parents and grandparents, and then separately sued the Brattleboro

Retreat and Northeast Kingdom Human Services. The cases against Rapoza and his family were dismissed by a court.

The lawsuit against the Retreat said that it knew the man was a high risk for violence when they discharged him to live with his parents and were negligent for the discharge itself, for not warning his parents about his risk to the public, and for "failing to train [the parents] how to supervise him, monitor and manage his medications, and take necessary and appropriate measures to protect potential victims."

The same claims about duties to warn and educate the parents were made against Northeast Kingdom Human Services, where Rapoza was an outpatient client after his discharge.

Did Providers Owe Duty?

The Supreme Court, in its opinion, said that the claims that were made in the lawsuit would still have to be proven in court. Its decision addressed whether there was a possible duty that the Retreat and NKHS owed that could be the basis to argue that Kuligoski's injuries were caused by a failure to meet that duty.

Rapoza was first admitted to Central Vermont Medical Center, and the court said records showed he "made threatening remarks, reported auditory hallucinations, was easily agitated, and had fair-to-poor judgment" and was tentatively diagnosed with a schizophreniform disorder.

He was transferred to the Vermont State Hospital after an involuntary examination was ordered, where "further reports indicate auditory and visual hallucinations, menacing behavior, and homicidal and suicidal ideation."

He was then transferred to the Retreat, where it was reported that he "had verbalized homicidal ideation toward staff" and "continued to exhibit 'grossly psychotic' behavior, lack of insight, and severely impaired judgment."

During his time at the Retreat, the court said, his behavior did not improve. In an assessment two days before discharge, his physician said that if discharged, Rapoza "would be a high risk for decompensation, might stop his medication, and might not participate in aftercare treatment."

On November 12, the day he was discharged, the physician "noted that he stopped taking his medication and had been hearing voices commanding him to kill himself. E.R. said of the commands, 'I feel like I should do it.'" His physician wrote in his assessment, "Obviously [E.R.'s] refusal of medications is very worrisome and exactly what this writer was concerned about. Not only abstractly is it a bad idea, but he actually seems to have experienced an increase in his voices with only missing one night's medications."

The Supreme Court ruled, however, that the Retreat did not have a duty under the law to keep Rapoza in the hospital in order to protect the public. Instead, it focused on the man's relationship with his parents as "caretakers," because he had been living with them and was discharged to them.

The court said that under the facts being presented in the lawsuit, it appeared that the Retreat's aftercare treatment plan was developed with Rapoza's parents, and included regular visits to NKHS. He was prescribed daily medication, "which his mother was told to administer to him."

The NKHS treatment team met with Rapoza and set up a plan for therapy. A month later, the court said, Rapoza's mother contacted NKHS in mid-December to report that he had stopped tak-

ing his medication. A physician there told her "that this was a cause for concern but that E.R. had to decide to take care of himself."

There were no other meetings between NKHS staff and Rapoza between that time and late February, when Rapoza accompanied his father to an apartment building in St. Johnsbury owned by his grandparents. Kuligoski was at the building, working on the furnace, and Rapoza "went down to the basement where Mr. Kuligoski was working and assaulted him, causing serious injuries," the court said.

The Supreme Court said that mental health professionals do not have a duty to warn the general public about a patient who might be dangerous, but that the issue was a "much narrower duty: to warn E.R.'s caretakers, here, his parents."

The court said the parents "had assumed responsibilities, the discharge of which could be affected by the information they received. For example, the limited facts indicate that in a discharge conference, Retreat staff told E.R.'s mother that she should give E.R. his medication... A complete warning of the effect of E.R. discontinuing the medication may have affected the parents' degree of involvement in ensuring E.R. took his medication."

As a result, the court said that it concluded that if a patient with a psychotic disorder is transferred to the custody of a caretaker who is known to lack psychiatric training and expertise, there is a duty of care "to provide sufficient information to the parents so they could fully assume their caretaker responsibilities to assist E.R. and protect against any harmful conduct in which he might engage."

The court said that it considered the claim of a "duty to train" the parents as being a duty "to provide the parents with particular information" that would depend upon the specific facts of a case. The court said that NKHS had the same duties as the Retreat.

The court's decision ruled that no state or federal confidentiality laws would be broken by the disclosures it was setting as a standard, because they all fit under the existing "dangerous patient exception to the confidentiality requirement" or the exception for giving relevant information to caretakers if a patient is not competent.

Rapoza's mother, Christine, declined comment to *Counterpoint* on the parents' reaction to the court decision, which implied they could have acted to prevent the assault if they had received more information and guidance from the Retreat or NKHS.

Clients May See Impact

Hospitals, mental health agencies and advocates across the state have expressed concern about what impact the court's ruling might have on client care.

According to Robert Pierratini, MD, Chair of Psychiatry at the University of Vermont Medical Center, the new standard set by the court requires predictions about potential violence that are not realistic and are not likely to bring about the benefits in public safety the court intended, "We may be disclosing personal information for very little gain," he said.

A.J. Ruben, senior attorney at Disability Rights Vermont, said that, "Both DRVT and providers of care are now concerned that providers will be less willing to authorize community placements for people previously consid-

(Continued on page 13)

Must Receive Patient Information

(Continued from page 12)

ered appropriate for such more integrated settings,” he said in an email to *Counterpoint*.

In addition, “potential caregivers (undefined by the Court) [may] be less willing to provide a place for patients to live and the needed support for their successful reintegration,” he said.

Ruben said in comments filed with the court that an expansion of warnings that were not actually appropriate or needed “would also have the negative consequence of furthering the harmful and false stereotype that people with mental health conditions are generally a danger to the public.”

Policy Changes Underway

At the University of Vermont Medical Center, the hospital agreed that it sees its new obligation as requiring the potential for much broader disclosures about its patients.

“We routinely screen for risk of violence or

danger, but our screening has traditionally focused on relatively short-term risk,” Pierratini told *Counterpoint*.

“As a result of the Vermont Supreme Court decision, we have adopted processes that attempt to identify risk of violence or danger in the long-term. We then must try to determine who are caretakers or other people in the ‘zone of risk.’ Ultimately, there is a clinical judgment that must be made about whether the risk is sufficient to merit a warning to others and a disclosure of what would otherwise be confidential information.”

He said, however, that he was not sure that the requirements of the court decision would produce the results the court assumed. “We are not really able to predict risk of violence in the long term. We don’t know if our notification will actually reduce the risk to others. There may be very little that others can do to mitigate violence — at least very little that they would not have done otherwise.”

Mary Moulton, Executive Director of Wash-

ington County Mental Health Services in Montpelier, said that designated agencies see the Kuligowski decision “as one that sets back the hands of time” and will impact the ability of agencies in “assisting people with serious mental illness to live as Vermonters in their chosen communities.”

Agencies are now consulting with their attorneys on individual cases when a disclosure “would violate patient confidentiality in ways we would not have done in the past.”

“We had hoped the days of being pigeonholed as a person who is dangerous due to a diagnosis should be long behind us,” she said. “This case tells us that biases are still held.”

Assigning a caretaker role as a person who needs to be “educated regarding the care of their ‘ward’ is a step backwards in recovery and provides no greater safety, particularly in a case such as this one where the person’s future behavior could not have been predicted,” Moulton said.

Inmate’s Lawsuit To Result in Increased Services

MONTPELIER — Promises for improved care for inmates with a diagnosis of a serious mental illness have been made once again by the state as a result of a legal complaint.

The settlement of a lawsuit brought by a person identified as Patient A has resulted in a finan-

cial payment for the individual’s injuries and a requirement for significant increases in mental health care being given to inmates who are being held in prison after being found to be in need of a transfer to a hospital.

