Criminal Courts Stymied by Lack of Hospital Space

Special Report, Back Page

News, Commentary and Arts by Psychiatric Survivors, Mental Health Consumers and Their Families

Counterpoint

Vol. XXVIII No. 3 | From the Hills of Vermont | Free! | Since 1985 | Winter, 2013

Opposition Stalls Soteria Beds

by ANNE DONAHUE
Counterpoint

BURLINGTON — The residence under development here to provide an alternative to hospital stays is facing last-minute challenges that may delay a projected opening from early in 2014 to at least the spring, its director has confirmed.

Both the City and HowardCenter have applied for interested party status in a state regulatory process for a Certificate of Need for new health care projects. If either receive that status, the Soteria proposal will no longer be eligible for an expedited review — something that would have been needed to stay on schedule, said Soteria Vermont Project Director Amos Meacham

"It's disappointing," Meacham said, but "they have some things they need to have answered" and "this is part of the process." Soteria is part of the expansion of community services funded under Act 79 in 2012 after the state hospital was closed by flooding from tropical storm Irene, in order to allow for less reliance on hospitalization when it might not be necessary.

The City said Soteria has a "direct and substantial impact" on it, the standard required for receiving party status, because it believes the program will create an increase in demand for police services and that the proposed location in the Old North End is not appropriate.

HowardCenter said that as the state's designated agency to provide mental health services in Chittenden County, it has an interest in ensuring that access to clinical services is adequate for program residents. Soteria will not have clinical staff, but will rely on connecting residents with services in the community, HowardCenter noted.

Act 79 directed that the program be "peer-supported and noncoercive" with treatment "focused on a nontraditional, interpersonal, and psychosocial approach, with minimal use of psychotropic medication." Despite the critical comments in its

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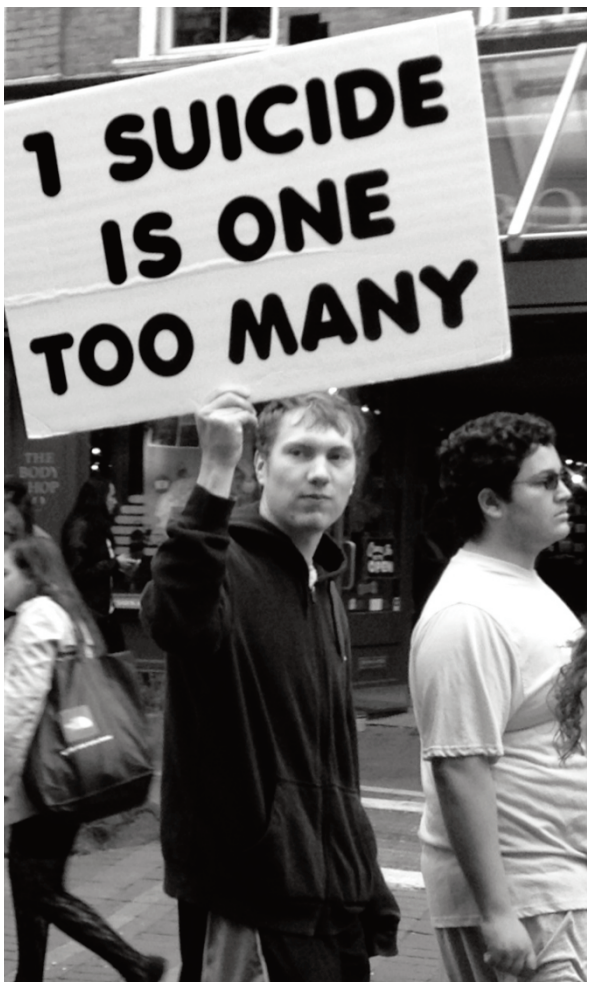

SUICIDE AMONG YOUNG ADULTS outranks car accidents as a cause of death, but receives less attention, and students are taking action to educate others. Above, a participant in the fall "Out of the Darkness" Walk in Burlington. See article, page 4.
(Counterpoint Photo: Donna Iverson)

Attention Lost On Youth Needs

MONTPELIER — Days of waiting in emergency rooms for lack of inpatient beds. Increases in severity of illness. A lack of resources.

It sounds like the type of crises the adult mental health system has been facing since the state hospital closed more than two years ago — but it isn't.

It is about services for children, as heard by the Mental Health Oversight Committee this fall, after legislative leaders decided that attention to children's needs had been ignored as a result of the crisis in the adult system. The committee heard testimony about stresses in the system, but also about new efforts to address youth suicide and other issues of young adults and

(Continued on page 4)

Bill This Year Will Debate Expediting Forced Drugs

MONTPELIER — A subject that has lurked in the shadows for years appears destined for a showdown in the legislature this spring: whether to change the law to allow a faster process for a court order for psychiatric medication over a patient's objections.

Leaders in both the Senate and the House told *Counterpoint* they anticipate the issue will be raised this session, and Governor Peter Shumlin has made public statements supporting quicker action to administer involuntary drugs.

Hospital representatives have pressed for a change for years, and have lobbied this past summer and fall with legislators, testifying that long hospital stays by "unmedicated patients" have contributed to the shortage of psychiatric hospital beds.

"I have been approached by legislators; I have been approached by the administration; I have been approached by advocates," House Speaker Rep. Shap Smith said, explaining why he believed a bill would likely come forward.

Sen. John Campbell, the Senate leader, said that he, too, thought a bill would be taken up in the new year, based upon "hearing back from some of my members."

Despite the governor's comments, the Commissioner of the Department of Mental Health, Paul Dupre, said in late November that he hadn't decided upon a course of action yet.

"I'm still kind of listening to see where things are" and to "try to see if the judicial system can be streamlined" while still protecting the civil rights of individuals, he told *Counterpoint.*

At a meeting of a work group that was reviewing a number of aspects of mental health law, he said he had visited all three of the state's highest-acuity hospital units and that there were "high, high danger levels" at times because of patients who were not accepting treatment.

"There's some real stuff out there that has to be dealt with," he told the group.

Rights advocates have also been speaking up, urging others to recognize the trauma that forced treatment causes. Morgan Brown said that forced medication was "the worst that the state can do." It is not just about patient rights, he said, "It's their dignity, their self-respect."

Dupre told members of the Transformation Council in November that the Department would be gathering data to identify the current time frames and delays, but he was challenged about the sincerity of discussion about it. "I cannot see how you can have an honest conversation" about data when

(Continued on page 3)

Opportunities for Peer Leadership and Advocacy

Meeting Dates and Membership Information for Boards, Committees and Conferences

Peer Organizations

Vermont Psychiatric Survivors
Must be able to attend meetings bi-monthly. Experience with boards preferred but not necessary. For more information call (802) 775-6834 or email vpsinc@sover.net

Counterpoint Editorial Board
The advisory board for the VPS newspaper, assists with editing. Contact counterp@tds.net

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

Alyssum Peer crisis respite. To serve on board contact Gloria at 802-767-6000 or Alyssum.info@gmail.com

NAMI-VT Board of Directors:
Providing "support, education and advocacy for Vermonters affected by mental illness." Contact Marie Luhr, mariel@gmavt.net, (802) 425-2614 or Connie Stabler, stabler@myfairpoint.net, (802) 852-9283

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

Hospital Advisory

Vermont Psychiatric Care Hospital
Advisory Steering Committee suspended; new format for future advisory group now under review; For advisory group for Green Mountain Psychiatric Care Center [Morrisville], contact the Department of Mental Health (Jeff Rothenberg) for further information.

Rutland Regional Medical Center
Community Advisory Committee; fourth Monday of each month, noon, conference room A.

Fletcher Allen Health Care
Program Quality Committee; third Tuesdays, 9 -11 a.m., McClure bldg, Rm 601A

Brattleboro Retreat
Consumer Advisory Council; third Tuesdays, contact Retreat at 800-738-7328.

State Committees

Program Standing Committee for Adult Mental Health
Advisory committee of peers, family members, and providers for the adult mental health system. Second Mon. of each month, 12-3 p.m.; Redstone Bldg, 26 Terrace St., Montpelier. Stipend and mileage available. This committee is currently looking for new members who have an interest in working to improve the system of care in Vermont. The committee is the official body for review of and recommendations for redesignation of community mental health centers and monitors all aspects of the system. For more information, contact the Department of Mental Health (Melinda Murtaugh).

New members under active recruitment!

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

Transformation Council
Advisory committee to the Commissioner on transforming the mental health system. Third Monday of each month, 12:30-2:30 p.m.; Redstone Bldg, 26 Terrace St., Montpelier, Contact the Department of Mental Health (Judy Rosenstreich).

CORRECTION

Locked Versus Open Programs

Some confusion occured about different programs that were updated in the same article in the fall ***Counterpoint.*** The secure residence in Middlesex is a locked program, as are all hospital units. Second Spring, Second Spring North, Meadowbrook and Hilltop House are all voluntary residences.

How to Reach
The Department of Mental Health
Redstone Building, 26 Terrace Street,
Montpelier, VT 05609-1101
802-828-3824
http://mentalhealth.vermont.gov/
For DMH meetings, go to web site and choose "calendars, meetings and agenda summaries."
E-mail for DMH staff can be sent in the following format: FirstName.LastName@state.vt.us

Patient Rep Again Seeks Contributors For Christmas Gifts

RUTLAND — In the third holiday season since the closing of the Vermont State Hospital, contributions are again being solicited by a peer for Christmas gifts for patients who are involuntarily hospitalized.

Kitty Gallagher, now a patient representative at several of the hospitals, said that there are more challenges in delivering gifts now that patients are spread among different hospitals with different policies on what items can be donated. However she said her determination to ensure that patients are not forgotten at Christmas has not changed.

Financial contributions towards the project can be made out to Gallagher with "Christmas gifts" on the memo line of checks, and mailed to Her care of Vermont Psychiatric Survivors, 1 Scale Ave., Suite 52, Rutland VT 05701. AD

Counterpoint

1 Scale Avenue, Suite 52, Rutland VT 05701
Phone: (802) 775-2226
outside Rutland: (800) 564-2106
email: counterp@tds.net

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Have News To Share?
Send It to *Counterpoint!*
Your peer newspaper

1 Scale Ave, Suite 52, Rutland, VT 05701
or counterp@tds.net

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Back Issues can be accessed at www.vermontpsychiatricsurvivors.org

VAMHAR Sets Its New Tone

MONTPELIER — Peter Espenshade, speaking at the first annual meeting of the Vermont Association for Mental Health and Addictions Recovery since taking over as executive director, stressed a new role for the association as a host of a "public square for safe, open and public conversation" on the most difficult issues of the day.

He said that VAMHAR wants to be the "neutral convener" for discussions on issues such as involuntary psychiatric medication and the legalization of marijuana. It was a different emphasis from its past role of advocacy on the issues.

Espenshade also stressed the importance of educating others that "recovery works," and of creating a unified health care system. With health care reform, he said, there was "perhaps a once-in-a-lifetime opportunity to get things right."

He said VAMHAR also wants to be a resource to all those working in the field, adding, "I believe the most beautiful words in the English language are, 'how can we help?'"

The meeting featured presentations by filmmakers Mark Utter and Bess O'Brien, the GYST (Get Your Stuff Together) group for young adults in Lamoille County, the Vermont Federation of Families, and Miss Vermont USA Hannah Kirkpatrick.

Utter addressed the audience demonstrating assisted communication prior to the showing of his film, "I Am In Here." The film shared his inner thoughts as one with autism who cannot communicate with the outside world.

Members of GYST testified about how it built success. Eric Breyette said when he began to attend, "the first week it was for the pizza, the second week it was for the pizza, the third week it was for the people" he met there.

Kirkpatrick, who finished 15th among the 50 Miss USA competitors, described herself as a person in long-term recovery from "suicidal depression and addictions."

She thanked members of the audience for their work, saying "I would not be alive today" but for her own recovery team. AD

STAR OF RECOVERY — Hannah Rose of VAMHAR gives a hug to Bob Wolford after presenting him with the Knight Leadership Award for his "passion, vision and values." He is Coordinator of Criminal Justice Programs at HowardCenter in Burlington.

(Counterpoint Photo: Anne Donahue)

Bill This Year Will Debate Expediting Forced Drugs

(Continued from page 1)

"the administration has already taken a position," advocate Laura Zeigler told him.

The system should not trade off a few weeks in the hospital for the "life-long effect" of trust being broken in a therapeutic relationship, said Ed Paquin of Disability Rights Vermont. He also expressed concern that a faster process would further increase the number of petitions for drug orders.

When Act 114 was passed in 1998, it was based upon an estimate of affecting about 20 persons a year. There were 31 petitions filed in 2010, 39 in 2011, 45 in 2012, and 58 in the 11 months thus far of 2013, according to Jack McCullough of the Mental Health Law Project.

Kitty Gallagher, a patient representative, said that often no explanations are given about why a medication is being prescribed. The result is an exchange limited to a doctor saying, "You will take that," and a patient saying, "No I won't."

"I think we could resolve at least 50 percent [of medication refusals] if we could improve the bedside manner of doctors," she said.

It is "really, really important for everyone to have informed consent," agreed Betty Keller.

She said that wasn't necessarily the job only of the doctor but that there needed to be patient educators, nutrition counseling, and more work with peer support. Don't change the law "until we've really done all these other things," she said.

Others questioned whether hospitals were using motivational interviewing, open dialogue, and recovery planning facilitators.

There are hospitals that have cut back on therapeutic activities, leaving patients with very little to do, and now their involuntary medication applications have increased, Linda Corey of Vermont Psychiatric Survivors said.

As for danger to others in a hospital, it is the "state burden to pay" to create "separate environments" if they are needed, Zeigler said.

In contrast, parent Ruth Grant argued that some persons are "direly ill" and the waiting is too long.

That was also the position of NAMI-VT's legislative advocacy group, which believes that decisions "should be made in a timely manner" that addresses each person's individual needs, said Wendy Beinner.

Hospitals should be "pushing forward with treating people [in other ways] while waiting," as the state hospital had finally learned to do, she said.

In a November meeting on the shortage of inpatient beds, Senator Kevin Mullin of the Health Care Oversight Committee asked if the same number of new hospital beds would still be needed if the law allowed "proper treatment" to occur sooner.

Gordon Frankle, MD, Medical Director at Rutland Regional Medical Center's psychiatric unit, answered that assuming adequate community resources, 25 is the right number for the new hospital in Berlin. However, he said there is a "need to change the law if [25] is to remain the right number," otherwise, no number of hospital beds would ever be enough.

Jeff McKee, Ph.D., Director of the Rutland units, testified at a separate hearing that "the length of time it takes to receive active treatment" means long stays that keep beds unavailable for others who need them. Those patients continue being ill, he said. "During that time they are not getting treatment and they are not getting better." AD

Opposition Stalls Soteria Beds

(Continued from page 1)

party status application, HowardCenter Executive Todd Centybear said that it was not intending to block the project's progress.

"I'm an advocate for this type of program" as part of the continuum of services available, he said. He said HowardCenter wanted to know more about it and to help "figure out how to make sure" Soteria became fully a part of the community. Pathways Vermont — the parent agency developing Soteria — "needs to do more in terms of collaboration," he said. "They would be best served to reach out."

Meacham said he realized that the disruption caused by the party status applications might have been avoided if he had made earlier contacts, but "we were plowing ahead" with the technical aspects such as addressing zoning and planning boards.

"I had no intention to freeze them out," but saw working with other providers as a next phase of program development, he said.

The project has now received its zoning and building permits, but the City challenged the site.

"Locating intensive services of this kind in the most densely populated neighborhood in Vermont enhances the risk to both patients and residents of the neighborhood," its application for party status said.

The City said that residents at Soteria would themselves be at higher risk "based on the proximity of residents and the intensity, frequency, and severity of the stimuli that patients at the facility will be exposed to based on this location."

Meacham disputed that concept. He pointed out the importance of full community integration, which he said can't happen in a rural setting. The City's concern "has to be weighed against the needs of the community and people's rights," Meacham said. "Hopefully it's a chance to raise some awareness."

The 5-bed residence has its contracter ready to go with construction and renovations on the leased house, Meacham said. If a CON had been granted in early December, as he had hoped, that work could have begun before any deep frost.

HowardCenter's application for party status included pages of criticisms of the project description, ranging from asserting a failure to recognize that its residents would likely not be eligible for CRT services, the likelihood of drawing residents in from other parts of the state, and failing to meet CON standards for integration of mental health, substance abuse and primary care.

It also said that the statements for asserting cost-effectiveness were "problematic" because "it is not clear that all or even most of the individuals it would serve would otherwise have been hospitalized. Since Pathways Vermont is targeting nonviolent persons who are opposed to the use of anti-psychotic medications, these are individuals who... would most likely be referred for out-patient treatment."