The case has similarities to the promises made

in 2014, when a Human Rights Commission case was settled and the state said it would create new procedures to protect the rights of inmates being held in prison despite having been ordered to receive an inpatient evaluation.

The new settlement requires improved services to persons already in corrections who are determined by staff there to be in need of inpatient care. It also requires increased training for staff making those determinations.

Patient A was serving a 21-day sanction for parole violations in August of 2013. He became ineligible for release and was held in segregation because of disciplinary violations that were largely the result of “disability-related behaviors,” the lawsuit alleged.

In February of 2014 he was found to be in need of inpatient care because his mental health was getting much worse, but he was held another two months before being transferred to the Vermont Psychiatric Care Hospital, the complaint said. By then, he had suffered significant physical and psychological harm, including psychotic breaks, malnutrition and weight loss, bruises and trauma from uses of force, and injuries from self-harm, the lawsuit said.

According to Disability Rights Vermont, which brought the lawsuit on behalf of Patient A, the new requirements represent progress. The settlement does not resolve the major problem, however, of inmates continuing to be held in prison in segregation after being found to need hospital care, it said.

The settlement was announced just days after a legislative committee appointed a special commission to look at the issue of treatment of prisoners with serious mental illnesses. That action was the result of a separate inmate’s case before the Human Rights Commission. (*See separate article, this page.*)

A lack of capacity has been cited as the cause for the waits in corrections, as well as for long emergency room waits for patients who are being held after being found to require hospitalization but who are not in the criminal justice system. According to the most recent report, close to half of all those being admitted involuntarily wait for more than a day, and some for multiple days. The figures for June and July show a new increase in emergency room delays after a period of decrease. AD

Legislators Appoint Group on Prison Mental Health Needs, Use of Seclusion

MONTPELIER — The legislature’s Criminal Justice Oversight Committee has directed a group of state leaders and advocates to report back in November on how to respond to the needs of persons in the correctional system with diagnoses of serious mental illness.

The Committee’s action followed discussion earlier this year about a Human Rights Commission decision which found that the state had violated the rights of a person with a disability by

failing to provide adequate care, including the inappropriate use of segregation.

The Committee also heard a warning from the head of Pennsylvania’s Department of Corrections, who testified that his state was sued by the local disability rights organization and investigated by the Department of Justice over allegations of “overusing restricted housing or solitary” for inmates with serious mental illnesses.

“They were 100 percent correct,” John Wetzel said. However, being sued is not a good path for making change, he advised Vermont’s lawmakers, because the state then loses control over how to resolve the problem. Pennsylvania added extensive training, more correctional and treatment staff, and new specialized housing units. Pennsylvania’s Corrections Department also has more than 500 inmates who are trained as certified peer specialists, he said. Its new policies recognize that for those with a serious mental illness, “they’re going to get worse if they’re in restricted housing,” Wetzel testified. “None of these [responses] are cheap... but it’s the right thing to do.”

The Justice Oversight Committee said that the group that it is appointing — titled the “Commission on Offenders with Mental Illness” — needs to identify how to divert individuals out of corrections, develop best practices for identifying and meeting needs of those with mental illnesses, severe developmental disabilities, and traumatic brain injuries, once incarcerated, and how to finance such housing and treatment.

Committee Chair Sen. Dick Sears noted the ruling by the Human Rights Commission, which can lead to a lawsuit if the violation is not resolved within six months. “We have to take that seriously,” he said. (*A few days later, a lawsuit that was already in progress was settled, requiring new standards of care. See separate article, this page.*) AD

Patient Care Plan Deficiencies Resolved

BERLIN — Multiple deficiencies in patient care plans at the Vermont Psychiatric Care Hospital were determined to have been adequately addressed by The Joint Commission on the accreditation of hospitals at a two-week follow-up visit in August.

The August visit was required because deficiencies identified during a July evaluation meant that the hospital was failing to meet some required conditions for federal funding. Of 44 deficiencies cited in July, 17 were rated as creating a “moderate risk” and found to be widespread. There were no “high risk” deficiencies; the others were either low risk or not widespread. The rankings are based upon “the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope,” according to the report.

“The hospital will continue to address all standards improvement areas that were identified in its plan of correction,” said Frank Reed, Commissioner of the Department of Mental Health. The re-survey established that areas of deficiency “have been improved and must now be sustained,” he said. AD

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

Editorial**Forewarned**

In 1998, *Counterpoint* published a front page article asking the question, “Is ‘Recovery’ Losing Its Roots?” It questioned whether the original concept of recovery — a concept that arose from the psychiatric survivor and ex-patient movement — was being co-opted by the professional mental health community, and getting watered down in the process.

The difference:

The original movement defied the common belief that one never fully recovered from a mental illness. It defined recovery in the same way as one would say one recovered from pneumonia or a broken arm. You got better. Completely better.

The replacement version said that persons could maximize their independence and not “be defined by” their mental illness as they continued to live with it. All mental health services are now supposed to be “recovery-oriented.”

Today, a debate has emerged about another concept, peer support. It’s the same question: does peer support live and thrive only when it is an alternative that is outside of the traditional system? Or can it become a part of the system itself, yet still hold true to its values?

Part of the question, unfortunately, always seems to be about money.

To receive public funding, any services must be just that: a “service.” Services have to be measured, reviewed for quality, and tested for effectiveness. That doesn’t blend well with being anti-institutional and countercultural. It doesn’t blend well with being a grassroots movement that functions on the individual level.

It does make it more sustainable.

It’s a tough balance. Is it selling out to adapt to the institutional needs of the system in order to have the funds to provide peer support? Does it actually enhance peer support, because by coming into the mainstream, it is available to more people, and the system itself learns and grows?

One thing seems clear: the danger of losing the authentic roots and spirit of peer support is real. Bringing peer initiatives more fully into the existing system places them at risk of being controlled by that system.

This past year, for example, a bill in Congress proposed a definition of a peer-support specialist that required receiving mental health or substance abuse treatment for at least the preceding two years and being supervised by a licensed professional. The established system would thereby control who can be identified as a peer provider and how they must provide support.

This warns of the need for great caution in comingling with traditional models of care. We lose the mutuality of peer support the moment there are “we, the service providers” and “you, the service recipient,” instead of “us,” the human persons struggling to support one another.

If that is lost, whether it is inside or outside the established system doesn’t really matter. It has lost the “peer” in peer support.

Those who seek to change the system must always be on guard against being changed by the system instead. It can happen without being noticed.

Forewarned is forearmed.

PUBLISHER’S COMMENTARY**NAMI Does Not Speak for Me**

by **WILDA L. WHITE**

As a 50-something, black, gay, woman who has lived most of her life in the United States, I have some experience with oppression. I remember grade school classmates in Massachusetts who would not sit next to me in the school cafeteria for fear of turning black. I remember applying for a job as a high school track coach, and my own high school track coach cautioning against hiring me simply because I was gay. I remember the Burlington auto repair shop that refused to hire me as a car mechanic because I was a “girl.” I remember the violence, threats of violence, and the name-calling.

I also remember my mother introducing me to the likes of Thurgood Marshall, and Martin Luther King, Jr., when as an eight-year-old I asked her if anyone was working to end racism. I went on to discover Angela Davis, the Stonewall Riots, and ACT UP as I became interested in ending not only racism, but also sexism and homophobia.

They were my heroes, and my role models. They inspired me to find my voice, claim my power, and speak up and fight back against oppression.

In the fifth decade of my life, I find myself facing yet another form of oppression: oppression against people who have been labeled by psychiatry. We’re locked up, lied to, forced drugged, disenfranchised, betrayed by family, traumatized by doctors, shot and killed by police, and physically and mentally harmed by mind-altering drugs. We’re scapegoated for gun violence. We’re underemployed, or paid less for the same work, if we’re employed at all. Name-calling against people psychiatrically labeled is a regular feature in major, metropolitan newspapers, and has become something of a national past time since Donald J. Trump announced his candidacy for president of the United States.