Centybear said the legal language of the agency's application for party status might have come across as too strongly worded. "The bottom line is... we don't have a position that we don't support Soteria House."

More background about the Soteria model can be found on page 5 of the Winter, 2012 issue of Counterpoint *at www.vermontpsychiatricsurvivors.org/counterpoint/*

Youth Needs Seen as Urgent

With State Hospital Crisis, Attention To Children's Services Was Lost

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mental health. Charlie Biss, Child, Adolescent and Family Unit Director told the committee that residential services were running over budget as the result of increased demand, and children's inpatient admissions at the Brattleboro Retreat were also increasing.

Biss said that the state was in the middle of its last year of a 3-year federal "Youth in Transition Grant" that has proven to be very successful, and one challenge the department was facing was how to sustain the program when the grant ends. *(See article, below.)*

Another division initiative has been the work on prevention of suicide, Biss said. Data show that only 28 percent of all Vermonters who commit suicide have received services, with "many people we would never expect" or see as high risk. That demonstrates the need for a public health model that recognises that "all children need to have mental health support," not just those with specific symptoms or diagnoses.

That approach, however, is a major reason that the Division's budget has gone from $5 million to $88 million in the past 20 years, he said. Half of that is in contracts for school-based services. In addition, needs have increased, he said. "There's been just more and more acute situations." The lack of diversion options and of hospital step-down programs is contributing to the problem, he said.

Peter Albert, who spoke representing the Retreat, agreed. He said that children "get stuck" in the hospital — a place which should be a last resort — because of the lack of community resources both for emergency diversion and for step-down. He said a stronger team approach among all the entities serving children was also necessary.

Albert also made a plea for a change in law so that parents can admit their children to the hospital without a requirement for the child's consent. *(See article, page 8, on the debate over changing the state's mental health laws.)*

A parent, Amy Powers, also testified about the challenges of the system and her son's often unsuccessful years of treatment.

"The conventional mental health system has traumatized my son," she said. She cited high doses of drugs, school restraints in situations when he was not hurting himself or others, and being removed from home and said she often felt bullied by professionals who threatened to taker her son out of her custody. "Drugs are merely a tool rather than a means of attaining well-being," Powers said. They can have serious adverse effects and cause unknown amounts of damage to a developing brain, she tolf the committee, adding that "If I knew then what I know now, we would not have gone the same path." AD

Young Adults Program at Risk As Grant Funding Nears End

MONTPELIER — An initiative for reaching out to young adults is proving itself with an increase in employment, housing and education, and a decrease in criminal justice involvement for the youth it serves.

However, its future is uncertain, Charlie Biss told the legislature's Mental Health Oversight Committee this fall, because its federal grant is running out. The Department of Mental Health will need to find $1.3 million to continue the program.

The Youth in Transition grant targeted new ways to address those from ages 18 to 28 who were not being reached by the traditional system, he said. The grant asked, "How do we talk to young adults?" "How do we go where they are?"

Biss said the initiative has shown that to provide meaningful services, the focus must shift to youth leadership and empowering all young adults.

At a fall meeting of the YIT leadership team, members worked on how agencies across the state can make services more welcoming to young adults.

"What does welcoming look like?" asked Joy Livingston, a facilitator from the grant oversight contractor, Flint Springs Associates. She said it can't just be, "we know it when we see it." Measures are required to show accountability for results, so for this part of the initiative, the measures need to be "assessing [the] degree to which a program is welcoming to young adults."

The team identified its very top measures out of a list that had been developed at earlier meetings:

- As a welcoming "face" of a program, to have accessible language on written and electronic materials understandable at all reading levels;
- As a welcoming space, to have trained and friendly greeters; a space created by those who use it (both simple, uncluttered space and informal, filled space); and to have the setting clean and in good repair;
- As a welcoming community, not to use clinical language and to use supportive, not directive assistance; and to focus on support needs, not diagnosis;
- For welcoming policies, to provide support "on-the-spot, not just through appointments;" and
- For welcoming activities, engaging people in multiple ways, including sharing food, music and art.

The team also began a discussion about how peers can "tell the story" of their experiences as an advocacy tool. This is a part of creating sustainability, or convincing others of the need for ongoing support of the project, said Donna Reback, also with Flint Springs. AD

Students Respond To Suicide Crises Among Their Peers

MONTPELIER — Young adults are becoming more involved in fighting stigma against mental illness and helping to prevent suicide among peers, the legislature's Mental Health Oversight Committee learned this past fall. University of Vermont students have a chapter of the college suicide prevention group, Active Minds. South Burlington High teens, some of them who have attempted suicide themselves, are learning to help others. A Norwich University student hosted a presentation from a volunteer suicide prevention group this fall.

Jenna Sweet, 20, testified to the committee representing Active Minds at UVM. The university has a good counselling program, she said, but not nearly enough support for someone with a severe illness, like a close friend who was hospitalized after cutting herself.

John Everett, 17, said he spoke as someone with the personal experience of feeling the "urge of suicide from the age of 11." He survived two suicide attempts, and urged the committee, "we need more outpatient services" and "we need more preventive services."

Kendra, 17, said that "our society frowns on asking for help... [seeing it as] a sign of weakness" instead of an illness like any other. Education about mental illness needs to begin much earlier in schools, she told the committee.

Brittany, 17, another member of the South Burlington "Big Picture" program, said that when her best friend attempted suicide, "I had to wrap my head around" the thought of someone no longer wanting to live. "I have witnessed first hand how depressed my generation is," she said. "I have to help."

Rep. Kitty Toll told those who testified how important it was for their voices to be heard in the legislature. "When you talk, I hang on to every single word."

Several parents also testified. Suzy Marek was 16 when her mother died of suicide, but no one acknowledged it, and there is "still shame in our world about mental illness and suicide." She described her feelings of helplessness in realizing how much "suicide was in [the] world" of young people today, and began meetings to form a suicide prevention information group in South Burlington, "working to fight stigma and to educate."

Kelly DeForge of Essex Junction said that the depth of stigma is not obvious "until you have a child with mental illness." In her neighborhood, with a 12-year-old severely ill son, "we often feel like we are under house arrest."

One voice, supplied by tape, spoke about the hope that treatment brings, saying how grateful he was for all those who helped his son. "He was lost for a very long time." AD

RAISING AWARENESS — Members of the University of Vermont's Active Minds chapter Alicia Gusan and Mike Davis show their information at the annual Association for Suicide Prevention "Out of the Darkness" walk against stigma. (Counterpoint Photo: Donna Iverson)

Youth Suicide Prevention Speaker Encouraged Hope as the Message

by DONNA L. OLSEN
Counterpoint

RANDOLPH — "Changing the message concerning suicide from negative to a positive discussion. Changing the conversation from one of death to one of hope. We are about suicide prevention, but we need to market hope. Decrease that feeling of hopelessness "

That was the message delivered by Phil Rogers, PhD, from the Association for Suicide Prevention (AFSP), a guest speaker at a meeting of the Vermont Youth Suicide Prevention Coalition held this fall.

"In both schools and community, there are interventions that can be initiated which have proven effective," he said.

"These include training of professionals in mental health and social services agencies in suicide risk assessment and intervention, which are critical," Rogers told the audience.

"Also needed are gatekeeper training programs to train adults and professionals to identify warning signs and refer those in need of help," he said.

According to Rogers, in Vermont, 211 call responders are trained in the national Lifelines Applied Suicide Intervention Skills Training (ASSIST) model for response.

He said other interventions include recommendations for reporting on suicide, screening for warnings of suicide in primary care and aftercare follow-up for suicidal people.

Aftercare for suicidal persons would include psychotherapy, such as Dialectical Behavior Therapy (DBT) and cognitive therapy, he said.

"Engagement of gunshop owners is an essential part of any community interventions," Rogers added.

Representatives of local mental health agencies, high schools, universities, and organizations invested in the prevention of youth suicide attended. Among persons attending were several family members of persons who were victims of suicide.

JoEllen Tarallo-Falk from the Center for Health and Learning (CHL) facilitated the meeting.

The stated mission of the coalition is to create school and community-based support for youth prevention planning statewide, which includes the development of a multi-year plan to ensure long-term, sustainable approaches to prevention and early intervention.

"We look forward to continuing the conversation with designated mental health agencies on how to better coordinate services with schools, which is really a major focus, and how to better integrate them in terms of support," said Nicole Miller from CHL.

Guest speaker, Greg Marley, LCSW, is the training director for the Maine Suicide Prevention Project as well as a family suicide survivor.

State agency partners in Maine include Health and Human Services, Education, Labor, Public Safety and Corrections. Community partners include schools, primary care providers, colleges and universities, community-based organizations, military and veterans, clergy and family suicide survivors.

Marley explained that "training in Maine includes gatekeeper awareness, awareness education with training of trainers, protocol development, Lifelines, student curriculum on suicide, and suicide assessment for clinicians.

A unique component of the Maine Suicide Prevention Project is conducting training for all state employees about suicide prevention, he said.

Maine also worked on the passage of LD609: An Act to Increase Suicide Prevention in Maine Public Schools. Each school administrative unit must have at least two staff trained as gatekeepers. Staff must have training every five years, and all new or rehired staff must have the training, Marley said.

Maine also has a legislative partner in Rep.Paul Gilbert and the support of Governor Paul Lepage, he said. The bill passed unanimously in both the House and the Senate.

"Together they had an engaging coalition of powerful testimony. It was a real team approach." said Marley.

"There are challenges. We have an unfunded mandate. How to fund training and which agency oversees implementation?" he added.

Marley offered these considerations.

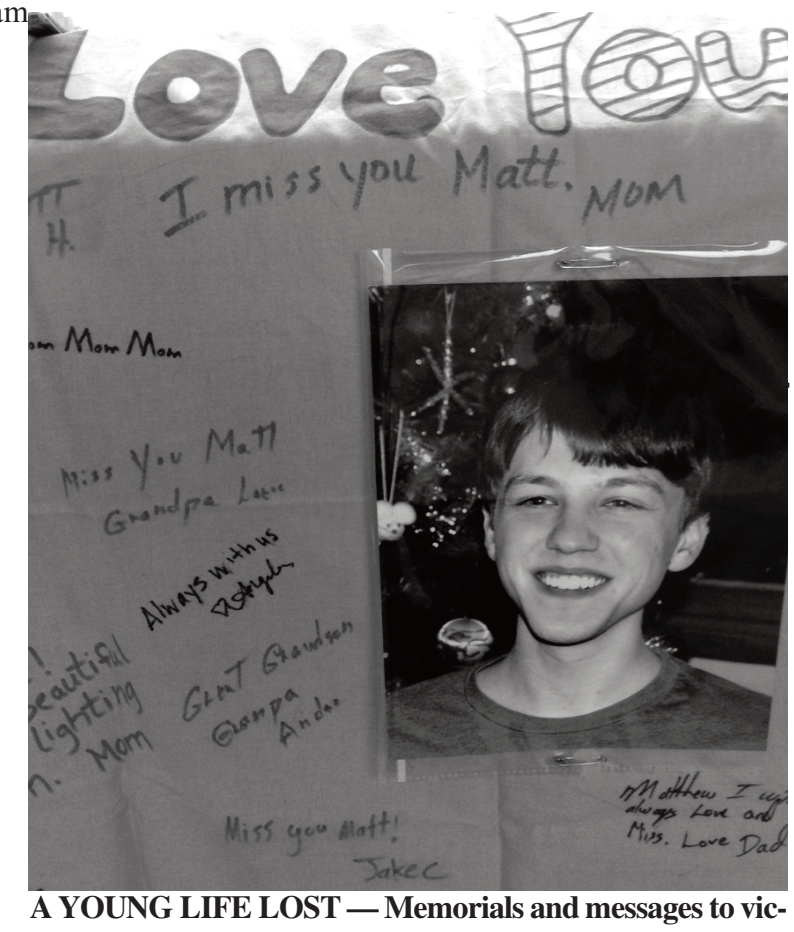
"What does your state want to do? Who are your champions? Who are your stakeholders? Anticipate and address potential resistance. Honor and celebrate success," he said

"Be careful what you ask for. The devil is in the details." said Marley.

The coalition also discussed the Youth Behavior Surveillance System data which was to be published in November. There seems to be an association between factors reported on it and self-reported sadness. Members noted that nearly all risk factors were associated with being sad.

The coalition concluded with discussion of possible legislative initiatives, such as state workforce training, legislative training and educator training. Others included creating partnerships and collaborations with veterans groups and other agencies, with a mission for a suicide prevention coordinated approach within the Agency of Human Services and between the major state agencies, and starting a pilot program implementing Rogers's upstream model in communities for school-age populations and college campuses.

Future meetings of the Coalition are scheduled for December 5, and March 6 and May 29 of 2014. There is a "Wellness in Windham" awareness training in Brattleboro on December 10, an ASSIST training in Brattleboro on March 19-20, 2014, and an ASSIST training in Montpelier on May 15-16, 2014. The annual Statewide Suicide Prevention Symposium will be on June 12, 2014.



A YOUNG LIFE LOST — Memorials and messages to victims of suicide in Vermont were on display at the annual awareness walk. (Counterpoint Photo: Donna Iverson)

WALK FOR AWARENESS — Parents and young people alike took part in the annual Out of the Darkness community walk this fall to break the silence and fight stigma about suicide. The walk is sponsored by the Vermont chapter of the Association for Suicide Prevention. An Association speaker was one of the presenters later in the fall at a meeting of the Vermont Youth Suicide Prevention Coalition. (Counterpoint Photo: Donna Iverson)

A BIRTHDAY CELEBRATION — The state's peer-directed and staffed crisis respite residence celebrated its second anniversary this fall. Visitors got a chance to share music, tasty goodies, and tours of recent expansion of space. A porch has been added and a garage has been turned into a staff training and meeting space that will be available for peer workforce development among peers across the state. There were some fun activities as well. In the photo above, staff members Eliyssa Osborne (left) and Jessica Laplante (center right) demonstrate tie dying T-shirts to Carolyn Wendel (rear) and Uma Laker, 9, (right), both visiting from Burlington. (Counterpoint Photos: Anne Donahue)

Programs Make Progress; Gaps Remain

MONTPELIER — Reports to different public groups showed continued progress in expanding the system of community care created under Act 79 this fall, but ongoing gaps as well.

Housing Issues

"Housing is the linchpin" to move people much more rapidly through the system — out of hospitals and intensive residences — Nick Emlen of the Council of Mental Health and Developmental Disabilities told the Mental Health Oversight Committee in September.

Housing alone isn't enough, though, according to a Burlington police representative who told the committee that inadequate support for those receiving housing vouchers made such programs "unfair to the tenant, unfair to the neighbors, unfair to the landlord." Brooke Hadwen said that placing persons with poor social skills and no "housing retention skills" in housing made it "unreasonable to expect" the ability to maintain housing.

But Hadwen also acknowledged that "I know about the ones that don't work" — about five such situations where police are called on repeated occasions — and not the ones that do.

Emlen commented that the program that was being criticized was called "Housing First," not "Housing Only," and that services were an essential part once individuals were in stable housing.

The Department of Mental Health's dashboard for data states that 176 persons have been housed long-term as a result of new Act 79 funding for the voucher program. DMH housing coordinator Brian Smith said that data show very positive outcomes for such individuals.

Need of Elders

Senator Sally Fox, Chair of the Mental Health Oversight Committee, questioned the lack of a program for elderly persons with dementia who may be ready to leave the hospital but are "stuck" because their psychiatric symptoms block them from other elderly housing. She cited a St. Albans program that never got off the ground after discussion in 2012.

"We have a very severe need here" regarding dementia, Susan Wehry, MD, Commissioner of the Department of Disabilities, Aging and Independent Living responded, but she questioned "whether segregation is the appropriate treatment."

Intensive Residences

Another residence opened; Second Spring North in Westford quickly reached its capacity of eight. The former bed and breakfast is a traditional clapboard house sited on a rural lot.

"You really need an environment that encourages you to get back on your feet," Jim MacDonald, director of Collaborative Solutions Corp., said. CSC is also the parent for the Second Spring operating in Williamstown since 2007.

DMH Commissioner Paul Dupre told the legislative oversight committee later that the shortage of capacity around the state led him to a decision to keep six overflow beds open in Williamstown until two additional residential programs open.

A 4-bed residence in Rutland and the 5-bed Soteria Vermont in Burlington have projected opening dates for winter. The total number of high-support residential beds will reach the planned total of 47 when they both open. That will be an an increase in bed space by 27 since the Act 79 plans began in 2012.

It's "not just about beds," Dupre told the committee, but "the culture… how to get the flow going" from inpatient care to community independence.

The Vermont Support Line

A call-in support line [1-888-604-6412] reported on its success and challenges at a meeting of the Mental Health Transformation Council in October. The call volume continues to exceed staff ability to answer, Director Tanya Vyhovsky reported. In its first six months of operation, it provided 1,690 instances of support to callers, but on average, only 37 percent of calls can be answered, she said.

The center operates from 3 to 11 p.m., 7 days a week, from call centers in Washington and Chittenden counties. Calls are coming in from every county in the state, Vyhovsky told the committee.

Vyhovsky's report included comments from some of the callers. "I was feeling suicidal and now I'm not," one said. Among others:

"I don't call crisis anymore. I call you guys. You're much better. And you talk back."

"I don't feel like I am welcome anywhere in the world, but I have felt like I am welcome here on this call." AD

Retreat Announces 'Emerging Adult' Unit

BRATTLEBORO — The Brattleboro Retreat has announced the opening of a new 12-bed inpatient unit for young adults ages 18 to 26 who are dealing with a variety of serious psychiatric illnesses including schizophrenia, bipolar disorder, anxiety disorders, and clinical depression.

The Retreat's press release described the new "Emerging Adult Program" as "another in a series of specialty inpatient programs that have set the hospital apart as a leader and innovator in clinical programming." The unit began accepting patients in October, the news release said.

The 6,053 square foot renovated inpatient unit compares with a 9,380 square foot unit for the 14-bed intensive unit renovated and opened by the Retreat in 2012 for high'intensity patients in the custody of the Commissioner of Mental Health. A Retreat spokesman said that involuntary patients are eligible for admission to the Emerging Adult Program, although Level 1 high intensity patients would not. AD

Springfield Cited for Suicide 'Near Miss'

SPRINGFIELD — A woman awaiting a crisis mental health screening was able to make a suicide attempt in the hospital emergency room here because she was left unattended, according to a state regulatory report. The event was termed a "near miss" of a serious event.

The woman was referred to the Sprinfield Hospital ER because of a problem with her pregnancy, but was crying and saying "life wasn't worth living," the report said. A screener was called, and on arrival, she found the woman pulling on oxygen tubing which was wrapped tightly around her neck multiple times. Other potentially hazardous items had not been removed from the room.

The hospital was found to be in violation of rules from the federal Centers for Medicare and Medicaid Services (CMS). The hospital submitted a plan of correction for its emergency room practices, which was accepted by regulators. AD

Support Grows To Assure 25 Beds Open at Vermont's New Hospital

MONTPELIER — Legislators from the state's money committees heard a forceful recommendation from their health care committee peers this November to budget the money needed to open all 25 new hospital beds in Berlin as soon as possible after construction is complete in midsummer.

"The conclusion that our two committees drew after a lot of testimony" was to recommend "that the state hospital be fully funded at 25 beds," Sen. Sally Fox told the Joint Fiscal Committee.

The administration later said it agreed with the recommendation. In a letter to an emergency room doctor on November 27 on behalf of Governor Peter Shumlin, Deputy Commissioner Frank Reed wrote, "The state is... working to ensure that the full 25 beds... will be opened as soon as possible, a decision that is in accordance with the recommendations of the Legislature's oversight committee."

The report of the committees said that "[c]reating a successful mental health system in Vermont requires the opening of 25 beds in Berlin, and it therefore should be fully funded regardless of the source of the funds."

She also stressed that the recommendation included the assumption that the legislature "continue to support and fully fund the community system." Fox said that "the other thing we were really concerned about" was the many individuals "that have sought a bed in the hospital and were turned away." As a result of the stresses on the system, she said that the administration's plan to phase in units caused "consternation" among committee members and that they asked "that [plans] be accelerated."

The "clinical optimum of slowly phasing in beds at the new hospital" had to be balanced with "the existing stress present throughout the mental health system," the report said. Fox is the chair of the Joint Mental Health Oversight Committee, and she was joined in testimony by Sen. Ginny Lyons, chair of the Joint Health Care Oversight Committee.

The committees met together, as required by this year's budget bill, to assess the status of the mental health system and report on whether there was still the need for all of the 25 beds planned at the Vermont Psychiatric Care Hospital.

When the budget was passed last May, the estimated opening date had been April of 2014.

Lyons told the Joint Fiscal Committee that it asked the Department of Mental Health to relook at its initial staffing plan to ensure it was "embedded in best practice."

House Appropriations Committee Chair Martha Heath, a member of the Joint Fiscal Committee, asked Fox whether it concerned her that $22 million had been invested in expanded community services, "yet we still require as many Level 1 beds" as before. Fox said that it did.

The system designed and funded in Act 79 was intended to reduce the need for high-acuity inpatient care. "We're not seeing that" reduction, she said. "I'd like to think that the jury's still out" and time and better analysis will show results.

The report of the committees also found a need for contingency planning for times of high census, and noted another two to four beds are likely required for the unmet need for Level 1 treatment of persons from Corrections.

Paul Dupre, Commissioner of the Department of Mental Health, questioned the ability to have them all operating as quickly as the report recommended. "We agree, the sooner we can get it up the better," he told the Joint Fiscal Committee, but he believed that early September was a more realistic date for full operations.

The two health care oversight committees met the week prior to hear testimony.

Patient-to-patient and patient-to-staff assaults have increased significantly, and there are patients who are "afraid to come out of their rooms," testified Lauren Tronsgard-Scott, manager of the inpatient program at Flertcher Allen Health Care. The chaotic environment sometmes causes setbacks for patients who are making progress, she said.

Tronsgard-Scott said that "lost in the dialogue" were the patients who are regularly turned down for admission because of lack of space.

Sometimes, admissions have to be limited because of the high-risk patients on the unit, rather than a lack of actual beds, she said.

Level 1 patients, who would have been admitted to the Vermont State Hospital, are "very, very ill" and often refusing medication, said Lesa Cathcart from Rutland Regional Medical Center. Although the new, 6-bed high-intensity unit has made an "amazing difference" in improving care, the unit immediately hit capacity and the long patient stays block new admissions.

There is also a "lack of availability of the next level" of care to be able to discharge patients, said Paul Capcara, Clinical Nurse Manager of the Adult Acute Care Unit at the Brattleboro Retreat. Testimony from community mental health centers indicated that the new crisis beds and residences created under Act 79 are usually at operating capacity, which is an average of 85 percent occupancy. AD

Access to Hospitals Remains a Patient and Community Crisis

Despite an increase in resources for both community and hospital care, individuals waiting for an inpatient bed continue to face days of delay in emergency rooms or Corrections. Data presented by the Department of Mental Health show that there were seven persons each day, on average, waiting in an emergency room or in Corrections in September. Those who waited for more than 24 hours in the first nine months of 2013 ranged from 25 percent in January to 53 percent in September. A November letter signed by 87 emergency room staff at Fletcher Allen Health Care in Burlington stressed the consequences both to patients and others waiting for care there, noting that community hospitals "attempt to care for psychotic individuals while keeping the pediatric and individuals safe when only separated by a curtain. Not only is this frightening to our medical patients, but inhumane to our psychiatric patients who lack privacy and areas to shower" and are in a "chaotic and unstructured environment" that is the "worst place" for someone in crisis. The letter urged that the eight-bed hospital in Morrisville be kept open, along with utilizing all 25 beds when the hospital in Berlin opens. AD

3 Death Investigations Focus on Mental Illness

Police Shooting Is Reviewed

BURLINGTON — A man reported to be wielding a spade was shot and killed by police in November, and the Vermont State Police are investigating whether the lethal response was justified, according to news media coverage.

Wayne Brunette's mother had called police reporting that he was agitated and destroying property. The police shots were fired about two minutes after officers arrived on the scene.

Brunette, 49, lived in an apartment in his parents' home on Randy Drive and the confrontation occurred in the front yard of the home, the media reports said. Brunette was reported to have had a history of mental illness. Police had responded to calls at the home in 2001 and 2003. Criminal charges resulted, but were later dropped. He was referred for a competency evaluation at the time. No more recent court involvement was found, news media reported. AD

Corrections Is Questioned

MONTPELIER — Legislators have raised concerns after receiving investigation reports on the death of an inmate who hanged himself in a mop closet at the state prison in Newport in September, media reports indicate.

According to the Vermont State Police report, Robert Mossey, 33, fashioned a noose ahead of time and jammed the lock and tied a rope to the door to prevent anyone from entering.

VSP found no evidence of criminal wrongdoing, but Mossey was on antidepressants and there was no evidence of the recommended medical follow-up, according to the report of the Defender General. That report also cited a delay of more than an hour between the time other inmates first reported the jammed door and Mossey was found. The report also criticized the use of other inmates to clean the blood and tissue remains from inside the closet. AD

Hospital Reports Suicide

BURLINGTON — Fletcher Allen Health Care reported the death of a recently discharged patient to state and federal authorities this fall. The Centers for Medicare and Medicaid Services requires reports of suicides that occur within 72 hours after a discharge from an inpatient psychiatric unit.

"This was a tragic event for everyone involved," said Mike Noble, from Fletcher Allen. He said that along with following the reporting requirements, Fletcher Allen conducted a thorough internal review of its care practices.

FAHC did not disclose the former patient's identity. The date of death reported to the Department of Mental Health corresponded to news accounts of the death of Kathleen Cook, the associate director of the Department of Residential Life at the University of Vermont. Her death certificate stated that she died Oct. 30 as a result of a self-inflicted gunshot wound at her home. AD

CMS: Police Calls Must Be Limited

by ANNE DONAHUE
Counterpoint

MONTPELIER — If a hospital needs to call on police to control patients outside of rare emergencies, it isn't meeting clinical standards for the level of care being provided, according to a clearer understanding of federal standards several hospitals have acknowledged this year.

In addition, police can not be asked to assist with emergency involuntary procedures.

The issue came to public attention after an investigation by the federal Centers for Medicare and Medicaid Services (CMS) into an incident in which a Taser was used at the Brattleboro Retreat this summer.

The CMS report noted the Retreat had "four male mental health workers, two security guards and six female staff (including nurses and MHWs)" present. However the Security Supervisor said, "We are not equipped to handle a patient this size and strength...," so police were called to do a "therapeutic hold" while medications were injected. According to the police report, the officers refused to assist with the shots, but when the patient lunged forward, a punch to the face and a Taser were required to subdue him.

The CMS survey found that the patient's rights to a safe environment and to the appropriate use of restraint and seclusion were violated.

It was one of a number of uses of police force recorded there in the past, including use of a police baton that bruised the shins of a 15-year-old boy in July, and use of a Taser on a boy in 2007.

The State Survey Agency Director for CMS, Fran Keeler, told *Counterpoint* that there are some uses of police back-up that can be appropriate — even calling police for a "show of force" — as long as is it clear with police "what the expectations are."

If police are called as back-up in a dangerous situation, it must be with the understanding that they cannot provide clinical assistance, such as applying emergency procedures. However, if an assault then took place and the intervention resulted in an arrest, it would be appropriate, Keeler said: it would be a law enforcement intervention at that point rather than a clinical one.

Police in Brattleboro said the Retreat asked them to assist in restraining a patient for emergency involuntary medication in three of the eight times they were called in the past year. Each time, they refused.

Keeler disagreed with some characterizations that suggested that the violations cited at the Retreat reflected "new rules" on addressing violent patients. The regulation in question has been in effect since 2008 as part of the restraint and seclusion rules, she said. They apply to any part of any hospital.

Counterpoint described a memo to Keeler that was submitted by a Brattleboro police officer to his supervisor after responding to a request to hold down a patient for staff to give him a shot; the patient had a history of hiding contraband and was believed to have a razor blade hidden in his mouth. Police refused that request and he allowed staff to give him the shot, but then objected to having his shoes taken away. The patient was on the floor of the seclusion room, and "leaned his torso up" reaching forward, and at that point the police forcibly restrained and handcuffed him.

The officer asked in his memo, "First, why would the Retreat admit a patient whom they know exercises dangerous habits (hiding weapons in mouth) when they know they do not have the staff, training, or facility to deal with that particular problem? Second, if they are going to admit such a patient, why would they allow him through admissions and into a common area of the ward with other patients and staff without first checking to see if he has hidden weapons or drugs in his mouth?"

"Those are good questions to raise," Keeler responded. Keeler said that every aspect of a specific situation needs to be taken into account to determine whether there is a violation. "Where are [police] standing by?" for example — in the hallway, or visible in a place that could make the situation worse? In some instances, it was the Retreat staff that escalated a situation that resulted in the need for police intervention, she said.

Effect on State-Run Hospitals

Paul Dupre, the Commissioner of the Department of Mental Health, said that what was helpful after the Retreat incident was that "CMS really become clearer with what was OK or not."

Dupre said the survey conclusions at the Retreat have resulted in changes there and at the state's Green Mountain Psychiatric Care Center in Morrisville. It is one reason the Department of Mental Health has increased its budget request for staffing levels at the Vermont Psychiatric Care Hospital under construction in Berlin, he said.

At the Retreat "we have revised policies to reflect CMS requirements of no police involvement in patient care and have trained all staff accordingly," said Peter Albert, a spokesman.

The Retreat was under a threat of decertification, but CMS accepted the new policy and in November conducted a full survey and found Retreat practices to be in compliance.

The state's hospital in Morrisville had an incident that resulted in injury to three staff last summer and police used pepper spray after they were called to assist. Executive Director Jeff Rothenberg said that there were "multiple conversations" with the state's Division of Licensing and Protection when the 8-bed interim hospital was developing its plans for operations last December.

After the July assaults, he again discussed the parameters with Keeler, and it was "a reiteration of what we knew all along," Rothenberg said. Since then, "we've really tried hard to staff so that it doesn't happen again," through a better distribution of coverage for different shifts.

"What she told us is that if a dangerous crime is being committed that we can't handle" the police should be called, he told the hospital's advisory committee. The incident in July met that criteria.

The requirement is that a hospital "shouldn't admit [a patient] if we cannot provide care" to handle a crisis, he said, so in making such a call for help, that standard has already been broken.

Improvement From Six Years Ago

At the Retreat, in the one year period prior to the 2007 Taser incident, there were 13 times the police were called to intervene on inpatient units that resulted in "hands-on" interventions, the Retreat reported at the time. That included at least one incident in which a patient was handcuffed to be given shots. At that time, the Retreat committed to a review of its policies and consideration of hiring staff security personnel, who are now in place.

In contrast, a review of Brattleboro police records by *Counterpoint* this November showed only the three occurrences in the 12-month period ending on October 31 in which police force was used on patients. After the CMS survey this past summer, Retreat statements cited the challenges in now addressing patients who used to be admitted to the Vermont State Hospital.

The Retreat responded to an inquiry about the police reports from *Counterpoint* by saying, "We, too, reviewed police reports and I think there may be differences in what you reported and what we see." Peter Albert, the Retreat spokesman, did not offer any details or other response to questions.

In at least four of the Retreat incidents, there was no record of a report being made to CMS or the Department of Mental Health. A self-report by a hospital to CMS would not be required solely because police come to the premises, Keeler said, if there was no indication of neglect or abuse of a patient.

She said that oversight by CMS in response to such reports was limited to asking for other samples of case files, but not to do a comprehensive hospital review.

Dupre said that the role of the Department in quality oversight of hospitals that care for patients in his care and custody was something he was working on. That includes the question of what should be reported by the hospitals, he said.

Other Hospitals Don't Rely on Police

Counterpoint requested police records for the past year from all towns that have psychiatric units, and found that only the Retreat had called on police multiple times.

Berlin police reported one response to Central Vermont Medical Center. A patient was throwing computer equipment at staff and smashing it. The police were called to intervene and arrest the individual. Jim Tautfest, the nurse manager of the psychiatric unit, said that if police are called, "We're dealing with a situation with a threshold that's beyond our ability to handle."

"You're acquiescing to giving over control" to the police in such circumstances, he said.

Tautfest said the hospital was familiar with the long-standing CMS guidelines, and was particularly "sensitive to it" with the "Level 1" patients often held waiting in the Emergency Room. CVMC is not a hospital contracted to admit Level 1 patients.

Police in Rutland, Burlington, and Bellows Falls reported no situation in which they were called to assist on the psychiatric units in their towns.

Rutland police chief Jim Baker said his officers are not permitted on the unit at all, although they are working on a protocol for when it might be required in extreme situations.