When I scan the national landscape in search of people speaking out about the plight of people psychiatrically labeled, I don’t find anyone like Angela Davis or Martin Luther King, Jr. What I have found are the likes of Rep. Tim Murphy (R-PA) and the National Alliance on Mental Illness (NAMI). After the House of Representatives passed the mental health bill, which was cast as a response to mass shootings, Murphy, who sponsored the bill, said: “We’re here, finally, to speak up for the last, the lost, the least and the lonely.

That is those that suffer from mental illness.” NAMI worked alongside Rep. Murphy to lobby for the passage of the bill that called for increased forced drugging, decreased privacy rights for people psychiatrically labeled, and blamed people psychiatrically labeled for mass shootings. As the saying goes, with friends like these, who needs enemies?

NAMI, which says it was started in 1979 by a small group of families, describes itself as the “leading voice on mental health” and the “largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness.” It claims to “shape the national public policy landscape for people with mental illness and their families.”

NAMI is not an organization run by people who have been psychiatrically labeled. NAMI allows people who have been psychiatrically labeled to participate in an advisory capacity. Nevertheless, NAMI has appointed itself our voice. This is unprecedented. Imagine the leading voice on racism, coming from self-appointed white people, or the leading voice on sex discrimination coming from men, or the leading voice on homophobia, coming from heterosexuals.

NAMI may have a role to play as an organization for families affected by mental health challenges however it has no business purporting to speak for people marginalized by psychiatric labels, particularly when it uses its voice to support legislation that codifies our oppression, marginalization and second-class citizenship.

NAMI and Rep. Murray are not going to stop speaking on our behalf simply because their voices are illegitimate. It is up to us to speak up, drown out, and de-legitimize their voices. We must let them and everyone else know through personal letters, letters to newspapers, social media campaigns, and the example of living our lives, out and proud, that we are not “the last, the lost, the least and the lonely.” We are mad, loud, and proud. And, we can speak for ourselves.



Wilda L. White

**vermont
psychiatric
survivors**

ANNUAL MEETING

September 24, 2016

10:00 a.m. to 2:00 p.m.

Franklin Conference Center
at the Howe Center

1 Scale Avenue, Building 3,
Rutland, VT

GUEST SPEAKER

Celia Brown

info@vermontpsychiatricsurvivors.org

Patients Are at Mercy of Hospital Staff

To the Editor:

I love reading your quarterly papers.

I read with great interest the ‘State of Emergency’ in the Summer, 2016 edition.

I was mulling over in my head a response to said article. For a month now I have drafted it in my head, making changes so when I sat at the computer I would be all set to go.

The longer I thought about the letter the higher my blood pressure rose. Not because of the article per se, but because when all is said and done we mental health patients really have no rights or avenue of appeals.

Yes, after the fact maybe DAIL [the Vermont Department of Disabilities, Aging and Independent Living] might find that your rights were violated and make the facility do a Corrective Action Plan. Big damn that helps after one has suffered more at the hands of those who are supposed to be helping us, not adding to the burden and stigmas.

And, for example, if you were to call the Patient Relations Office aka “Protect our Rear-end” hospital staff people, you might get a “Sorry Letter” and “we will try to do better next time... and we need to do more Education with that person.”

Sorry, folks, but if a staff member isn’t qualified or trained appropriately enough, they do not belong with that set of patients.

At a recent CAC [Community Advisory Committee] meeting at Rutland Regional Medical Center (RRMC), I mentioned this and a comment was made about how expensive and difficult getting staff trained is. BULL.

When I was on the Rescue Squad, I had an Emergency Care Attendant license. That allowed me to provide basic emergency care; I wasn’t allowed or trained to start IVs, for example. If we needed to do an IV on someone we radioed for an IV tech or met Regional on the way.

I mention the above in part because I said “NO” several times to an emergency medical technician working in the RRMC emergency room one particular time. “No” was not an acceptable response from this patient. So after coercion (read, threats), I finally gave in.

And as an aside, with healthcare costs going up and so forth, expect more EMT staff people in the emergency rooms across the state and country. And as they are licensed, through a different place than the nurses, etc, GOD help you if they screw you over as you really have no recourse in the matter.

In fact, I have let it be known I will not step foot in the emergency room at RRMC again. Between the EMT and Security (who I believe suffers from Little Man Syndrome with three ounces of tin on his chest) I would rather jump off the Quechee Bridge than suffer through that again.

In fact, before the CAC meeting began one in-

dividual mentioned a situation where Security was talking about inappropriate topics while looking after a patient in crisis they were with. Now to be sure, make no mistake, the nurse I had and the “babysitters” I had were great.

I am also not sure how if one is in a hallway on a gurney a patient might call a nurse if needed. After all there is no call bell for you. However, we patients are supposed to know what to do and how to do things — while staff needs more training.

Supposedly at RRMC there is to be cross training and more psych staff available in the ER. Some may say better late than never. I say what the hell have hospitals and the state been doing all these years post-Irene besides waste time, money, and not make the situation better?

And let’s be honest, there aren’t enough mental health providers or beds and other facilities in Vermont. I will say, if one could skip the ER at Rutland and just go straight to PSIU [Psychiatric Services Inpatient Unit], they would be blessed with the best care anywhere.

However, that isn’t possible and not only must you go through the ER, you then get doubly blessed (NOT) with staff from Rutland Mental Health. This group should have been decertified years ago. But we are talking the State here, and planning like that would need some common sense and foresight.

Now that you have some idea of my opinion about RRMC, let me tell you what a difference in experiences I had in Burlington [University of Vermont Medical Center].

I presented to the ER and was getting registered. I forgot my cell charger in the car and told security I was going out to get it. They politely refused to allow me to go out and went and got it for me. I mentioned to the registrar that I drink bottled water instead of that chlorinated stuff they call water. She told me they don’t have any in the ER but would make sure I had some. And indeed later, when I asked for water, I got it.

The “babysitters” in Burlington were just as wonderful as Rutland’s. I will say the room one goes into while waiting to be seen I called the “Execution Chamber” as it was small, stark and drab. Rutland’s hallway was a step above the room in Burlington.

All of this to say in the end, we mental health patients are at the mercy of our “jailers,” who control just about every aspect of what you do

when going to the ER in crisis. One can advocate till the cows come home and it still won’t make any difference. Trust me, I have called every agency and department that I know of, was told about, and was referred to.

The main thing is we are mental health patients and those whose job it is to help us on the State or Federal level are merely collecting paychecks, as best I can tell.

Now back to the PSIU for a moment. As I say, the best care anywhere and if you have a choice of places to go ask for this location. Staff are marvelous. Caring and truly concerned.

The one area I fault them on is patient confidentiality. The nursing station is completely open, so having private conversations in this outer area is almost impossible — to the point that staff asked me to move from a place where many of us sit.

Yet not more than ten feet to the right of this staff member is the open area where meds are given out. At night people line up and get the meds they are taking. Now to be sure, in all likelihood everyone is on some psych med(s). However, I mentioned the fact that I know what several patients got besides the psych meds. And some people I run into from time to time and I know, I don’t want to have know the meds I take.

Yet the Hypocritical Bastardy staff doesn’t appear to care about this. And for almost a year now apparently nothing has been done to fix either situation.

In fact, I mentioned this at the recent CAC meeting and the room was dead silent. No outcries from anyone other than me. Not a question was asked — nothing. And the people at the meeting I would have thought would have raised some concerns, didn’t. This tells me the CAC is really a public relations group.

So if I sound bitter, maybe I am. Maybe because I expect better from those whose duty it is to do no harm, when they help inflict more harm and trauma on mental health patients.