Other Police Responses at the Retreat

The additional six police reports of calls for emergency assistance at the Retreat included:

- Use of a police baton and a knee strike to the stomach of the 15-year-old boy who was threatening violence and refused to go with them to a seclusion room.
- Response to "out-of-control" patient on Tyler 1; police refused request to help medicate; stood by while staff administered shot.
- Response to "unruly male" on Tyler 2; police convinced the patient to accept medication.
- Response to "out-of-control" patient breaking things on Tyler 2; calm on arrival; stood by while staff administered medication.
- Response to stand by for patient "creating a disturbance" at admissions; calm on arrival.
- Response to "unruly" patient at admissions; calm on arrival; stood by until sheriffs arrived to transfer to Springfield Hospital.

There were also five police reports of assists at the Retreat for an overdose. None were on the reports list to DMH, and if they involved patients, "that would be a concern," Dupre said. The police reports indicated that one situation involved a woman in a parking lot, but the others included no details. The Retreat did not respond to the *Counterpoint* report of these police calls.

NAMI Connects Hospitals To Its Support Groups

RUTLAND — NAMI-Vermont has piloted a Connection Recovery Support Group at the psychiatric unit at Rutland Regional Medical Center to help create a bridge to support in the community, and is now expanding it to the Brattleboro Retreat, the mental health organization has reported.

Laurie Emerson, NAMI Program Director, said in a press release that the Rutland program, now underway for a year, was one of the first in the nation, and that NAMI is now in the process of replicating it at other psychiatric units throughout the state.

REACHING OUT — NAMI facilitators pictured include (from left) Thelma Stout, David Remington, Darlene Manning, and Dirk Nakazawa. (Photo Courtesy of NAMI-VT)

The groups are led by trained NAMI facilitators and are flexible so that patients on the unit can come and go as they need to, Emerson said.

"Hospital staff sit in on meetings and find that many patients open up and discuss their feelings quite freely" with the facilitators, who "help to problem-solve and guide the discussion to a positive outcome."

Individuals living with a mental illness need to talk with someone who understands — someone who has been in the same situation they are in and who can give them hope and inspiration for their recovery, she said. While NAMI Connection Support Groups provide that for individuals in their community, individuals who are in severe crisis and have been hospitalized "desperately need someone to talk to and bridge the gap to recovery," Emerson said.

NAMI Connection Coordinator Dirk Nakazawa said he has found that "many people living with mental illness are too afraid or intimidated to leave the comfort of their home and walk into a room full of strangers to find support."

"What we have been finding since starting about ten months ago is that many of the people who end up on the psychiatric unit really lack supportive people who truly understand what they are going through," he said.

Through the NAMI Connection Recovery Support Group in a hospital psychiatric unit, participants can learn about a valuable resource waiting for them once they are discharged and can feel comfortable to attend a meeting in their local community, Emerson said.

In Brattleboro, the initiative includes the development of the community-based support group as well as the inpatient group.

"We hope that when they leave the hospital the chances that they might seek out a support group to attend in order to find people who truly understand them would increase," Nakazawa added.

"We are extremely pleased to have been able to partner with NAMI-Vermont in developing this much needed resource on our inpatient psychiatric unit," Dr. Gordon Frankle, Chief of Psychiatry for the hospital, said in the NAMI news release.

"The impact of this group is best described by one of the participants, who said, 'The NAMI group was awesome!' when asked for feedback upon discharge."

Emerson said that NAMI-Vermont has formed a close partnership with Rutland Regional Medical Center, which provides space for its Family-to-Family classes, Family Support Groups, and Provider Education courses.

"I am so proud of our Connection facilitators, Dirk Nakazawa, David Remington, and Darlene Manning, who have made such an impact on people's lives in their recovery process. They are truly making a difference in Vermont through their dedication and commitment by leading through example and giving people courage and hope for their future," Emerson said in the news release.

NAMI describes its Connection Recovery Support Group meetings as free, weekly 90-minute recovery support groups for people living with mental illness, "where people learn from one another's experiences, share coping strategies and offer mutual encouragement and understanding." Emerson said all meetings are facilitated by trained NAMI peers living in recovery.

DEATHS

Peg Franzen, Disability and Human Rights Leader

MONTPELIER – Vermont human rights advocate Peg Franzen died this November after battling cancer.

In 1979, Franzen co-founded the Vermont Center for Independent Living, which has since grown to a statewide organization with offices and members across Vermont fighting for disability rights. She also co-founded the Peace & Justice Center in 1977.

When she was working for the Committee for Temporary Shelter in 1989, she started the COTS Walk, which now raises hundreds of thousands of dollars for the state's largest homeless shelter.

Franzen's long career working for disability rights and social and economic justice had been ongoing for more than 30 years when she joined the Vermont Workers' Center in 2002. She was its president from 2009 to 2013.

Over the last five years of her life, she was a driving force for the Healthcare Is A Human Right Campaign and played an instrumental role in the push for universal health care in Vermont with the passage of two landmark laws. She served on the Advisory Committee for the Green Mountain Care Board after its creation in 2011 under the health reform laws.

"Peg Franzen's legacy is enormous. She has profoundly impacted the lives of thousands of people,"said James Haslam, Executive Director of the Vermont Workers' Center. "She showed what it is to be a real leader in every sense of the word. Peg never wanted to be in the limelight.

"She wanted the focus on the broader collective of people taking action together. In that way Peg was an example of the kind of leader we can all aspire to be. She showed us how we can change the world." A celebration of Franzen's life is scheduled for Sunday, December 15, at 1 p.m. at the Old Labor Hall in Barre.

Trina Tatro, Warmline Director and Advocate in Rutland

RUTLAND — Trina Tatro, 45, coordinator of the Rutland County Peer Run Warmline, died this November. She had worked on the Warmline for four years before becoming its director three years ago.

Her death brought tributes from her peers at Vermont Psychiatric Survivors.

"Her consistent advocacy for herself and others as well as her warm care through the Warmline will be sadly missed," said Linda Corey, VPS Executive Director.

Tatro was instrumental in the expansion and management of the Warmline, a non-crisis phone support system. Under her stewardship the program grew significantly as she developed ways to reach out to more people in need.

Tatro was educated in Richmond, Maine and at the University of Maine at Augusta where she earned high distinction honors, completing her bachelor's degree in business administration in 1994. She furthered her education at the College of St. Joseph and became an advocate for persons with mental illness.

George Nostrand, another long-time friend, said that "Trina will be truly missed for her unflagging commitment to peer support and her ability to lead by example."

"When I think of Trina Tatro, the first word that comes to mind is 'survivor'. I'm not just referring to her involvement with Psychiatric Survivors, but the multiple physical health and life challenges she's had over her life," Nostrand said.

"Despite these challenges, I rarely if ever heard Trina complain or even talk about any of the pain or suffering she endured.

"I learned a lot from Trina. Despite her often quiet appearance, she was a strong self-advocate as well as advocate for others.

"I am happy to say that Trina also knew how to have fun. I believe her marriage to Ernie Tatro gave her a second lease on life."

Corey said that Tatro's favorite activities were crafts and attending KISS Concerts with her husband. "Trina will be missed by all whose life she touched," Corey said.

She is survived by her husband, Ernie Tatro, and her son, Ronald Harriman, of Rutland, her mother, Carolyn Bailey, of Chelsea, Maine, her brothers Michael Bailey and his wife Lorraine, of Clarendon, Shawn Bailey of Waterville, Maine and Troy Bailey of Augusta, Maine, her sister Glenda Doubleday and her husband Jack, of Sharon, Wisconsin and several nieces and nephews. Memorial contributions can be made to "Rutland Warmline" and mailed to them c/o Vermont Psychiatric Survivors, 1 Scale Ave. Suite 52, Rutland, VT 05701.

Death at Retreat Leads To a Query About Defining Hospital Programs

by ANNE DONAHUE
Counterpoint

MONTPELIER — Health facility regulators determined that they had no jurisdiction to investigate issues of care specific to the housing where a young woman died of suicide at the Brattleboro Retreat this past fall.

The woman was discharged to Ripley House on the hospital campus after six days as an inpatient. She was found dead of an overdose in her bathroom in a search conducted by staff two days after she was last seen, according to the Brattleboro police death investigation.

In the interim she had failed to show up for any of her scheduled meetings at the Retreat's "Birches" intensive outpatient program, the report said.

The Division of Licensing and Protection reported that it was limited to a review of the hospital discharge planning and the outpatient services because it only has jurisdiction over programs that are billed under the hospital's provider number. There were no findings of violations regarding those programs.

The L&P determination was consistant with the Retreat's report to the Department of Mental Health when it described Ripley as a "room and board" alternative to "other hotel services in the area" for those in the outpatient program.

According to the police report, Ripley is run by Retreat staff and in collaboration with the Birches and other outpatient programs there; residents are warned that the violation of house rules will be reported to their treatment teams.

Pamela Cota of Licensing and Protection said state staff discussed with Retreat staff the "blurring of lines" that is created by Ripley House being on the hospital campus. Cota suggested that the Department of Mental Health "may have more leeway and flexibility to address this potential gap in care/oversight of the on-campus housing for outpatients."

The Department Commissioner, Paul Dupre, said later he wasn't sure whether he had oversight. "I think it's grey," he said.

Neither the Retreat's press release nor its report to the Department of Mental Health identified the fact that the woman had been recently discharged from the hospital, or that she had been missing for two days before a search by Retreat staff began.

A summary of the 34 pages of the police report that were released indicated that:

On August 22, Samantha Siano-Joseph, 36, from New Hampshire, applied for admission to the Birches program but was assessed at too high a suicide risk and was instead admitted to an inpatient unit.

She self-identified as having dual disorders of both mental illness and substance abuse.

On August 28, she was discharged from the inpatient unit and admitted directly to Birches, with accommodation at Ripley House.

During the Labor Day weekend, she spent some time away from the Retreat with a friend and later police interviews with various individuals, including that friend, indicated that she appeared in good spirits and unstressed.

On Monday evening, she "signed back in" to the Ripley Building and waved at a Retreat staff person in charge of the building. The last person to see her was another client who was watching the same TV show with her in the common area lounge at about 10 p.m.

Siano-Joseph did not attend any of the intensive day programming on Tuesday or Wednesday, (September 3-4). On Wednesday afternoon, her social worker asked that someone at Ripley check on her. Her bathroom door was locked; a staff person from Ripley and a Retreat security guard unlocked it and found Siano-Joseph's body on the floor.

The investigating officer said the woman's body "was cool and had begun to decompose." What police described as a "suicide note," dated September 2, was found in the bathroom. The final autopsy report indicated the manner of death was suicide (prescription drug overdose) and cause was acute intoxication. Siano-Joseph was divorced and had a 5-year-old daughter.

In response to a description of the police report and inquiry about the circumstances by *Counterpoint*, spokesman Peter Albert said the Retreat had "different views" on the issue. but did not specify what those were. He said the death was "tragic and unforeseen."

Further Corrective Plan Added To Retreat Troubles

BRATTLEBORO — Eight days after being found in compliance with federal regulations on November 6, the Brattleboro Retreat had an additional plan of correction accepted on a new violation of patient rights identified in October.

The Retreat said it immediately discontinued a practice of random searches of patients without any specific suspicion of hiding contraband. The violation occurred on its adolescent unit.

Department To Pospone Seeking Changes in Mental Health Law

MONTPELIER— The Department of Mental Health will probably not be seeking changes to the laws that establish the involuntary mental health system this winter, according to Paul Dupre, Commissioner of the Department of Mental Health.

He said that the debate about possible changes this past summer and fall had value because "it's gotten people talking," but that he was still new in learning about many aspects of the system.

"I'd like to put it off for a year" before making decisions about what changes may be needed, he said.

Last spring then-Commissioner Mary Moulton told Rep. Ann Pugh, Chair of the House Human Services Committee, that she would assemble a stakeholder work group to consider proposed changes. A bill that addressed some of them — S. 128 — already passed the Senate with Moulton's backing and is awaiting action in Human Services.

This fall, the work group debated when and how individuals can be taken into police custody and admitted to a hospital involuntarily, who can consent for admission of a minor, and what sort of independent oversight should exist. There was little consensus.

The group divided most sharply at its October meeting on whether children under age 14 should no longer have a legal right to object to being hospitalized if a parent is consenting to the admission.

It would be a "big, big mistake" to allow a child to be hospitalized "on the whim of a parent," said Sarah Laundeville, Director of the Vermont Center for Independent Living.

Among those who supported the change were Wendy Beinner, Director of NAMI-VT, and Jill Olsen, from the Vermont Association of Hospitals and Health Systems. Beinner suggested that a law could be drafted that provided protection against inappropriate admissions, but that avoided an involuntary commitment process based upon a child's opposition to being admitted.

At an earlier meeting, there had been agreement that the wording in current law was confusing and difficult to follow for the steps to hold individuals in an emergency room, admit them involuntarily, and keep them hospitalized for at least 72 hours.

Advocate Xenia Williams said that the timeline for legal protections should begin at whatever point a person was no longer free to leave.

"An individual suspected of being crazy" is held in a way applied to no other persons, she said. "If you're accused of a crime, you have a lot more rights."

There was agreement that continuing to hold someone in an emergency room indefinitely, or having them held in Corrections waiting for an inpatient bed, should not be permitted.

That raised the question as to what would then happen if there were no beds available, as is often the case now.

Would a person have to be released?

Task force member A.J. Ruben from Disability Rights Vermont reminded the group that the law requires the state to maintain enough hospital capacity so that there is "an inpatient bed for everyone who needs a bed."

Several members spoke in support of a requirement for a preliminary review of whether a person is being held legally within a few days after admission. An individual can currently request such a hearing within five days, but without a request, no review occurs.

There was disagreement over whether the Board of Mental Health should be eliminated from the law. The Board has broad oversight power but has not been active for a number of years.

Jack McCullough of Vermont Legal Aid said it should be restored to being "real," rather than be eliminated, and Williams agreed, saying that "oversight has been sadly lacking in the past."

Michael Sabourin, a patient representative, suggested a list of principles: that consent be required to be informed and capable, with full due process when addressing treatment for persons lacking capacity; that there should be a "firm requirement" to show that voluntary care is not possible before a person is committed; to document capacity regularly — every 15 days if a person is under an involuntary medication order; that hospitals be required to have active plans for reducing coercion as a condition of designation; and that all parts of the system be required to provide alternative treatment options. AD

Study Finds Firearm Use, Mass Murders, Have No Relationship to Psychiatric Illness

A September report in Clinical and Research News says that a new study has found no relationship between the presence of psychiatric disorders and the use of firearms or offenses involving multiple victims. The text of the report, with minor edits due to space restrictions, states:

Psychiatric factors do not appear to predict whether a homicide defendant used a firearm, killed multiple victims, or is convicted of the crime, a finding that would seem to counter the popular notion — prevalent in the wake of recent mass killings that have made the news — that perpetrators of mass gun violence are invariably mentally ill.

The finding is from a study appearing in the September *American Journal of Psychiatry* that assessed the association between homicide and a wide range of demographic and clinical variables.

"It is notable that clinical variables, such as Axis I diagnoses, were not associated with offense characteristics or case outcomes when demographic and historical characteristics of the cases were included in the models," wrote lead author Edward Mulvey, Ph.D., of the University of Pittsburgh Medical Center, and colleagues.

"In particular, while age and race were significantly related to the use of a firearm, the addition of clinical variables to demographic and historical variables did not improve model fit.

"Furthermore, a model including demographic/historical and clinical variables did not significantly predict a guilty verdict, suggesting that case-specific factors were more salient in these determinations."

In the study, defendants charged with homicide in a U.S. urban county between 2001 and 2005 received a psychiatric evaluation after arrest. Demographic, historical, and psychiatric variables as well as offense characteristics and legal outcomes were described.

The researchers examined differences by age group and by race; they also looked at predictors of having multiple victims, firearm use, guilty plea, and guilty verdict.

Fifty-eight percent of the sample had at least one Axis I or II diagnosis using *DSM-IV* criteria, most often a substance-use disorder (47 percent). Axis I or II diagnoses were more common (78 percent) among defendants over age 40. Although 37 percent of the sample had prior psychiatric treatment, only eight percent of the defendants with diagnosed Axis I disorders had outpatient treatment during the three months preceding the homicide.

That suggests limited opportunities for prevention by mental health providers, Mulvey and colleagues said.

"The rate of previous treatment observed in this sample raises issues relevant to mental health policy," they wrote.

"Although 53 percent of the sample were diagnosed with an Axis I diagnosis (including substance-use disorders), less than half of these individuals had ever been hospitalized. Also, among those with an Axis I diagnosis, only eight percent had received any treatment in the three months preceding the homicide offense.

"Moreover, this low frequency of recent psychiatric treatment differed markedly by race… Widespread disparities in access to care and cultural differences regarding help-seeking are likely explanations for this difference.

"The low rate of treatment in the months preceding the offense, however, highlights the need for enhanced engagement of high-risk individuals (especially during times of emotional crisis) if mental health care providers expect to have an impact on serious violence."

Steven Hoge, M.D., chair of APA's Council on Psychiatry and Law, reviewed the report. "Individuals with an Axis I disorder were overrepresented among homicide defendants," he told *Psychiatric News*, "but this was due to the high rate of substance-use disorders found. The relationship between substance use and serious criminal behavior is well established.

"The study identified only 15 individuals — just 5 percent of the sample — who had a mental disorder and no co-occurring substance-use disorder. Identification and treatment of substance-use disorders are important not only to alleviate individual suffering, but also to improve public safety.

"The study findings address current concerns regarding gun use and mass killings by those with mental illnesses," he continued. "There is widespread belief that mental illness is an important cause of firearm violence and mass murder.

"In fact, the researchers found no relationship between the presence of psychiatric disorders and the use of firearms. Nor did the presence of a psychiatric disorder relate to offenses involving multiple victims.

"These findings suggest that policies designed to keep firearms out of the hands of individuals with a history of mental illness will not prove to be effective as a targeted strategy."

Hoge also said the study underscores the need for better access to psychiatric treatment, particularly substance-use treatment. However, crime-prevention strategies that rely on psychiatrists' reports are likely to be ineffective because most of this population is not in treatment or getting timely treatment.

Emergency Rules Found Contrary To VSH Standard

MONTPELIER — A legislative oversight committee voted 6-1 in November to object to a rule proposed by the Department of Mental Health for emergency involuntary procedure standards across the state, saying the rule was "arbitrary and does not meet legislative intent."

The Department can still put the rules into effect, but they have less weight if they are challenged later. Commissioner Paul Dupre said in late November that he had not yet made a decision about next steps.

Dupre had testified that he believed that the rules would provide at least the same protection as patients had at the former Vermont State Hospital, which was the requirement set in Act 79. Until a state rule is in effect, the hospitals can continue to operate under existing federal regulations, which have fewer restrictions.

Patient advocates objected to the fact that the draft rules apply only to adult inpatient units, saying that Act 79 references "patients in the custody of the Commissioner," which would include children's units and other parts of a hospital.

In addition, advocates said that the proposed rule changed a VSH requirement that a physician prescribe involuntary medication.

The new rule permits a broader group of prescribers and it allows "specially trained" nurses to be the ones to observe a patient before obtaining an order. Since nurses would obtain a prescription from another provider, the person writing the prescription would no longer have to personally examine the patient, advocates said.

VSH policy was clear that "you can't just phone these things in," argued Laura Zeigler. "This is being retrofitted to be responsive to the complaints of hospitals," which testified that it would be too expensive to always have clinicians who can prescribe medication on site.

DMH did add a requirement for debriefing for patients after restraint or seclusion, something urged by patient representative Kitty Gallagher.

"Staff go off and get debriefed. Where is the debriefing of the peer?" She said there needed to be a discussion asking "do you know why?" the procedure was used, "so that it doesn't repeat itself."

The rule also included new language on membership requirements for an Advisory Board that requires "a peer and a person with lived mental health experience (who may be a peer or family member.)" AD

MYSTERY OF HISTORY — A chair of the design once used for delivery of electroshock treatment was discovered this fall in a storage area of the Northfield Savings Back corporate offices and donated to the Northfield Historical Society. How it got there, and where it came from, is a mystery, says Historical Society member Sally Pedley. Now the Office of the State Curator has joined in the research. It has learned that the chair was built by a company that went out of business before electroshock was being used, and that it was apparently modified for electroshock use. (Photo Courtesy Northfield Historical Society)

Personal Reflections

State of mind:
Reframing mental illness

Image by Kate Richards

by George Nostrand

There are people who choose their career paths, and others whose paths are chosen for them. When most of my friends were heading off to college, I was checking in for my first of several visits to the Brattleboro Retreat, a mental hospital in southern Vermont.

For the next seven years, I was in and out of similar hospitals. I was labeled first with major depressive disorder, and later with bipolar disorder. I was tried on numerous different medications and told I would have this illness, "for the rest of my life." Try as I might, I was unable to stay in school, hold a job, maintain relationships and thus move forward in life.

Since then I have been very fortunate in my life and recovery. I have also received a lot of support to get where I am today. For the past 15 years I have worked in the mental health field in a variety of capacities. I worked one-on-one with a man transitioning out of the Vermont State Hospital. I provided a variety of supports at a drop-in center. A majority of my focus has been on employment, helping people who have been diagnosed with mental illness find and keep jobs in the community.

I have also facilitated training and educational opportunities, not only for people with mental illness but also family members, staff and even some policy makers and bureaucrats. What makes my story unique is that my expertise comes not from a textbook but rather my own personal experience. I understand the people I work with and what they are going through because I have, as they say, been there and done that.

So when I speak, write or present on issues relating to mental illness, it is with a passion that literally burns within me. It is not only close to my heart, it is from my heart and from deep within my soul. Rather than scarring over and becoming hard I have remained raw by having mental illness present in my daily life. Whether I am well and helping others or struggling myself, I am constantly reminded of how painful it is to live with an illness that no one understands.

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When a person has a broken leg, the flu, diabetes or cancer you would not just say that he or she has a physical illness. You would say that he or she has a broken leg, the flu, diabetes or cancer. These physical illnesses are all quite different. The precipitating factors are different, the treatments are different, and the times of recovery are different.

When the illness relates to the brain or mind, however, we tend to clump them all together as mental illness. You would likely say, "This person has a mental illness," when referring to someone, whether his or her diagnosis was depression, schizophrenia or Asperger's.

There is a wide array of mental illnesses and degrees of mental illness. You could even argue that some are as different as diabetes is to the flu.

It is also quite common to hear about "the mentally ill." Again, people don't talk about "the physically ill" as a population or "the diabetics." This is just one example of how our perceptions and means of addressing mental illness differ from physical illness.

When you group people together based on one or two common traits, then apply general sweeping characteristics to the whole group, it is called stereotyping. Recently, we saw stereotyping of mental illness rear its ugly head in the aftermath of the tragic school shooting in Newtown, Conn.

Statistics have shown time and again that people with mental illness are actually less violent than the general population. In fact, most studies show that somewhere between 5 and 10 percent of murders are committed by people with mental illness. This means that 90 to 95 percent of murders are committed by "normal" people.

Still, this false portrayal of "the mentally ill" as violent people was falling off the tongues of reporters, politicians and so-called experts everywhere — even before there was any evidence that the shooter in Connecticut was mentally ill. In fact, to this day it's unclear whether Adam Lanza had a diagnosed mental illness or not.

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Despite all the research over the last 100-plus years, our true understanding of mental illness — what it is and where it comes from — is still questionable at best.

In recent decades, the trend has been to pin everything to a biological defect within the brain and then find a corresponding pill to address it. An untold amount of money has been spent by the pharmaceutical companies — in research as well as advertising — yet instead of seeing improvements, diagnoses of mental illness continues to grow each year and are expected to continue to do so. This is especially frightening when looking at the increased diagnosing of children.

Just like the body, the mind has many different parts and can be affected in many different ways. There can be birth defects, traumatic brain injuries and other physical damage done to the brain. But when most people think of mental illness they think of some of the more traditional diagnoses like schizophrenia, major depression, anxiety and obsessive compulsive disorder to name just a few. While diagnoses allow for people to receive services or insurance coverage, they don't always help clarify the person's issues.

Symptoms can cross diagnostic definitions. Therefore, it's more common than not for someone to receive multiple or different diagnoses over time. Consequently, treatment with medications can appear to be a crapshoot — individuals are subjected to trials on multiple medications, all with different effects and side effects.

To make matters worse, from what I have seen professionally and experienced personally, traditional treatment can be as damaging to the person long-term as the illness itself. In efforts to "fix the problem" and "save people from themselves," the systems of care designed to help people with mental illness ends up leaving them overmedicated, dependent on various government programs and systems of care and, most significantly, with little sense of hope or self-worth.

I have traveled all over the country speaking to different groups about mental illness and recovery, and while Vermont is more progressive than some states, its overall treatment of people with mental health issues is still, in most cases, appalling. If we looked at applying the same low standards in addressing physical illness in our society as we do in providing for the mentally ill, there would be a public outcry. And since people with mental illness are often so disenfranchised, their outcry is less likely to be heard.

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Fortunately, things are beginning to change. In recent years, journalist Robert Whitaker has helped fan the flames of a fierce debate and dialogue with his recent books, "Mad in America" and "Anatomy of an Epidemic." Whitaker challenges the philosophy of "medicate now and ask questions later." His intense and in-depth research is hard to refute.

Other leaders like Dr. Daniel Fisher, Sherry Mead and Mary Ellen Copeland, have called for and proposed different approaches.

Peers, or people with lived experience with mental illness, are not only acting as advocates but are also designing programs and providing care in new and unique ways.

One area that is now being highlighted in the search for answers is the connections between trauma and mental illness. This is most apparent in war veterans. Suicides have surged in the armed forces to the point where death by suicide is almost twice as likely as by enemy action. Trauma is a big factor in these cases. Trauma is also being looked at in a broader sense in mental health. Trauma can result from one event or from a series of events. There may be immediate reactions like shock and denial, but trauma can also have long term effects on a person's well-being. Both short-term and long-term responses to trauma can be mild or severe. In some cases, people may suppress feelings and not be affected for years.

In reaction to these traumatic events or experiences, people can develop any number of coping mechanisms. Some may appear healthy, or at least work temporarily. But more often than not these coping mechanisms can lead to problems later in life. People who have experienced trauma often have trouble trusting and communicating, impacting their ability to maintain healthy relationships. Their self-esteem, self-image and self-worth are all severely damaged. In some cases, they may appear to shut down altogether or develop their own reality, where they can be safe and separate from the world that has hurt them.

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For many, recovery is a long-term process. It takes time and painfully hard work to unlearn the unhealthy behaviors or coping mechanisms that have been part of their survival. Processing and working through the traumatic experiences in their lives cannot be done overnight.

Recovery is also a process that cannot be done alone. Friends, family and professionals all play a role. So does the larger community. The way in which we either accept or reject people who are different than us or are struggling can have a big impact on their recovery.

In my new professional role, I am looking at ways that people with mental illness can both

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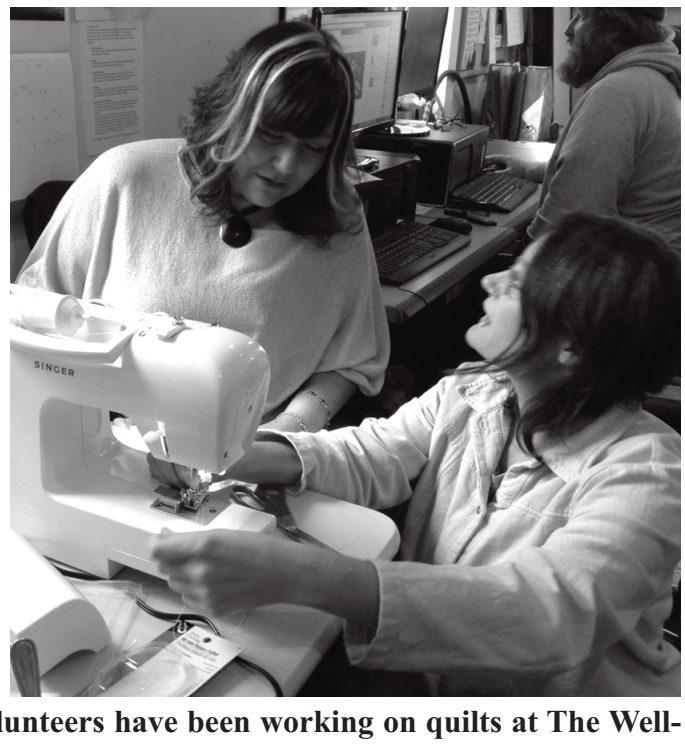


ALL IS SEW SEW AT THE CO-OP — Volunteers have been working on quilts at The Wellness Co-op in Burlington to welcome residents at Soteria House when it opens. Left photo, Cathy Rickerby looks up from the sewing machine. Center, April Clogston sews while Mel Jannery assists. After finishing the five quilts for Soteria, they hope to complete 25 more for the new hospital now under construction in Berlin. Right photo, Keron Asencio irons quilt pieces.
(Counterpoint Photos: Donna Iverson)

Quilters Hope To Comfort Residents

by DONNA IVERSON
Counterpoint

What is soft... comforting... colorful... gentle... unique... and warm?

These words easily describe the handmade quilts being made from scratch by volunteers of The Wellness Co-op on King Street in Burlington.

But these words apply to more than quilts, as these quilts are a metaphor for how persons with mental illness would like to be treated by the psychiatric establishment, according to Cathy Rickerby of Middlebury.

On a Wednesday afternoon this fall, Rickerby was one of several volunteers who were creating quilts to cover the beds of the first Soteria house being planned for Vermont.

According to the dictionary, Soteria is a Greek word designating a safe space for people experiencing a mental crisis.

Soteria will provide a safe and secure space for people experiencing their first or second psychiatric crisis, Rickerby explained. Admission will be purely voluntary, providing an alternative to hospital emergency rooms or, in some cases, a jail cell, she added

"I was really excited when Cathy approached me about this [the quilting] project as she has a lot of care invested into it. It's been personally heart-touching for me to have her coming to The Wellness Co-op to work on the quilt with us," said Mel Jannery, house manager and peer support specialist.

"I am remembering it's not all about getting to the end, but the process of nurturing the conversations in between the measuring, stitching and ironing," she added.

Once Soteria House is furnished and operational, The Wellness Co-op volunteers will begin sewing quilts for the psychiatric hospital being built in Berlin, according to Rickerby. There are 25 beds planned at this facility, which broke ground for construction in January, 2013.

Quilt-making sessions take place every week at The Wellness Co-op, which is also soliciting help from volunteers around the state in the quilt-making effort.

On one Wednesday, as four people worked on the Soteria quilts, a half-dozen people were enjoying other amenities offered at The Wellness Co-op, such as computers, free wi-fi, games, kitchen facilities and companionship.

The Wellness Co-op is a place "to hang out and be with one another," said Jannery. "Our drop-in center offers a welcoming open, relaxed atmosphere to share skills, learn new ones, and find support."

"Working with Cathy on this project has been bringing up a lot of good memories for me," Jannery reflected. "My mom and I used to make quilts together and I miss those days."

She said it was personally inspiring as well.

"After the first time Cathy came, I went and bought a bunch of thrift store shirts, washed them and started to cut them up with the intent to make scrap curtains or a scrap quilt."

Jannery said the mission of The Wellness Co-op is to build community around holistic wellness with a focus on mental and emotional health in a non-judgmental and anti-oppressive environment, through the mutuality of peer support.

The Co-op provides drop-in hours weekdays that are free and open to the public. Located at 43 King Street, the peer-run community center offers scores of programs including laughter yoga, cooking, writers' circle, and a peer support group to name a few. The building is accessible, drug- and alcohol -free, smoke-free and chemical-free.

The Soteria house will be located in the Old North End of Burlington, according to Amos Meacham, program manager for Soteria-VT. It will offer five beds and will be staffed 24/7, Meacham said.

The leased facility will open as early as January or February of next year, he added. Meacham will be the director of the facility and will work with a house manager.

Soteria House and The Wellness Co-op are projects of Pathways Vermont, an organization that connects individuals to housing, under a grant from the Department of Mental Health. Pathways also operates the Vermont Support Line, which uses a peer approach and is available from 3 to 11 p.m. daily. The number is 1-888-604-6412.

For more information, check its website at www.thewellnesscoop.org, email the program at thewellnesscoop@pathwaysvermont.org, or call 1-888-492-8218, ext 300. The Wellness Co-op is also on Facebook.

State of mind:
Reframing mental illness

(Continued from page 12)

support each other and be more included in the community — seen not just as takers, but as givers, too.

The next time you hear the term mental illness on television or read it in the paper ask yourself, "How much does this person who is speaking really know about mental illness?" More than likely, the answer is, very little.

When discussing it with others, realize that the terms "mental illness" or "the mentally ill" are often stereotypical in nature. And ask yourself, "What do I really know and what are my views on mental illness?"