And maybe you think I am hard on the state and various groups. Until you have been in my shoes, don’t be so quick to judge.

Nope, I no longer believe we have any real rights, appeals processes and so forth any longer. But then again maybe I “need more educating or training.”

BRIAN E. FILLIOE
Proctor

Harassment of a 70-Year-Old Motorist Is Deplored as Violation of Rights

To the Editor:

On June 19, I was pulled over and stopped on Route 9 west of Bennington for driving a little bit too slowly!

I was ordered to get out of my truck and made to walk 10 steps toe-to-toe in a single line. I nearly lost my balance and fell sideways several times on the blacktop.

I was handcuffed with my hands in back, stuffed into the back of a police cruiser and given an intensive drug test and brought home after the 3- to 4-hour ordeal. My truck was confiscated and I had to pay \$89 to retrieve it on June 20. I was severely ill with pneumonia and my voice was

raspy. I told them this and they did not care one iota. I’m a harmless 70-year-old!

My right hand was injured from sitting on handcuffs. There were three cruisers involved!

This is a national phenomenon and a disgrace. People are afraid to speak out, so the needless torment continues. People are paying taxes to be tortured and harassed.

The American Civil Liberties Union should do something to help stop this immense transgression of the rights and peace of millions of harmless Americans.

RICHARD A. WILLIAMS
Bennington

Hats Off

To the Editor:

I would like to applaud Anne Donahue, *Counterpoint’s* long-time editor and currently news editor. She’s a wonderful reporter, writer and editor, and has fought the good fight for an awesome number of years. Hats off.

JEAN THOMPSON
South Burlington

Commentary

An Open Letter to the Disability Community On Black Lives Matter and ‘Allyship’

Our silence and neutral stance unless it involves those who look like us, or who are disabled, sends the message that we don’t care about what doesn’t touch us.

by ANITA CAMERON

Let’s face it, we suck when it comes to being good allies! I am referring to the recent murders of two Black men, Alton Sterling and Philando Castile, by police in Louisiana and Minnesota.

The vast majority of our community is silent on injustice to members of other marginalized communities unless the person has a disability. Barring that, if a disability isn’t present, we’ll make it all about us, thus derailing a critical conversation that needs to be had about how this must end and that Black lives matter.

Worse, when police murder someone Black, many in the disability community are complicit in the character assassination that follows. We’ll justify why the police had no choice but to kill them — they shouldn’t have resisted arrest, they shouldn’t have run, they shouldn’t have talked back — until it comes out that the victim had a disability.

Then, we care. We’re no longer silent, but expressing outrage at the killing of “our people.” The person’s Blackness is all but erased because it is only the disability that matters to us. It seems to be almost impossible for disabled — particularly White disabled folks — to focus on injustices to the Black community without chiming in, “Me too, me too. Half of those killed by police are disabled!”

There hasn’t been one time that I haven’t encountered that statement or others like it in the midst of us Blacks mourning our dead at the hands of police. Yes, it is very important to know and understand the fact that half of people murdered by cops are disabled, but not in response to the fact that Black people are being killed by police at an alarming rate. The disability and intersectional issues are critical conversations that must be had, but let’s not derail the conversation at hand.

Black lives matter! When I say that, I don’t mean that Black lives matter more than others, I mean that Black lives matter as well as other lives. That’s the reason for the movement and the hashtag — our lives matter, too!

The time has come for the disability community to take this square on, be good allies and



Anita Cameron with her cat and ‘Piss on Pity’ disability rights shirt, on her blog site.

speaking openly about police brutality in the Black community. I don’t mean hushed conversations with a couple of folks, I mean openly addressing and weighing in on this at the organizational level.

The face of the disability community and disability organizations is White, which is most likely why this isn’t being talked about at the level that it should be. Organizations hide behind the fact that they work on one or two national issues and in an effort not to “muddy the waters,” refuse to speak publicly about the extrajudicial killing of Black people by the police. Individual members may care, but the organization as a whole takes a neutral stance.

Even organizations that occasionally make statements on other tragedies have been strangely silent on this issue. Two years ago, when Michael Brown was murdered in Ferguson, Missouri, some disability organizations wrote a letter of “solidarity” that made it all about disabled — mostly White disabled — people killed by police. I’m still furious about that because while well-intentioned, it was a slap in the face and erasing of the Black community at the height of our mourning and outrage.

Now is the time to do better. For once, put aside the view that this is something that has

nothing to do with your organization and its goals or mission statement and speak up! Some of you — ADAPT and National Council on Independent Living — have Blacks in your organizations. Doesn’t this matter to you? I’m positive that some of the Blacks in your organizations worry that they may be the victim of police violence ending in murder. Full disclosure — I am a proud member of ADAPT for 30 years and know that individuals have spoken out, but I’m addressing ADAPT as an organization.

Even if your organization is lily White, speak out! American Association of People with Disabilities, why are you silent? National Council on Disability, are you not tasked with giving feedback and recommendations to Congress and the White House? Will you not weigh in on police brutality against Blacks and police reform?

Many of your service organizations have Black clients and their families. Speak out against this! Surely some of your clients’ families have someone who has experienced police brutality. Easter Seals, The Arc, and others, will you speak out?

If your organization wants to speak out or address this, but doesn’t know what to say, put it out there! Ask how you can speak out while centering Black voices and experience on this. There are some Blacks in our community who are very open about our feelings: our extreme rage, our deep sadness, our profound fear.

My beloved Disability Community, be silent no longer on Blacks being murdered by police! Our silence and neutral stance unless it involves those who look like us, or who are disabled, sends the message that we don’t care about what doesn’t touch us. We cannot hide behind silence and neutrality. Elie Wiesel said, “Neutrality helps the oppressor, never the victim. Silence encourages the tormentor, never the tormented.” Desmond Tutu put it even stronger — “If you are neutral in situations of injustice, you have chosen the side of the oppressor.”

Let’s not, by our silence, choose the side of the oppressor.

Anita Cameron wrote this letter on her blog, <http://www.angryblackwomyn.com/>

Creative Maladjustment Day Statement: ‘We Say Black Lives Matter’

Creative Maladjustment Day Statement, by the organizers of Brattleboro’s event, part of the Hive Mutual Support Network:

Dr. Martin Luther King, Jr., coined the phrase “creative maladjustment” to describe what psychology calls a disorder and what he believed was the characteristic of a prophet — someone who cries out for change in the midst of injustice. Psychiatric survivor and mad pride movements have taken up this term to celebrate our survival mechanisms and our identities that mainstream society pathologizes and devalues.

In organizing this event, we thought about what we are proud to be maladjusted to — standards of beauty, narrowly proscribed psychological norms, consensus reality — and what we

must work to become even more maladjusted to — including white supremacy and all forms of state violence.

In the past few weeks, we’ve had fresh reminders of the all-out attack on Black and brown people in this country. The world was still mourning 50 shot dead — mostly Puerto Rican — in a queer nightclub in Orlando when we got news that police had shot and killed two black men — Alton Sterling and Philando Castile — in two different cities within 24 hours.

Make no mistake that racial justice is our struggle, too. As mad folk, psych survivors, weirdoes, or whatever else we call ourselves — as queer and trans people, people with disabilities, fat people, poor people, white people, and people

of color, we say Black Lives Matter.

Our struggles are not the same. We all have multiple, intersecting identities. But because we each experience marginalization, because we are committed to a world in which everyone has what they need to survive and thrive, because we see a pattern of violence against those who are routinely devalued and dehumanized, we must begin to show up for each other in new and powerful ways.

Our liberation is bound up with one another’s. We need to work together to dismantle white supremacy, patriarchy, colonialism, and all systems of oppression. MLK said, “The salvation of the world lies in the hands of the creatively maladjusted.”

Let’s save the world.