George Nostrand works for Vermont Psychiatric Survivors, a statewide peer-run organization assisting in the expansion of support groups run by and for people with lived experience with mental illness. He also works as a consultant, trainer and speaker. The opinions expressed are those of the author and do not necessarily reflect those of his employers, past or present. His website is www.georgebygeorge.com. Send questions and comments to george.breakingthecycle@gmail.com

CEO for Berlin Is Named

MONTPELIER — Jeff Rothenberg, who developed and has been Interim Director of the Green Mountain Psychiatric Care Center in Morrisville, has been named as the Chief Executive Officer for the new Vermont Psychiatric Care Hospital in Berlin by Commissioner Paul Dupre. The GMPCC, an interim 8-bed hospital, opened in April. Prior to that, Rothenberg was a principal assistant to the Commissioner. He has had more than 20 years of experience in the community system with Washington County Mental Health Services and the Clara Martin Center, has a Masters degree in Community Mental Health, and is a Licensed Clinical Mental Health Counselor. AD

Medical Director Returns

MONTPELIER — Commissioner Paul Dupre has announced the appointment of Jaskanwar Batra, MD, as the Medical Director for the Department of Mental Health. Batra had left that position a year ago to become Medical Director of the Vermont Health Co-Op, a consumer-run health care insurance co-operative that was a pilot under the federal Affordable Care Act. The project was unsuccessful in getting state regulatory approval. AD

Editorial Page

Opinions and Letters

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

Editorial

Parity for Rights

We pride ourselves as being a state that understands that mental illness should not be a basis for discrimination. The new discussion about forced drugging ignores that.

Hospitals are complaining about long inpatient stays by a few persons in the state's custody who have refused to take medications that could help address the illness.

Existing law allows for involuntary administration of drugs by court order when such a person lacks the capacity for informed consent in a process that can take a number of weeks. That time line begins only after an involuntary commitment, which rarely occurs before 30 days.

The Shumlin administration suggests that Vermont law is "too lenient" when it comes to laws that protect the right of a person with a mental illness to make his or her own medical decisions. The fact is that most people with a mental illness still have the capacity to make an informed decision about different types of treatment, including the option of medication.

It is for the few individuals who cannot provide legal consent that we struggle to resolve how to address substitute decision-making, particularly in the traumatic situation when an aware individual is objecting to and actively resisting use of a drug that will affect his or her thinking and sense of self.

It is worth looking at how the process differs for persons with other than a psychiatric illness:

First, there is an assessment of capacity. If a person is found to lack the ability to make the specific medical decision, a substitute decision-maker is identified. Typically, if there is no conflict of interest, a family member is involved. If the person has an advance directive, an agent is the decision-maker. If necessary, a court can appoint a guardian.

Secondly, we recognize the right of the patient to have a decision made that is based on what he or she would have wanted.

Third, it is the substitute decision-maker, not the court or the physician, who considers the alternatives and provides the consent – or not. A patient who objects to the guardian's decision has a right to a court review.

Finally, our guardianship laws allow for more rapid action in urgent medical situations. That isn't available under the court process for persons with a mental illness.

If we treated persons with a mental illness as persons worthy of the same legal rights and protections as everyone else, we would enable those who lack capacity to get access to the treatment they would have wanted, as rapidly as needed.

There might need to be extreme exceptions when someone is very violent and there is no way to keep other patients safe. There is a time that individual rights are lost because we have to protect the rights of others.

But in every other situation, the choices we want when we are able to make decisions should be the ones that matter.

That would create parity of rights.

LETTERS TO THE EDITOR

We Should Focus On What Works

To the Editor:

By calling for the process of obtaining court orders for non-emergency forced psychiatric drugging to be expedited and made easier, Governor Peter Shumlin would have the State of Vermont further deprive what few rights citizens subject to these orders might actually have.

Depending upon who one listens to as well as believes, accounts about forced psychiatric treatment experienced within Vermont can vary rather drastically. The evolving rhetoric from some over the years in these regards has continued to make the mental health system overall, and forced treatment more specifically, sound much better than has truly been the case.

Ironically, this is easily done under the shroud of confidentiality functioning as a protective shield on behalf of the system more than it does in protecting those on the receiving end of what is, in truth, dehumanizing forced psychiatric treatment. Even more ironic, the use of force and coercion in these regards is referred to as a treatment failure by those working within this very system, yet is still heavily depended upon nonetheless.

Go figure!

By going down this particular route, one which is headed in the wrong direction, it means what is being built to replace the Vermont State Hospital (VSH) will merely be a new version of the same old thing. The problem with VSH was not only about the decrepit conditions of the buildings and related problems, but rather were also due to the failures of an old treatment model that had remained in practice in one form or another over the years.

Contrary to what is often reported by those in positions of authority and power as well as media accounts usually parroting such self-serving disinformation, the problem is not necessarily the fault of persons being held against their will and being forcibly treated within facilities meant to replace VSH type of beds.

The problems arising are the result of the same old treatment model or variations of it still being put into practice.

When the Vermont Psychiatric Care Hospital now under construction in Berlin is built and opened, it appears obvious about how the same old VSH treatment model or variations of it will be put in place and practiced there as well.

Although the expectations some might have about it call for there being different results this time around, one can not only foresee the same type of results as has been the case up to now, but these will once again be blamed on those the system keeps failing. Why Governor Shumlin and some within the state legislature continue to insist on rewarding failure after failure is beyond me.

When a person is treated in a fashion that no longer dehumanizes and humiliates them into submission, nor are they deprived of what little dignity and self-respect they might still retain; then and only then, might different results be brought about and realized.

What should be focused on and rewarded instead is what truly works, not what doesn't.

Although it can sometimes take time and plenty of it as well as lots of patience and understanding to bring about, including to (re)build trust and sorely needed relationships, and among other things being put into place along these lines, what has proven to work is Open Dialogue.

Open Dialogue is a holistic process that includes the person in various levels of need serving as a key player of a team that works with them.

No matter how great or dire a person's needs might prove to be, if people are provided opportunities to do different as well as better and they are worked with in a vastly different manner to help bring such about, they will be aided in achieving improved outcomes as well as a better quality of life.

We all will be better served as a result.

MORGAN W. BROWN
Montpelier

Faster Drugging Is Contradictory

To the Editor:

Giving patients psychiatric drugs makes them appear "stable" more quickly in an inpatient setting. They are released more quickly, with a shorter hospital stay, on average.

Patients who take psychiatric drugs when hospitalized also relapse at much higher rates than those who are not given psychiatric drugs in the hospital.

So, you could speed up the forced drugging process, and it would get patients out the door more quickly on average. They would also come back in the door more quickly and in greater numbers than if you were to be able to avoid drugging some of them. This would add to the load of mental health emergencies.

You could be providing a greater number of treatment visits, and a much lower quality of them, and have more relapses. The revolving door moves faster and faster, the quality goes down, and the number of available beds does not necessarily increase over time; in fact, the crisis of not having enough beds may decrease.

On the other hand, you could decrease the rate at which patients are medicated, by aggressively providing other treatments. This would decrease the relapse rates, which would decrease the rate of emergencies coming in. This might actually help alleviate the hospital bed crisis, and more and more so over time

HEIDI HENKEL
Putney

Energy for Leadership Without Needing Coffee

To the Editor:

When Aimee Powers came into the welcome meeting the first night [of the Peer Leadership Conference] and asked everyone if anyone would like for her to make coffee after dinner and no one responded, I felt a shared energy. NEVER have I experienced a time when I was with a group of people where not one person wanted coffee after dinner (and there were around 30 of us). In my heart, I felt an odd connection!

MELANIE JANNERY, Burlington

Op-Ed Page

Opinions and Letters

LETTERS TO THE EDITOR

Auditor, Please Review Poor Services at HCRS

The following letter was written to the Vermont State Auditor, Douglas Hoffer, and shared with Counterpoint.

Dear Mr. Hoffer (and the Vermont State Auditor's Office and the Vermont Department of Mental Health and State of Vermont):

I am a Vermont resident, and a survivor of mental illness. I am Bipolar, and suffer from Anxiety conditions, as well as PTSD. I am under the care of a psychiatrist and taking prescribed medications which allow me a normal quality of life at this time, and which allow me the ability to write you today to address the problems in our mental health care administration system in Vermont.

I just read an article stating that your office plans to audit several organizations that administer mental health services on behalf of state government. I am writing you to encourage you to include HCRS [Health Care and Rehabilitation Services of Southeastern Vermont] (and possibly Springfield Hospital Corporation) in this audit.

While living in the northern part of Vermont, I was under the care of a psychiatrist in Montpelier for my psychiatric conditions. I was doing good, and was fairly stable.

When I moved to Windham County, in southern Vermont, in 2010, I struggled to find any supportive mental health care. Due to the ineffective and badly administered mental health care services in this area, after suffering over a year of not receiving my prescription medications or any psychiatric support, I suffered a serious event in the late summer/fall of 2011, that led to an extended period where I needed intensive crisis intervention, leading to homelessness from late summer 2011 into summer 2012, when I suffered an extensive extended mental crisis.

In this county, Windham, and in Windsor County, the mental health care referral service is HCRS. In order to get into any crisis mental health care facility, one must be screened by a HCRS caseworker. HCRS provides emergency crisis care screening for the Springfield Hospital, the Rockingham Medical Center, and, I believe, the Brattleboro Hospital, possibly also other smaller hospitals such as Grace Cottage, and probably other area health centers as well.

Basically, in order to get into either of the two psychiatric hospital facilities in this area, the Brattleboro Retreat or the Windham Center, one must be sent to an emergency department in a hospital and screened, then "approved" by an HCRS employee/caseworker.

During my crisis, I was taken by ambulance to Springfield Hospital, and on two separate occasions, I was denied any mental health care services. HCRS deemed my crisis "not critical," and I was sent home without ever seeing a doctor from the emergency room where I went in crisis for care by referral of my primary care doctor or therapist.

One of those times I was homeless and they told me I had to leave Springfield Hospital at 1a.m., when there was no bus service, and my camp was in Bellows Falls, over eight miles away, and it was fall and raining (and obviously, dark). I had to beg them to provide me a cab and even then I was dropped off at the edge of the forest, and had to walk to my camp over a mile in complete darkness, in the rain, during a severe mental crisis.

Luckily, I had no way to kill myself at the time (I didn't have anything, just a tent in the forest), or I would not be writing you now.

During that summer/fall, I was in the care of a therapist who happened to have an office in the same building as the Windham Center, and I went to her after this event, and basically broke down in her office, and she had to "pull strings" to "get around" HCRS in order to get me into The Windham Center, even though she knew and recommended I should be in an inpatient care facility.

The HCRS office in the same building repeatedly told me that I simply do not qualify for their services, and refused to serve me. I've lived in Vermont since 2005, I'm 38 years old, and I am now on SS Disability, but I was not at that time. I did, however, have VHAP/Medicaid insurance coverage. I should have qualified for their services.

The staff serving HCRS was always discouraging towards me, and the caseworker that screened me at the Springfield Hospital was outright rude and mean. I do not believe that Springfield Hospital correctly/appropriately refers anyone for mental health care, regardless of the level of the patient's mental health crisis, and I believe that HCRS is extremely abusive of its power, and does not administer the services they are given the responsibility to administer.

I strongly urge you to audit them deeply, because they are causing a great deal of psychological harm to at-risk individuals, and likely literally killing people with their incompetence.

Luckily, my therapist was able to get me into an inpatient facility during that crisis (by asking for a favor and having "inside connections"), and since then, I have also been receiving assistance from Our Place Community Center, and Pathways to Housing Vermont, which are both excellent community service organizations that literally saved my life.

Our Place helped me apply for Social Security Disability, fed me (meals and food shelf), gave me a place to shower, and provided and gave transportation to me to a warm place to stay when it was too cold at camp.

Pathways to Housing assisted me by finding me a place to live (and by helping me get approved for a Vermont Department of Mental Health housing voucher), and helps me maintain both my housing and my mental health care by keeping a psychiatrist on their staff (critically essential since I have no other way to see a psychiatrist as there simply are no psychiatrists accepting outpatient clients in this area — crisis care is the only way to get mental health care in southern Vermont, and there simply are not enough beds or enough facilities with openings to administer non-crisis care) and providing me with a social worker who helps me with everyday needs/tasks.

Additionally, I have experienced that the general practitioner/internal medicine doctors in this area refuse to prescribe psychiatric medications (even when the patient has a history of being prescribed them, and they are known to work to prevent crises), therefore, it is impossible for the mentally ill of this area to get routine preventative care for psychiatric conditions.

When I moved to this area, I was unable to find a doctor who would prescribe the medications my prior psychiatrist had prescribed for me, and because of this, I had an extended period of severe instability, leading to several ambulance trips to the ER, homelessness, and even one violent legal conflict. (I shattered the door of the health clinic when they refused me care. I am not normally violent, but over a year of not being on my medication led to severe instability.)

All of this would never have happened if I had simply been able to continue my routine psychiatric medications when I moved to this area. The doctors at the Rockingham Medical Center (my primary care doctor at that time, the only local doctors), which is operated by the Springfield Hospital Corporation, when I approached them for care, specifically told me "I am not comfortable prescribing you these medications," and referred me to crisis care, which was a trip to the ER at Springfield Hospital, where the HCRS screener/social worker/referrer told me I didn't qualify for crisis care.

This is a problem. Please, please, look into it.Without Our Place and Pathways to Housing Vermont I might be dead right now, solely because there is no routine mental health care for individuals in this area of the state, and crisis care is almost impossible to get placed into.

I would be more than happy to speak to you, or make an official legal statement on this topic if helpful in this matter. I hope you will consider my situation and experience, and know that I am far, far from the only one experiencing these problems in Southern Vermont.

With Best Regards,
Jennifer (Phaewryn) O'Guin
Bellows Falls

Counterpoint offers agencies criticized in letters an opportunity to respond. HCRS chose not to do so.

Shout It Out!

Have an Opinion

About Things Going Right or Wrong?

That's What the ***Counterpoint*** Letters Page Is For!

Send comments to: ***Counterpoint***, 1 Scale Ave., Suite 52, Rutland, VT 05701, or to counterp@tds.net. Names may be withheld on request, but must be included in letter. Letters do not represent the opinion of the publisher, and may be edited for length or content.

Personal Reflections

On Being Different

by Melanie Jannery

Yes, I *am* different!

As much as we talk about us all being human, having human experiences… I still feel disconnected out in social spaces and it is uncomfortable and probably unnecessary. Out on 9/11 for a dinner gathering, everyone was sharing what they did on 9/11. I didn't share. I remembered, but I didn't share. I felt incredibly alone in not sharing, yet I didn't want to bring discomfort in the space that night with my presence there. I find often I do need to filter out things I share, but often I sit in silence.

On 9/11 I arrived with my ex-girlfriend to her grandmother's home as she stormed through the house, loudly as she often did. I remember sitting at the kitchen table watching the media coverage of the events that happened that day. I remember looking at my wrist, at the tape holding my cut together. I remember hoping that conversation at the table wouldn't happen. I remember sitting there feeling paralyzed thinking about the violence in my home the night before. I was remembering the glass, the plates, shattering above my head. I was remembering the fear. I was remembering how much I needed me in that moment of insanity and I remember grabbing that razor off the table corner and cutting, immediately feeling present and scared when I could see my two veins closer in that moment. I watched the planes over and over and over and over going into the towers feeling scared, petrified to get back into the car with my girlfriend to go home to another night of hell not knowing my way out... 9/11 was happening...

We have these dumb surveys at work that I feel grateful for every time I give them. The nine hospital stays and the five to 10 respite stays I had that year in Massachusetts, no one asked me if I was being abused. If they had, I would have said *yes*, as I have an extreme difficulty lying, so I don't! But... I am able to give others the opportunity to say "*yes*" if they need to!

Sometimes it's good to be "The Quiet One" when out. I've disrupted enough spaces over the years sharing what I needed to share when others were not wanting to listen. But how do we navigate these spaces of despair and continue to feel connected?

The next week at Peer Support Circle at The Wellness Co-op, I touched on the discomfort that I felt when out, sharing how different I felt that my memory of 9/11 wasn't so positive. Just saying this helped. It is hard to navigate the social spaces when unpleasant memories come up.

Melanie Jannery is a peer support specialist at the Wellness Co-op in Burlington.

Going Off Drugs Safely Means Slowly

by Heidi Henkel

To get off psychiatric drugs safely, it is necessary to taper them very gradually, with a reduction of 5 to 10 percent at a time, getting completely stable in between. In addition, it is very important to meet needs in other ways, such as spending time with friends,expressing feelings (through talk therapy, peer support, the arts, somatic emotional release bodywork, or any other means), doing fun things, being physically active, good nutrition, good housing, and addressing medical problems.

When people go off psychiatric drugs, especially if they do so at a faster rate than what I described, they often get withdrawal effects. This is not a sign that they "need" medication, though it is often perceived that way. It is usually a withdrawal reaction from the drug. It means that tapering needs to be done more gradually.

A lot of people stay on drugs because whenever they go off them, they do not feel good and they have bad mental health experiences. People need to taper off more gradually and be more aware of withdrawal reactions. Feeling bad when coming off a drug or shortly after coming off of a drug does not mean you "need' the drug. It probably means that there was a withdrawal effect. Anyone — even someone with no mental health problem to begin with — would have a withdrawal effect and feel bad when coming off the drug. It does not mean you "need" medication, it means you need a more gradual approach.

One of the obstacles to sufficiently gradual tapering of psychiatric drugs is that the drugs are not manufactured in small enough increments of dosages. To taper by 5 to 10 percent at a time, it is usually necessary to have a pharmacy compound the medication into appropriate dosages. Then there is another obstacle, which is that insurance seldom pays for pharmacy-compounded dosages of medications.

This is something that the Vermont legislature could change. They could make a law saying that all health insurance operating in Vermont have to pay for prescribed compounded dosages of medications.

Heidi Henkel is from Putney, and often shares health views on Counterpoint.

Updates from *The Key*

National Mental Health Consumers' Self-Help Clearinghouse

Guide to Alternative Treatments

Mental Health America has published an online resource "that provides a comparative, research-based approach [to] complementary and alternative treatments for mental health conditions."

The website evaluates SAM-e (which has been used in Europe for more than three decades), fish oil, rhodiola (which "has long been employed in Eurasian traditional medicine"), DHEA (a natural steroid), CES (Cranial Electrotherapy Stimulation), yoga, meditation, and ginkgo biloba (an ancient Chinese herbal remedy). Source: http://www.mentalhealthamerica.net/index.cfm?objectid=182EDDFA-EE9B-78EF-DDDA1E666389BFB9

Coffee Linked to Lower Suicide Risk

A Harvard University study has reported that drinking at least two to three 8-ounce cups of caffeinated coffee a day cuts the risk of suicide approximately in half compared to drinking one or fewer cups a day, *Psychiatric Times* reports.

The results were distilled from three large studies of Americans who responded to validated food-frequency questionnaires every four years. (Caffeine consumption from other sources was considered, but the major caffeine source was coffee.)

Out of the 208,424 individuals studied, there were 277 deaths as a result of suicide. According to a Harvard University press release, "Caffeine not only stimulates the central nervous system but may act as a mild antidepressant by boosting production of certain neurotransmitters in the brain, including serotonin, dopamine, and noradrenaline. This could explain the lower risk of depression among coffee drinkers that had been found in past epidemiological studies, the researchers reported."

Sources: http://www.psychiatrictimes.com/suicide/take-cup-o-joe-coffee-consumption-linked-lower-suicide-risk

http://www.hsph.harvard.edu/news/features/drinking-coffee-may-reduce-risk-of-suicide-in-adults/

Peer Services Video

A new 16-minute video about the value and importance of peer-operated services is available on YouTube at http://www.youtube.com/watch?v=vV0J SZ2k1oQ. The video, entitled "Side by SIDE," focuses on SIDE, Inc., a peer-run service in Kansas.

A lot of people are changing
the way they talk about
"mental illness" and being a
"consumer, survivor, or peer"...
Why is this?
Counterpoint would love to print your views.

Send your thoughts to counterp@tds.net *or 1 Scale Ave., Suite 52, Rutland, VT 05701*

Personal Reflections

Getting Attention

by Michelle L.

I thought negative attention was the only way to get attention. I did not care what I had to do to receive the attention. I intentionally told professional people I was suicidal or would hurt myself, just so I could get admitted to a psychiatric hospital and get more people to pay attention to me. I knew once I was in the ER I could get people to admit me to whatever hospital I wanted by acting up and getting to go where I wanted.

I remember I enjoyed getting the ambulance to pay attention to only me. I could go to the hospital and stay as long as I wanted because I knew all I had to do was say I am unsafe or act up and I knew I could control how long I stayed.

But then I learned how positive attention goes a lot further in life and you get sick and tired of acting up, so you make positive change in your life. You learn your life can be much better. Plus, people want to hang out with you instead of run away from you.

Once I changed my life for the positive, I got jobs, where I felt like I was a normal human in the community. I did not feel like I was having to cover up my arms, just to go out in the real world. I found friends who were involved in the same interests I was. I like Special Olympics, swimming, and traveling to different places, like New Hampshire.

I found friends who want to be positive and have a positive outlook on life. I now find myself staying busy in a good way, instead of focusing on the negative. I see now that I am not intentionally living in a psychiatric hospital, I can live in my own supported apartment, which gives me a whole new outlook on life. I have supportive people in my life. I have a family of the heart, not of the blood, which I love. I have two cats, Fangy and Baby, whom I love with all my heart.

You can choose to have a positive and rewarding life or a negative life. It is all up to you.

I hope by my sharing my personal recovery story it helps people see there is a light at the end of the tunnel. I 'm not saying you won't have bad days, but if you don't give up, you 'II see it is all worth the fight.

Michelle L. describes herself as, "Out of the hospital for three years, instead of out for days or weeks."

The Secret

by Elizabeth Derby

There is just one life for each of us: our own, listening to your heart, listening to your right brain. Be willing to accept others.

Being passionate means taking risks. You'll find your passion in what inspires you the most. And what does the word "inspire" mean? It derives from the words, "in spirit." You're living it.

What is your passion? Make a living doing it, and provide a service for others. As soon as you trust yourself, you will know how to live. You can't give away what you don't have.

Elizabeth Derby signs "from mental health client." She is from Springfield.

Resting

by CP

I press my face against the window of the group room. My forehead rests on one of the six rectangular panes. Two inches out there's a storm window, and the screen. Beyond that, small snowflakes waft on the air currents, floating downward and then rising gradually upwards again. I try to follow one but there's so many that it's impossible. Hordes of snowflakes dance down the six stories to the pavement and when I look up there are more and more going on forever up into the gray sky.

Do the windows open? They look like normal windows with regular glass. Someone ought to have considered the windows back when the decision was made to have a psychiatric program on the sixth floor. I mean, who finds themselves on the sixth floor looking down and doesn't have the thought, *What if I just jumped?*

I am so tired, so terribly tired. I've been awake for five hours today and it's worn me out; all I want is to go back to sleep, right now. I sit down at the table and lay my head down on my arms.

In fifteen minutes the group will begin with breathing mindfulness meditation. I will start to fall asleep and come back to the world even groggier and my head will ache as others laud the benefits of mindfulness practice and how it is making them well.

I am at the library and it's six o'clock in the evening. Outside are bright streetlights in the dark, breaths in the cold sharp air, busy city people, sidewalks, boots shuffling in the slushy street snow. I wish I could live here in the warm library forever. I could curl up in a cushiony chair and drift off, safe under the bright overhead lights.

I have to go to the bathroom. It's on the next floor up. I must drag myself up the stairs. Then I'll go out into the dark and plod the interminable distance home. In actuality, my apartment is less than a mile from the library. Even the slightest things feel like a huge effort now.

I sit on my futon as time passes through my red-numbered digital clock, hours flowing into one another like water. In these long nights of winter, once the sun sets each minute is the same as the next. They parade into the darkness that shines through my window. My cat rests stretched out on my legs, her tail curled against my belly, her chubby tabby body warming my thighs, her head resting below my knees. She purrs like there's blue, green, and gray marbles tumbling in her chest. We rest like this together.

That's what I'm doing these days: resting. I don't want more pills to make me better. I'm done with pushing/striving/high-functioning/grandiosity/ever upward. For so many years I kept going even when I couldn't stand it for one more second, spurred on by a raw desire for survival. At long last, I'm finally exhausted. I don't really want to die; I just want to sleep for a long, long time and wake up some new morning, months down the road, healed over, new buds sprouting and ready for the next step.

Until then, I'm resting. *CP is from Burlington.*

About Anonymous Writing

I used to think that someone submitting something anonymous, having submitted anonymous writings myself, was so that the person could have anonymity... privacy... free expression keeping some self-respect.

Now I realize that someone submitting something anonymous can give a message clearer than any attachment to the status of the person, should the person be well-known or not... freeing the reader of any opinions, but knowledge just of the words within the message: powerful! *(from an anonymous contributor)*

Arts Poetry and Prose

Pain falling upon deaf ears

I'm trying to fight off these tears
as the ongoing pain and fears radiate throughout my body.
My mind feels cloudy and unsteady.
I whisper in the ears of those I think can help.
I begin to fear though that my words are falling upon deaf ears.
I want to scream out aloud to all who are around
hoping someone will hear the pain and see and notice my fears.
That someone will see the words I speak for what they are.
I want to just cry, yet why?
What is it going to do for me; nothing, absolutely nothing at all.
But nor can I just let it be.
That's just too much for me.
I think to myself if I cry then they might see.
If I scream then they might hear
the pain and fear that's growing within me.
That then they might help save!

by NICOLE GAUTHIER
Burlington

Louise Wahl
2013 Runner-Up

If I was a moment

If I was a moment
I'd be reborn
long before my life was torn

I'd fix the things
that I did wrong
and write it down
in this song

I'd hold you close
and smell your skin
your baby hair
so smooth and thin

your toothless laugh
makes me smile
and gives me strength
to run this mile

now you're grown
and so I try
to set you free
and not to cry

by TAMI DAY, Brattleboro

Some Free Advice

Whatever you do,
don't ask for
help.
How they love
saying no. They collect
letters to put after
their names.
And they do all they can
to save the facility

money.
Don't ask for help. Better
to wait and wait. And
wait for full-blown
insanity to come
at last from out of the shadows
of proper and polite

behavior. And when
the chips fall, and
the shit hits the fan,
a hospital will
have to take you without
reimbursement —
absorbing the loss
on the q.t.

by DENNIS RIVARD
White River Junction

Louise Wahl
2013 Runner-Up

The Wait

By the heat of the Sun,
Or the white chill of the Moon,
A night sky filled with Stars
By the light of Day
And the gray of Dusk
In the Shadows I wait
For the unspoken word
For the touch of Grace
By the heat of the Sun
The chill of the Moon
Waiting, always waiting.

By LUCY LAHUE
Barton

Share Your Poetry and Prose Here Anytime... But **Win Big** By Entering The Louise Wahl Annual Creative Writing Contest!

~ ~ ~

Prizes Totaling $250!

The Louise Wahl Memorial Writing contest is named for a former Vermont activist and encourages creative writing by psychiatric survivors, mental health consumers and peers, and their families.

Only one entry per category; 3,000 word maximum. Repeat entrants limited to two First Place awards.

Send submissions to: Counterpoint, Louise Wahl Writing Contest, 1 Scale Ave, Suite 52, Rutland, VT 05701 or to counterp@ tds.net; include name and address.

Deadline: March 31, 2014

Arts

Poetry and Prose

REFLECTIONS — Still waters reflect the grasses along the edge of Lake Elfin in Wallingford, where a peer leadership retreat was held last summer. (Counterpoint Photo: Anne Donahue)

Watching and Feeding Squirrels Is Good Winter Therapy

I do this every winter to keep my spirits up: watch and feed squirrels. I enjoy watching them from my window.

I feed them ear corn on a feeder. I watch them reach through a metal spiral, which fits over the ears of corn, taking one kernel at a time and nibbling the center out of them. I watch them by the hour! Sometimes they carry whole kernels off to bury them in the soft earth or in the snow or even under old leaves.

In the spring, some of them sprout and grow into three- to four-foot stalks with ears of corn on them! In the fall the squirrels chew through the husks and nibble the kernels off. I cut the top portion of the stalks above the ears to use for winter bouquets.

I also feed them sunflower seeds in a plastic pretzel jar attached to a wooden box with three, three-inch holes through which the squirrels pass to reach the seeds in the bottom of the jar. They poke their heads out of one of these holes to nibble one seed at a time with their front paws. So cute!

by RICHARD A. WILLIAMS, Bennington

Complex PTSD and Me

Louise Wahl
2013 Runner-Up

I am considered to be Mentally Ill, stigmatized by society.
It's ironic, for this same society is the one responsible for my condition. Complex PTSD came into play by what society, systems, government and others have done to me for 45 years. Even now they continue to contribute to this condition.
I did not ask for the panic attacks, the disassociate episodes, the nightmares and daymares, limited sleep, fear, inability to trust, the isolation, the emotional upheaval, the scenes of traumas being relived over and over, never-ending as my mind does not have an off switch.
I did not ask for my reality to be blurred and distorted. I did not ask for all of my physical afflictions. I did not ask to have my identity stripped from me so that I do not know who to be, what to feel, what to think, what to do.
I was molded and remolded by others like putty in their hands.
My days are spent working hard in therapy to try and undo the damage that has been done to me throughout my life. Medication offers limited help, it does not fix the problem.
Only time can heal me.

by BONNIE L. MACHIA

Untitled

Louise Wahl
2013 Runner-Up

To have thoughts is to shape them into words and
letters. The titanic abysmal stream like the spring
flood whittles away a heavy earthen layer
freeing the green tenderness trapped in between.

Let the sludge pour through you in filaments
pushing cobwebs and dusty lace back from the
window in order to catch the slight warmth of
light faltering, paling, shuttering, yielding finally
to the towering mountains who don't mean to
intimidate.

They can't help their strength. But, tread ever so
softly: you are the moss beds to tuck in the sun.
A dryness in the back of your throat.

Cough. Persist, replenish, rehydrate. Rest and be
separate.

by MELISSA HAM-ELLIS

Full Circle

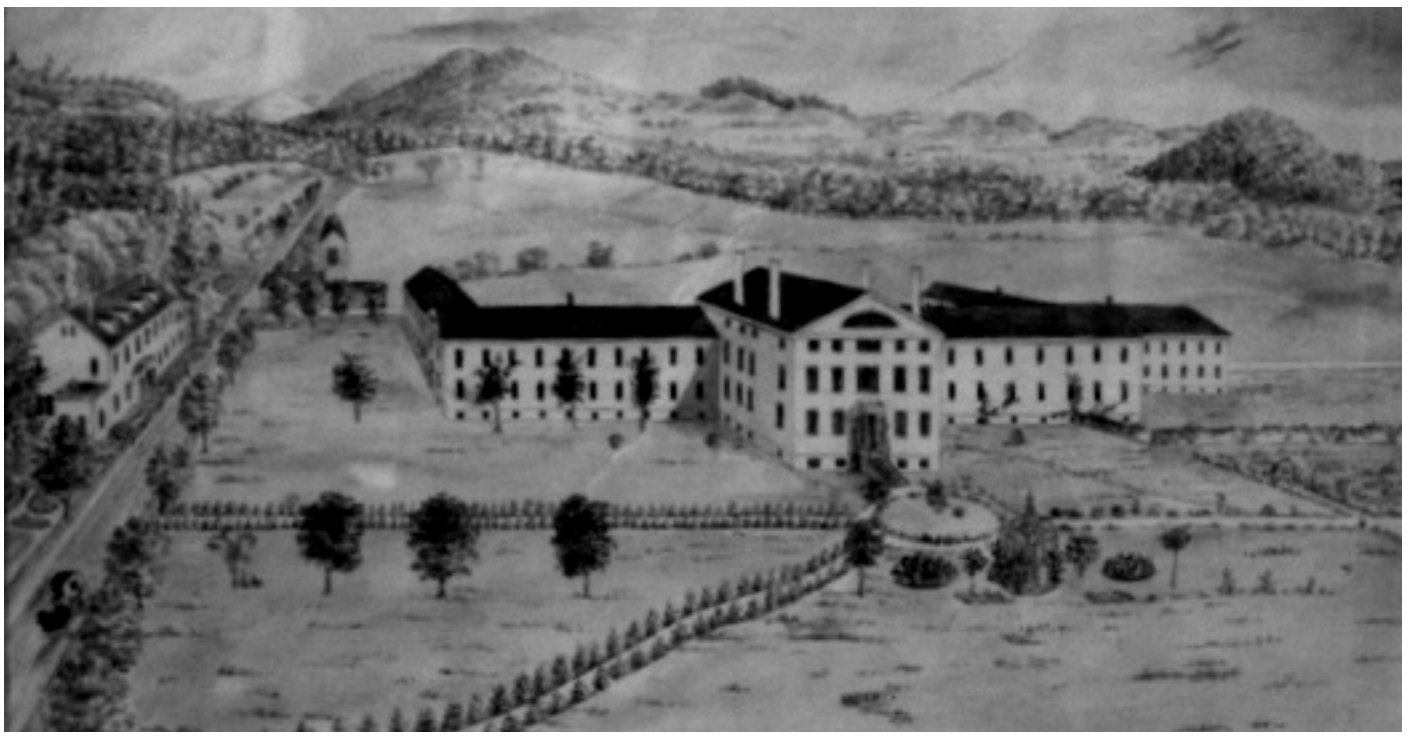
Notwithstanding all of the unknowns found within the growing darkness,
whether during the passing of one day into the next or one's eventual death;
given how great loathing and fearing of these no longer hold the same urgency
as once might have been the case, and although still somewhat reluctant to accept
inevitable cold and stillness; one becomes better able to embrace and welcome
circumstances taking a natural course flowing through life, and could be nearing,
no less so than what is typically faced during any given moment or evolving day
when welcoming the renewing warmth, energy and health dawning come sunlight.