— July 9, 2016

Commentary

Creative Maladjustment and the Movement for Black Lives

by CALVIN MOEN

“There are certain things in our nation and in the world which I am proud to be maladjusted, and which I hope all [people] of goodwill will be maladjusted, until the good society is realized. I say very honestly that I never intend to become adjusted to segregation and discrimination. I never intend to become adjusted to religious bigotry. I never intend to adjust myself to economic conditions that will take necessities from the many to give luxuries to the few. I never intend to adjust myself to the madness of militarism, to self-defeating effects of physical violence.”

- Dr. Martin Luther King, Jr.'s speech at Western Michigan University, December 18, 1963.

The mad pride movement has taken up King's banner of “creative maladjustment” to describe our



Calvin Moen

adaptations to a society that does not support and care for all of its members. In doing so, I hope we have not forgotten its racial justice origins.

Often I hear members of marginalized groups either distancing themselves

from other oppressed people (“We’re not like them, we deserve better treatment”) or co-opting and conflating experiences of marginalization (“We are treated just like them, why don’t you care about us, too?”).

Because psych survivors are also brutalized by police and criminalized by a system that narrowly defines acceptable behaviors, we have a common cause with people of color and others who experience similar mistreatment at the hands of state authorities.

As a queer white person who considers himself part of the mad/peer/survivor movement, I’ve noticed that my peers and I tend to see ourselves in the struggles of some folks and not others. We care most about what happens to people who look like us, talk like us, behave like us.

In beginning to cultivate a broader definition of who is included in “us,” I would like to see our (majority white) psych survivor community showing up for the Black Lives Matter movement in powerful and concrete ways.

As I was working with others from the Hive Mutual Support Network, getting ready to celebrate Creative Maladjustment Day in Brattleboro in July, I started to feel like every other day brought fresh news or reminders of some injustice.

On July 5 and 6, police murdered two Black men in 24 hours in a year that has seen (as of this writing) at least 169 police murders of Black people in the U.S. — a year that’s only half over.

July 6 was the 24th anniversary of the drowning death of Marsha P. Johnson, a Black trans

woman activist whose death was quickly ruled a suicide and blamed on her own mental health, despite contemporary testimony that she had been harassed and threatened earlier that day.

Also on July 6, the US House of Representatives passed the Murphy Bill, which increases forced medication for people diagnosed with “serious mental illness,” takes away their privacy protections, and limits peer-to-peer support and advocacy for rights violations. This legislation directly blames people with psychiatric labels for the mass shooting at Sandy Hook Elementary School.

I thought back to June, during which I had celebrated LGBTQ pride with my friends, and during which a Florida security guard of Arab descent shot and killed 49 people — mostly Puerto Rican — at a queer nightclub in Orlando. The shooter himself was killed by police. The media quickly characterized him as a Muslim terrorist with a history of mental health problems.

I thought back to March, in which police shot and killed a white man in his 70s in his Burlington home, later calling him “emotionally ill.” Police said they had spent hours negotiating and attempting to deescalate his “threatening” behavior.

Each of these events seemed to be pointing to values in our culture and who gets dismissed — whose lives matter least in our justice system. There is so much more than my short list above, but this snapshot of just a few months had my head spinning with overlaps and connections.

At a recent VPS staff meeting, we discussed similarities between police killings of Black people and those with psychiatric labels. Why do law enforcement personnel seem to place less value on those particular lives than others? Why are they so quick to shoot with deadly aim, while showing more skill and patience in apprehending others nonviolently? Why doesn’t the judicial system hold those officers accountable for their lethal violence? Do officers simply need more and better training, or are there more systemic root causes of their bias?

In addition to demanding more and better training for law enforcement, there are plenty of concrete actions we can take. To start with, we can challenge our own reliance on coercive systems in difficult situations. What are some alternatives to calling 911 or police that already exist in our communities, or that we can help create?

Those of us who are able can show up to demonstrations, protests, benefits, and other events organized by Black Lives Matter or affiliated racial justice groups. At our Creative Maladjustment Day events, we collected donations for the families of the two Black men who had just been shot and killed by police. As always, we can have conversations with our friends, family, and neighbors — particularly those who are quick to assume that a victim of state violence must have done something to provoke it.

Systems of oppression like white supremacy, ableism, and homophobia and the systems that carry them out — law enforcement, the mental health system, the judicial system — do not operate in silos. Harm done to one of us affects all of us in different ways to varying degrees. Some of us even benefit from these systems, whether or not we realize it or have asked for it.

We have celebrated our own forms of maladjustment — our survival mechanisms and our identities that mainstream society pathologizes and devalues. We need to go a step further and cultivate maladjustment to white supremacy, to militarism in our law enforcement, to unchallenged violence against Black and brown people, trans women, poor people, Muslims, immigrants, prisoners, and those with psychiatric labels. In order to realize the “good society” King envisioned, we can’t leave anybody behind.

I am reminded of the poem by German pastor Martin Niemöller about the Nazi holocaust:

First they came for the Socialists, and I did not speak out —

Because I was not a Socialist.

Then they came for the Trade Unionists, and I did not speak out —

Because I was not a Trade Unionist.

Then they came for the Jews, and I did not speak out —

Because I was not a Jew.

Then they came for me — and there was no one left to speak for me.

Our liberation is bound up with one another’s. Let’s work together.

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

Do You Have an Issue To Discuss with Other Survivors?

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Counterpoint, The Service Building, 128 Merchants Row, Room 606, Rutland, VT 05701, or to counterpoint@vermontpsychiatricsurvivors.org. Names may be withheld on request, but must be included in letter or commentary. Please identify your town.

Letters or commentaries do not represent the opinion of the publisher, and may be edited for length or content.

THIRD PRIZE, POETRY**Christmas Farewell**

by Kenn Ash

Walking down the snowy street
so bright with colored light
Christmas music everywhere
and smiles fill the night.

Couples strolling hand in hand
greeting one and all
Laughter echos 'round me
as I walk my darkened hall.

I climbed the stairs so wearily
until I reach my floor
and say "hello" to the faded Santa Claus
hanging on my door.

My thoughts return to when she was there
And we called each other "hon,"
when Christmas time and all the time
used to be so much fun.

Church bells rang at night
when we'd toast the spirit high
then opened gifts we'd shopped so long
I remember with a sigh.

I stare at my twelve inch Christmas tree
I got from the five and dime
there were better, bigger and brighter
but, that was another time.
I glance around the quiet room
dark, save my little tree
here and there a picture
of how I used to be.

With friends and loves and caring smiles
happy times I do recall
but now I sit here all alone
fading memories of them all.

The clock is now at midnight
and my mind has no more lies
and I toast once more to no one
and wipe the tears from my eyes.

I briefly see an image
of my Mom within my brain
her loving face provokes a smile
I almost seem to feign.

My mind's now fully focused
as I look down the cold steel pipe
And as my finger pulls the trigger
I say, "Don't believe the hype."

*Kenn Ash is from Bennington***SECOND PRIZE, POETRY****If I**

by Kevin Cook

If I were the sun,
I would shine all day.
If I were the rain,
I would rain all day.
If I were the snow,
I would snow all day.
If I were the moon,
I would light up the night.
If I were a star,
I would never fade away.
If I were a cloud,
I would never get in the way.
If I knew what I was,
I would not be saying "If I" this way.

Kevin Cook is from Orleans

FIRST PRIZE, POETRY**Everything Remains Still-Paralyzed**

by Emily Dooley

The colors have changed
 The faces are different
 The smells are sickening
 The sounds are unfamiliar

But the fears are still the same
 The hate is still there, we can't recognize it anymore
 But the evil is still present; the love is gone, vanished
 The feeling of dread is all around; the dark has consumed everything,
 The sun shines, but there is no light
 Everything remains still-paralyzed

This feeling is overwhelming, yet all is calm
 There is warmth, but we are numb
 There is pain, but we cannot feel
 We know so much, yet we know nothing
 Emptiness all around yet remains unnoticed
 We stand in crowds, and yet we're all alone
 We see so much, but we are unable to understand
 We hear everything, though it makes no sense
 We are lost, never to be found
 Everything remains still-paralyzed

Nothing has been done, yet there is so much to do
 Though we knew this time would come, we still did nothing
 Dreams no longer exist
 Memories have all faded into black
 Everything remains still-paralyzed

We're all so different, yet we're all the same
 Alas no one cares; our compassion is gone replaced with a cold emptiness
 No one thinks to question, for they are unable
 Don't bother fighting it, we're all too weak
 All that we believe will be proven untrue
 We all have the same destiny, don't attempt to control, for control does not exist
 We are nearing the end; the light has begun to fade
 Everything remains still-paralyzed

The blackness has become so thick, we can no longer see
 The silence has become so loud, we can no longer hear
 The smells have become so rotten, we can no longer smell
 We've become numb, in turn we feel nothing
 Soon we will know nothing but fear
 We remember nothing but evil, but we no longer recognize either
 We are so oblivious, that we do not realize something is really wrong...
 Everything remains still-paralyzed

Then blackness, it's over, in the blink of an eye
 Like no one or nothing ever existed
 The silence eternal, the darkness forever
 Everything remains still-paralyzed

FIRST PRIZE, PROSE

Angel in My Closet

by Vesna Dye

There's an angel in my closet. Mom doesn't believe me but Grandma does. "I've seen him, too," she says earnestly. He is dressed in a red robe and has long, blonde hair, a magic wand or something that looks like it, tucked under his right wing."

Grandma and I are psychics — we see things the others cannot see. It's not because we watch the TV serial "Medium" — it's because it's the truth. We just have to keep our gifts secret, otherwise it would look like we're both nuts.

We moved to this place in the Northeast Kingdom almost a year ago, fresh out of Boston. My parents are divorced. Dad had left our small apartment and moved to Arizona with his girlfriend. Dad is a carpenter; he built a doll house for me last Christmas. Sometimes he writes to me from Phoenix, says he's happy there, it's warm and sunny and his job is close to his new home.

He never writes to Mom — I know why. It's because she'd thrown a chair he made at him. She often threw things at him; Mom has never been the kind of woman to tolerate him smelling of whiskey and calling her "black bitch."

"Black bitch, you tricked me into marriage when you got pregnant. I stayed with you only because of Ruby. She's growing up, I can go now, have my freedom, my own life."

I never asked Daddy to stay with us. It's between Mom and him — I'm a big girl now, I'll be 10 in June. I can roller skate, swim better than the boys in my class, I can sing, I write poems and am learning to play guitar. I can do much more than that, but — I've already mentioned — I have to keep my psychic gifts a secret.

But then — there are those other, dark beings I'm afraid to see, such as devils or witches. Grandma says she'll teach me how to protect myself.

She reads me this book about Positive Thinking. We do the exercises together; we have to try to see good in whatever appears to be bad. Grandma says some people seem bad because they were hurt or mistreated

as kids. She says we need to look deeper into people's hearts, not judge them if they misbehave.

"Was Daddy hurt as a kid?" I asked her once when we were going to pick berries in the woods.

"I'm sure he was," Grandma said. "He never talked about it though. Some people are like that — they bury their hurt inside them, until it starts ripping them apart."

"Is it like carrying a knife inside your heart, Grandma?"

"Guess it must feel that way, Ruby."

My father collected gemstones when he was young. He's still young, but he doesn't collect gemstones anymore. He wrote to me he doesn't have the time now. Grown-ups never seem to find time for what is important. He named me Ruby; it's a gemstone of love and passion.

The name suits me — I'm like a wildfire, I burn inside from passion for life. Sometimes I feel like an eagle, flying high, watching the people down below. I wish people would be kinder to one another, I wish the knives inside them would become dull and they would not hurt anymore.

Sometimes I feel like a dolphin, swimming joyfully in the ocean, my Mom and Dad swimming beside me, making sure there's no shark around to scare me. Sometimes I feel like a lion cub, playing with her brothers and sisters.

I never had a brother or a sister. Mom said it was difficult enough to bring me into the world. She lost a lot of blood during childbirth, and didn't want to have another kid. There again — the color red.

Red is my favorite color, the kind of red when the summer sun sinks down to rest in the warm evening. Red like a fire that burns in the forest in summer.

Summers are too short in the Northeast Kingdom. I swim in the pond, collect stones on the beach, make jam with Grandma from berries we'd picked, read books and go hiking with my friend Lucy.

I don't have many friends like other kids — I'd rather have one good friend, like Lucy. Lucy is, beside Grandma, the only

person who understands me. Lucy is my age, but she is like a wise old woman. She reminds me of an owl. We don't seem to fit with other girls in our school. We don't play computer games, we don't like dressing up and we don't have cell phones.

We tell the kids in our class that we don't need cell phones — we communicate telepathically. They look at us in a strange way. You know, that kind of look that says: "You fell from another planet."

I like studying about planets — Mars is my favorite planet, huge and fiery. Once I saw a fairy that looked like an alien. She had huge, slanted black eyes and red curly hair. I thought she came from Mars. I didn't have time to ask her — these beings come to me for only a very short time and anyway, they can't speak. Very rarely do they appear in summer — mostly I see them in winter, usually around Christmastime.

I like the Northeast Kingdom, the mountains and forests and lakes, but I don't like seeing the snow. Everything disappears under heavy snow flakes, like a shroud covering the whole country. I don't like white; for me, it's the color of Death. When it snows, I like to be indoors near a fireplace, with a cup of hot chocolate and cookies.

Sometimes in winter I see a tall lady dressed in a white fur coat, her eyes are like crystals and she never smiles. Whenever I see her, I hear bad news so I always tell her to go away. Last winter I saw her through the window. That night, my cat died — a truck ran over her. I cried so hard, I made myself sick. It was the night before Christmas and I couldn't enjoy it.

"Don't cry so much, otherwise the knife inside you will grow bigger and sharper," Grandma said. "We'll get another cat."

We got a new cat a few months after our cat died; she looked a lot like our last cat, black with a white spot under her chin. I told Grandma she must be the reincarnation of her. Grandma agreed.

My Mother never believed in such nonsense, as she called all that "psychic stuff."

(Continued on page 21)

Angel in My Closet

(Continued from page 20)

My Mother is a hard-working woman, spending her days in her hair-salon. She loves to curl my red hair, or braid it. I look like my father more than like her, except for a bit darker skin.

My Mother always disappears at Christmas time. Usually, she visits her sister in Spokane or goes to Hawaii with her friend. She says she needs her time off and Grandma and I respect that.

This Christmas grandma got us a big fir tree, we decorated it the old-fashioned way, with popcorn and cranberries. We always bake our own pies and cookies, read Christmas stories to each other and sing Christmas songs.

Grandma and I don't like to buy Christmas gifts in stores. Grandma says those are all made in China anyway. We make our own gifts - Grandma knits socks and scarves and I make paper angels. I like to draw and color my angels in bright colors, with long blonde hair; just like the one that appears in my closet.

"Grandma, I'll tell angels what gift I want for Christmas," I tell her.

"I know what you want," she says.

"Really? I'll sweep the kitchen floor if you guess it right," I promise.

"Ruby, you want a new guitar. You need a good one, that old yard-sale guitar is not enough for you anymore."

"I'll get the broom," I say, "Then we'll wrap our surprise gift for our angel in the Closet."

The floor is swept; our little house smells of gingerbread hearts and apple pie. Grandma puts a log in the fire; I put out a meat pie for our cat. Outside, it's snowing heavily. I draw the curtains, but I can still see the flakes through the laced fabric.

"Let's open the closet door now," Grandma says. The door squeaks. Grandma is behind me, flashlight in her hand. We wait for a moment ... We are absolutely silent ... We wait ... Then I hear a sigh; but it's not our angel - it's Grandma.

"He's gone," she whispers.

"He left us on Christmas Eve," I say, suppressing my tears.

"Think positively - he left because someone else needs him more," Grandma says.

"But I need him, Grandma, Mom and Dad are not with me, they never are with

me at Christmas." I cry now.

"At least Father built me a doll house last Christmas, but now he moved far away and he didn't even send me a Christmas gift." I cry louder now.

Grandma is silent. Then I hear her scream.

"What the hell is that?" she points to the window. I come to the window; there, between a pile of snow and a fir tree, I see a tall woman in a white fur coat. She looks at me with her icy eyes... I scream... Then a phone rings. Grandma answers: "Where, you said? Five miles out of Burlington? An accident?"

I knew what happened even before Grandma put the phone down ...

I see him, in a ditch, his head bleeding, drops falling on the white snow... Broken guitar near his feet.. I can smell whiskey on his torn shirt ...

"I know, Grandma, I know," I say, now in a calm voice. "I'll never get my new guitar. But I will keep his doll house even when I grow up ..."

Vesna Dye is from Essex Junction

Announcing

The 2016 Louise Wahl Memorial Writing Contest

Prose

First Place — \$100

Angel in My Closet

Vesna Dye, Essex Junction

Second Place — \$50

The Cherry of That Family

Fred Trombly, Colchester

(to be published in the Winter
Counterpoint)

Poetry

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Everything Remains Still-Paralyzed

Emily Dooley, Brattleboro

Second Place — \$30

If I, Kevin Cook, Orleans

Third Place — \$20

Christmas Farewell

Kenn Ash, Bennington

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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.

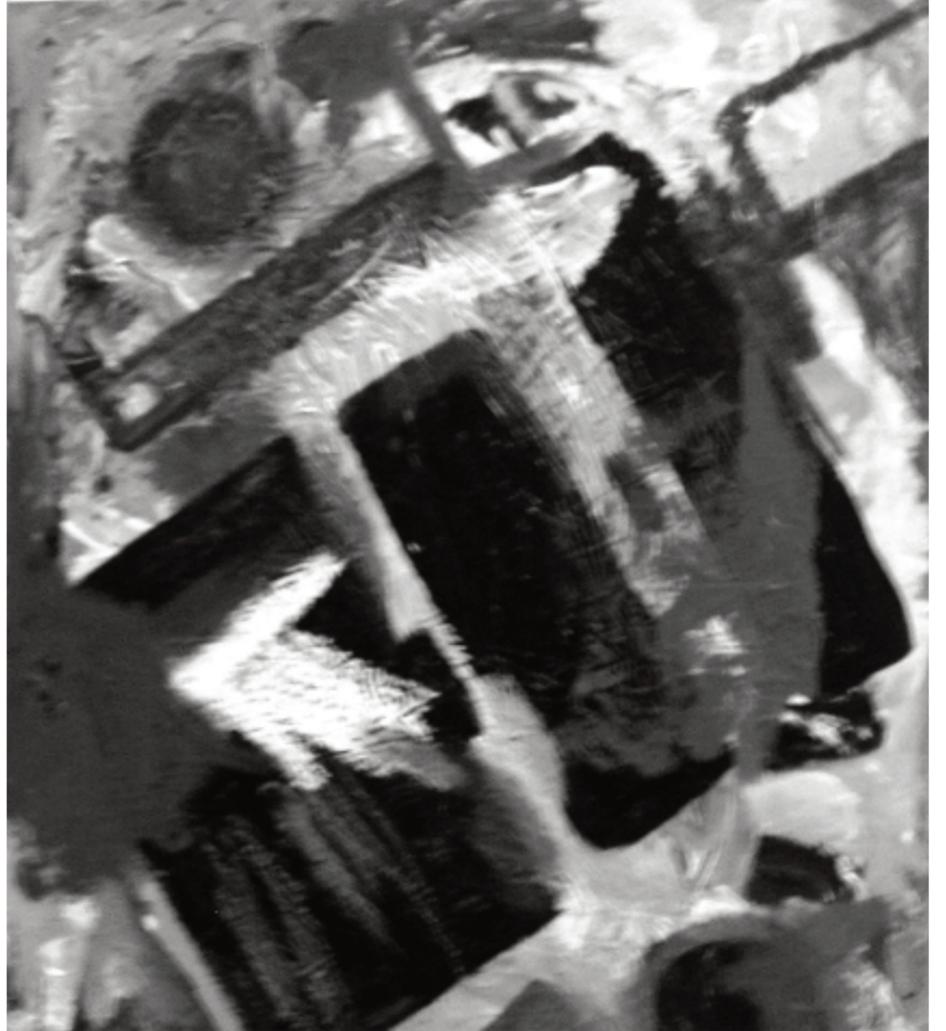
Contest Deadline March 15, 2017

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.

Arts



'Cutest Cubist Puppy'



'Colors of the World' by VB

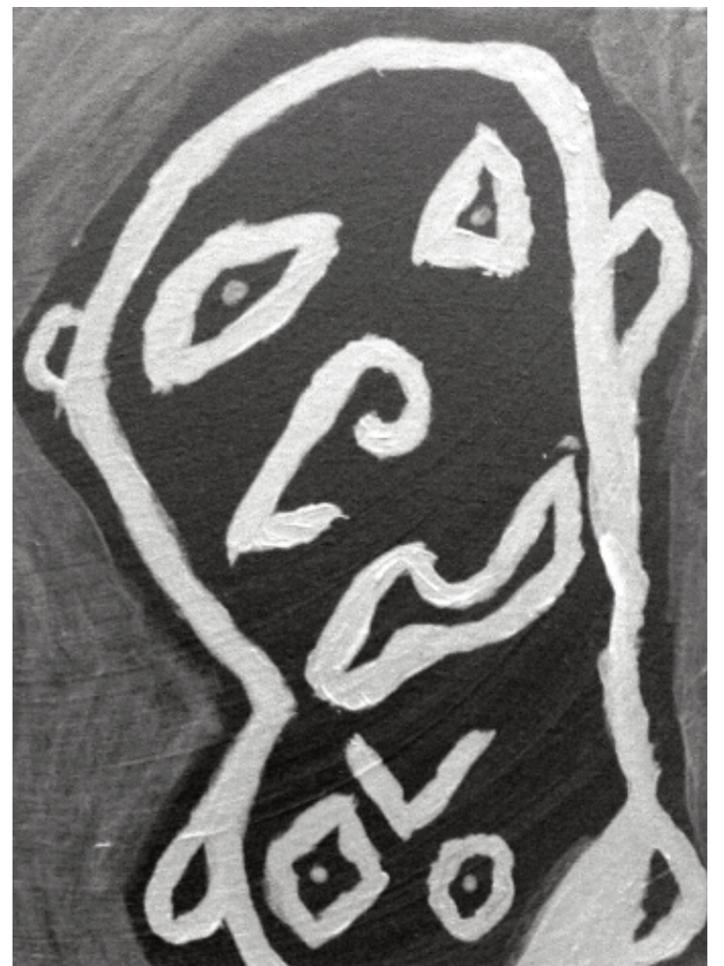


'Google Image Collage' by J#J

The Howard Center Arts Collective presented a show this past summer at the Burlington Record Plant on Pine Street. This is a small sampling of the works on display and for sale.



'Field Dogs' by ABJ



by TLJ

The Moons Behind My Eyes

Look into my eyes and notice –
they are darker than a nightmare,
swimming with secrets and thoughts
that I can't tell you because they would make you shiver,
because for some twisted but understandable reason
these negative forces feed into the part of me that wants to be punished
for who I am

Nobody wants to feel this way
unless it,
for some reason,
becomes familiar and even safe
to feel this way
But even then...

To remember this, helps:
we all seek belonging
in a world where we are all connected
yet at times feel painfully alone
we are all born from the stars
My heart is made of angel wings
My skin is birch bark that peels in the summertime and my lips –
the petals of a white rose
what are you made of?

My eyes have turned
black as the thoughts race through my veins,
ache in my stomach
But behind my eyes are two full moons,
and the moon never ceases to appear,
glowing through the dark

by Emma Benard

CALLING WILLIE

You are so ill and far away,

But you are an old tree in my heart,
Other men are but twigs.

Willie, when we met it was

A quiet whisper in the night,

Soft and yet so true.

But now my heart is lost,

Lost in a jungle of pain and sorrow.
I call out your name as if
You could hear my heart's gasp.

by Mary Lisa Pine
Rutland

A Path to Hope

I saw a man today by the side of the road, shivering in below freezing weather,
as cars drove by. Not seeing him
or not wanting to

He held a sign with a quiet, desperate scrawl that pleaded,
"Homeless, hungry please help."

"That could be me," whispered a terrified and defeated voice inside, stripped by
the realities of losing my daughter, almost losing my mind and my life, my dog, my
work, my home and probably, most importantly, hope and a sense of purpose.
As I contemplated my intense, unexpected relentless suffering, these wise words
came back to me

"Home is not a dwelling, it is about what you create."

Finding a path to hope, I've discovered, is a gift and a process.
I've learned that it is about life's journey through joy and despair,
abundance and loss,
beginnings and endings.

And new beginnings.

It is about walking the road with friends who don't just "wish you happiness,"
because as Anne Morrow Lindbergh painfully writes after her young son's kidnap-
ping and murder,

"I don't expect to be happy all the time.

It's gotten beyond that somehow."

Finding a path to hope is about not being unhappy all the time.

And finding hope again.

She writes, "Wish me courage and strength, and a sense of humor.

I will need them all."

by Alana RaQuel Nancy Hodgkins
Burlington

**Got
Poetry?
A Story?
A Picture?**



Share Your Art!

Send to:
Counterpoint,
The Service Building, 128
Merchants Row, Room 606,
Rutland, VT 05701 or to
counterpoint@vermont
psychiatricsurvivors.org.
Include name and address.

Resources Directory

Survivor Peer Services

Vermont Psychiatric Survivors Peer Support Groups

Brattleboro: - Changing Tides, Brattleboro Mem. Hosp, 17 Belmont Ave., Brattleboro; every Wednesday, 7-8:30 p.m.

Call Sandra at 802-579-5937

Bennington/UCS - United Counseling Service, 316 Dewey St., Bennington; Mondays and Wednesdays, noon-1 p.m.

Call UCS at 802-442-5491

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

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

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

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

www.vermontpsychiatricsurvivors.org

Peer Support

Warm Lines

Vermont Support Line (Statewide):
888-604-6412; every day, 3-11 p.m

Peer Access Line of Chittenden County: 802-321-2190, Thurs-Sun, 6-9 p.m.; residents of Chittenden County.
Washington County Mental Health Peer Line: 802-229-8015; 7 days/wk, 6-11 p.m.

Mutual Support Network

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

Crisis Respite

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

Peer Centers and Employment Support

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

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

Vermont Recovery Centers

www.vtrecoverynetwork.org

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

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

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

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

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

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

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

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

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

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

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

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.

National Suicide Prevention Lifeline

1-800-273-TALK (8255) 24/7 confidential support

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.wholevpeb.com/

Pride Center of Vermont LGBTQ Individuals with Disabilities Social and Support Groups

Connections and support around coming out, socializing, employment challenges, safe sex, self-advocacy, and anything else! **Burlington**, Wednesdays, 4:30 p.m. at Pride Center, 255 S. Champlain St.

Brain Injury Association

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

DBT Peer Group

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

Trans Crisis Hotline

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

Crisis Text Line

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

LGBTQ Youth Crisis Hotline:

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

NAMI Connections Support Groups

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

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

Montpelier: Every Friday 2-3:30 pm; Another Way, 125 Barre St.

Newport: Every Wednesday 6-7:30 pm; St. Mark's Episcopal Church, 44 Second St.

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

St. Johnsbury: Thursdays 6:30-8 pm; Universalist Unitarian Church, 47 Cherry St.

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

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

Veterans' Services:

www.vermontveteransservices.org

Homeless Program Coordinator: 802-742-3291

Brattleboro: Morningside 802-257-0066

Rutland: Open Door Mission 802-775-5661

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

Burlington: Waystation/Wilson 802-864-7402

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

Homeless?

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



www.MakeTheConnection.net

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

Public Community Mental Health

Counseling Service of Addison County, 89 Main St., Middlebury, 95753; 388-6751

United Counseling Service of Bennington County; P0 Box 588, Ledge Hill Dr., Bennington, 05201; 442-5491

Chittenden County: Howard Center, 300 Flynn Ave., Burlington, 05401; 488-6200

Franklin & Grand Isle: Northwestern Counseling and Support Services, 107 Fisher Pond Road, St. Albans, 05478; 524-6554

Lamoille County Mental Health Services, 72 Harrel Street, Morrisville, 05661; 888-5026

Northeast Kingdom Human Services, 181 Crawford Road, Derby; 334-6744; 800-696-4979, 2225 Portland St., St. Johnsbury; 748-3181; 800-649-0118

Orange County: Clara Martin Center, 11 Main St., Randolph, 05060-0167; 728-4466

Rutland Mental Health Services, 78 So. Main St., Rutland, 05701; 775-2381

Washington County Mental Health Services, 9 Heaton St., Montpelier, 05601; 229-6328

Windham and Windsor Counties: Health Care and Rehabilitation Services of Southeastern Vermont, 390 River Street, Springfield, 05156; 886-4500; 51 Fairview St., Brattleboro, 05301, 254-6028; 49 School St., Hartford, 05047, 295-3031

24-Hour Crisis Lines:

Involuntary Custody Screening

(Addison County) Counseling Services of Addison County 802-388-7641

(Bennington County) United Counseling Service, 802-442-5491 (Manchester) 802-362-3950

(Chittenden County) Howard Center (adults) 802-488-6400; First Call: (child/adolescents) 802-488-7777

(Franklin and Grand Isle Counties) Northwestern Counseling and Support Services, 802-524-6554; 800-834-7793

(Lamoille County) Lamoille County Mental Health, Weekdays 8 a.m.-4 p.m. 802-888-4914; Nights and weekends 802-888-4231

(Essex, Caledonia and Orleans) Northeast Kingdom Human Services 800-696-4979

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

Rutland Mental Health Services, 802-775-1000

Washington County Mental Health Services, 802-229-0591

(Windham, Windsor Counties) Health Care and Rehabilitation Services, 800-622-4235

Vermont Veterans Outreach:

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

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

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

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

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

Jericho Area Outreach: 802-899-5291; cell: 802-310-0631

Newport Area Outreach: 802-338-4162; cell: 802-399-6250

Rutland Area Outreach: 802-775-0195; cell: 802-310-5334

Vergennes Area Outreach: 802-877-2356; cell: 802-881-6680

White River Area Outreach: 802-295-7921; cell: 802-881-6232

Williston Area Outreach: 802-879-1385; cell: 802-734-2123

Outreach Team Leader: 802-338-3022; cell: 802-881-5057

Toll-free Hotline (24/7) 1-888-607-8773

VA Mental Health Services

VA Hospital: Toll Free 1-866-687-8387

Mental Health Clinic: Ext 6132

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

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