by MORGAN W. BROWN
Montpelier

‘More Like You Than Not’

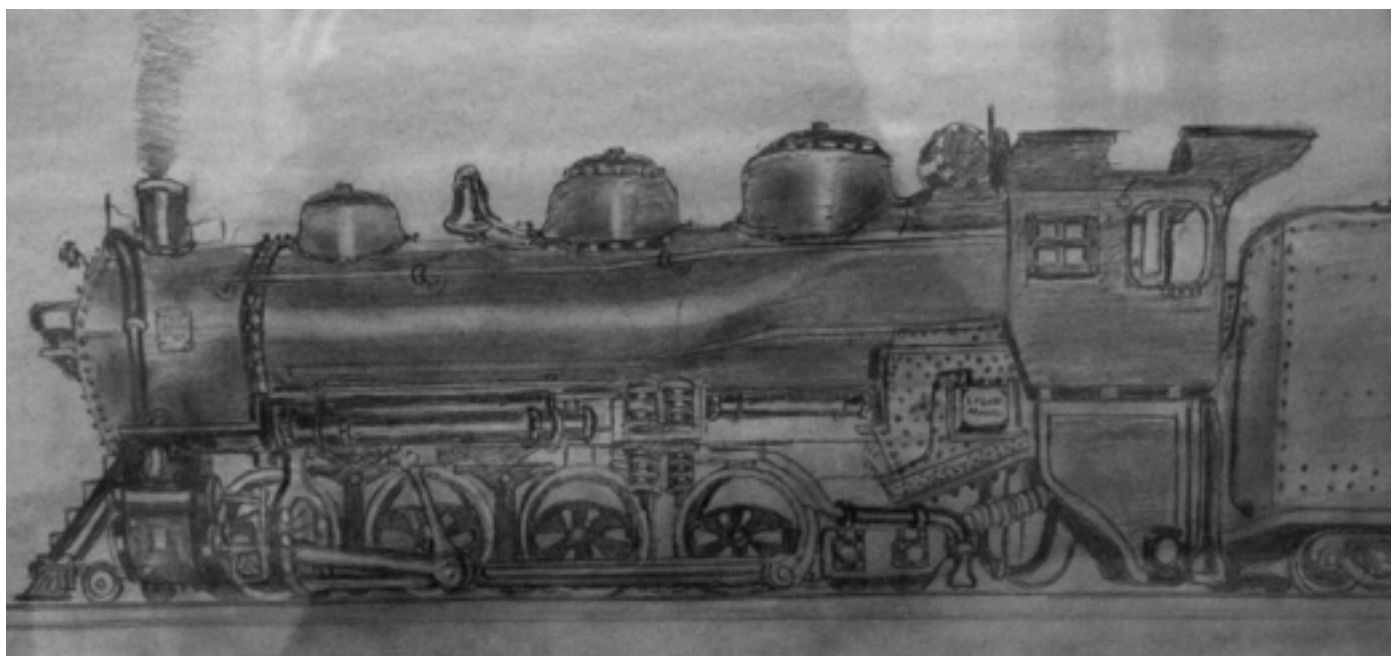
Bennington Museum Art Exhibition Features Work of Those with Disabilities

This exhibition examines some of the varied, always evolving contexts in which people with disabilities have created artwork in Vermont and the surrounding region during the last 200 years. Individuals with real or perceived disabilities have been ostracized from mainstream society for their supposed “differences” for far too long. In fact, the disability rights movement... has been called the “final frontier” of America’s larger civil rights movement. The art in “More Like You Than Not” — a quote from Vermont artist and autism activist Larry Bissonette — reminds us that we all share a universal humanity... The artists represented here, like all great artists of any ability or disability, have found creative solutions to a wide variety of obstacles — whether they be challenges related to their unique physical or mental make-up or aesthetic challenges — that has allowed them to communicate their personal perceptions of the world. The works on view have the power to bring our shared experiences as humans to the fore... *Text on these pages by the Bennington Art Museum. Photos of the display by Anne Donahue,* Counterpoint.



Vermont Asylum, Brattleboro, 1850
Angelica Whiting (1811-1871)
Watercolor, ink and graphite on paper
Collection of the Vermont Historical Society

A handful of drawings dating from the 1840s to mid-1850s and depicting the Vermont Asylum’s buildings and grounds from a bird’s eye perspective are known in public and private collections... Finely executed and highly detailed, the drawings of the asylum closely relate to drawings executed by young men and women at private academies during the same period. Angela Whiting, who signed this drawing, was a patient at the Brattleboro Retreat [originally named The Vermont Asylum] from 1846-1861.



Central Vermont Canadian National
c. 1955
Merrill Bennett (1908-1989)
Graphite on paper
Courtesy of the Vermont State Curator’s Office

Merrill Bennett was a nearly life-long resident of the Vermont State Hospital in Waterbury, Vermont, which was built in 1892 in response to overcrowding at the Vermont Asylum in Brattleboro. Per inscription at the upper center, Bennett gave this drawing to Dr. George Brooks, who was instrumental in introducing innovative treatment techniques at the hospital during the 1950s, including occupational and recreational therapy.

Working towards expressing myself acrylically, Larry draws paint on the canvas to portray buildings and figures like poured on with light strokes images, 1997
Larry Bissonette (b. 1957)
Acrylic on board
Courtesy of Grass Roots Arts and Community Effort (GRACE)

Larry Bissonette, a native of Milton, was institutionalized for much of his early life, first at the Brandon Training School and later at the Vermont State Hospital, with various diagnoses, including mental retardation, schizophrenia, and autism. From an early age Bissonette had an insatiable desire to create art, often breaking into the locked workshop at the Brandon Training School to draw, paint and build through the night. Upon being introduced to facilitated communication in 1991, Bissonette, whose verbal communication skills are limited, blossomed into a poetic and passionate artist and autism activist. He creates his expressionist paintings at his own home studio and at weekly workshops conducted by GRACE at the HowardCenter in Burlington.

Art and Vermont's Mental Health Care System

America experienced sweeping social reform throughout the early decades of the nineteenth century. One of the most visible results of this movement was the creation of dozens of hospitals dedicated to the care of people diagnosed with mental illness... Patients were encouraged to engage in a wide range of cultural and recreational activities, including artistic pursuits such as painting, drawing and needlework, which were thought to relive stress and restore mental balance.

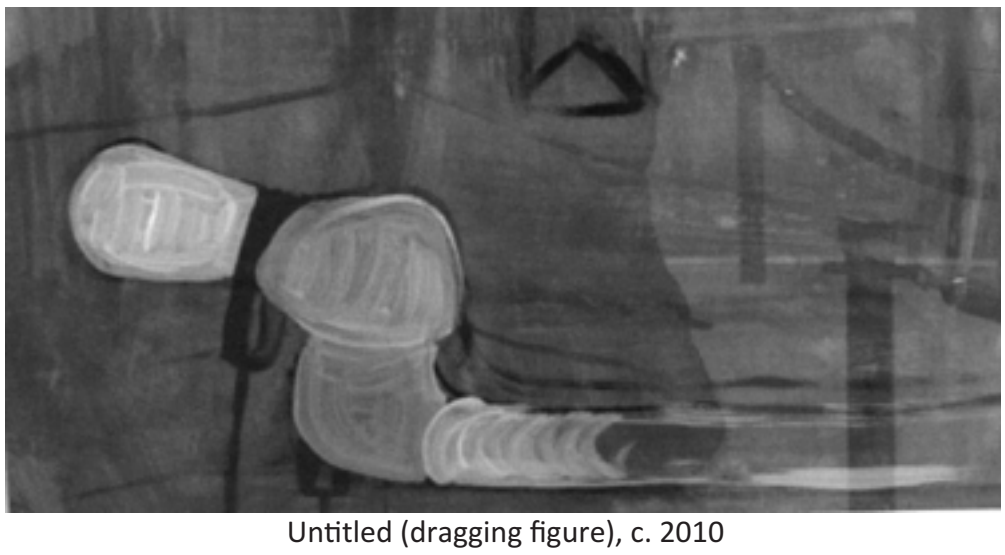
Art therapy, as we understand it today, came into being during the mid-twentieth century, combining creative activity with the burgeoning field of psychotherapy. Art therapy operates on the premise that through creating art and reflecting on the process, people can increase awareness of their self and others, cope with stress and traumatic experiences, enhance cognitive abilities, and enjoy the life-affirming pleasures inherent in the creative act...

The Brattleboro Retreat maintained an active creative arts therapy department from the mid-twentieth century through November 2012. The works of art in this exhibition labeled as "Courtesy of the Brattleboro Retreat Art Therapy Collection" were created during the last few years by participants in the... program. Though the artists must remain anonymous due to health care privacy laws, it is important to remember that these artworks were created by unique individuals who have created highly personal, insightful visions of the world around and inside of themselves.

Art Class, 2006

Anonymous Colored pen

Courtesy of he Brattleboro Retreat Art Therapy Collection



Untitled (dragging figure), c. 2010

Anonymous Acrylic on paper

Courtesy of he Brattleboro Retreat Art Therapy Collection

Untitled (fall landscape), c. 2010

Anonymous Watercolor on paper

Courtesy of he Brattleboro Retreat Art Therapy Collection

The Potala Palace in Tibet, 1990

Jessica Park, (b. 1958) Acrylic on paper

Collection of Rachel Park and Andrew Failes

Bird Man c. 2010

Anonymous Graphite on paper

Courtesy of the Brattleboro Retreat Art Therapy Collection

DISABILITY RIGHTS VERMONT ANNOUNCES FY 2014 PRIORITIES

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

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

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

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

After a year and a half of litigation, DRVT and Vermont Legal Aid came to a successful resolution of the lawsuit brought against the State of Vermont regarding the substantial backlog in investigations by the State's Adult Protection Services (APS) program. As part of the settlement agreement, APS has agreed to adopt changes to its policies and practices and to set performance benchmarks to address the problems raised by the plaintiffs in this lawsuit.

We have continued our work with DLP monitoring Special Education services for youth detained at Woodside Juvenile facility. In addition, DRVT staff is involved in monitoring and providing quality assurance regarding uses of force against youth detained at Woodside. DRVT continues to work with Woodside staff and DCF in the transition from the former status of Woodside as a detention facility to its current position as a treatment program.

DRVT has also been a vital participant in the ongoing work of the AHS State Interagency Team organized to assure that people with serious functional impairments (SFI) at risk of incarceration or delayed release from incarceration have access to the most effective and appropriate services to avoid their disabilities from causing them to loose their liberty. We are currently monitoring the committee formed by the Legislature that is studying the needs of prisoners with SFI.

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

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

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

DRVT has also worked to provide victims of crime who have disabilities with accommodated assistance as they deal with the criminal justice system. This work has resulted in DRVT participating in statewide ethics and civil rights training for victims' advocates, including issues of assisting victims with disabilities.

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

DRVT is publishing our formal Fiscal Year 2014 (10/1/13 - 9/30/14) priorities for the Protection & Advocacy for Individuals with Mental Illness (PAIMI) program on the adjoining pages. These priorities serve to focus the work of the agency and are developed by our Board and our advisory council, who get input from the community and staff. **Your input is appreciated!** We strive to do as much as we can with the resources we have and we can do that best when folks in the community let us know their greatest advocacy needs!

We need volunteers, too!

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

Each applicant must identify with one of the following categories:

- **You are a psychiatric survivor**
- **You are or have been a recipient of mental health services**
- **You are a mental health professional**
- **You are a mental health service provider**
- **You are the parent of a minor child who has received or is receiving mental health services.**
- **You are a family member of an individual who is or has been a recipient of mental health services**
- **You are a lawyer**

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

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

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

DISABILITY RIGHTS VERMONT FY'14 PAIMI PRIORITIES

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

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

Measure of Success:

A. Work on a minimum of 100 cases of abuse, neglect, or serious rights violations of people with mental health issues. Among closed cases, at least 75% of those not withdrawn by client or found to be without merit by DRVT staff should be resolved favorably.

B. In at least 2 opened cases, DRVT will advocate for adequate discharge of involuntary patients in the spirit of the community integration mandate of the Americans with Disabilities Act.

C. DRVT will assist at least 5 clients with medication-related issues including coercion, informed consent, and inappropriate medication and ensure that clients have been informed of the risks, benefits and alternatives to psychiatric medications.

D. Note whether the individual describes the issue as having occurred during a first contact with the mental health system because of the potential for coercion and trauma.

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

Measures of Success:

A. Work with at least two institutions to create respectful, trauma-informed, violence free and coercion free mental health treatment environments, particularly during an individual's first contact with the psychiatric system.

B. Advocate in the legislature, and with the administration, to preserve or enhance the right of Vermonters to be free from coercion in their mental health treatment.

C. DRVT will implement recommendations of our current cultural sensitivity self-assessment to insure that our services are delivered in a culturally responsive way.

D. Work in at least one community to improve the system-wide response to mental health-related emergencies to prevent unnecessary use of force, involuntary treatment and incarceration.

E. Work towards a constructive settlement in our litigation regarding Adult Protective Services.

F.DRVT will continue to offer Disability Etiquette trainings to volunteers or other personnel of organizations which deliver emergency services**.**

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

Measure of Success:

Outreach and monitoring is conducted at a minimum of 20 community care settings, including but not limited to residential care homes, therapeutic community residences or licensed residential childcare facilities.

Outreach is conducted, at a minimum, to the four state prisons housing the most PAIMI eligible prisoners.

Outreach is conducted at all designated facilities, including intensive rehabilitation residences and any state run facility.

DRVT literature is distributed to all of the community mental health agencies, prisons, and designated hospitals, including their emergency departments, intensive rehabilitation residences, and to homeless shelters, "club houses" and peer-run services.

Outreach to individuals labeled with a disability who are victims of crime or domestic abuse.

Monitor all treatment environments (e.g. designated hospitals & their emergency departments, residential care homes, correctional facilities) to assure that unnecessary or inappropriate use of seclusion, restraint, coercion or involuntary procedures are not used and that treatment is only administered with proper informed consent.

Continue outreach to diverse communities and non dominant cultures, monitoring that they receive services in a culturally competent way. Examples would include refugee resettlement programs, and organizations like the Association of Africans Living in Vermont, etc.

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

Measure of Success:

Four self-advocacy and/or advance directive trainings for 40 individuals.

Assist at least 5 individuals across the State of Vermont with their preparation of Advanced Directives.

Work with the administration, other advocacy groups and individuals on the implementation of Act 79, including a wide array of treatment options in the least restrictive and most community based settings possible.

Encourage the development of peer run services in Vermont's mental health system reform and educate peers on access to these services.

DRVT will participate in systemic efforts to improve state services for individuals in or at risk of incarceration to speed successful reintegration.

Participate in efforts to insure that state and local emergency planning efforts include the needs of people with mental health issues.

Participate in coalition efforts to address transportation infrastructure needs of low-income people with mental health issues.

Support the Vermont Communications Support Project in order to ensure that people with communications disorders related to their mental health can participate in the judicial and administrative systems.

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

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

How can you make your voice heard? Contact DRVT at:
141 Main Street, Suite 7, Montpelier, VT 05602
Or by phone: 1-800-834-7890 or, locally, at (802) 229-1355
By email at: info@disabilityrightsvt.org
Please visit our website at www.disabilityrightsvt.org

Criminal Courts Stymied by Lack Of Hospital Space; ERs Again Fill Gap

by ANNE DONAHUE
Counterpoint

Twice in November, criminal courts dropped charges and issued an Order of Hospitalization to commit a defendant, only to find they were powerless to actually get the individual into a hospital.

In Springfield, after finding James Butterfield incompetent to stand trial, Judge Howard Kalrus ordered that "[p]ending an available hospital bed Defendant shall reside at the Southern State Correctional Facility..."

Corrections refused to accept a prisoner who had no criminal charges pending, the Windsor state's attorney said, so he ended up under guard in the emergency room. That provoked the ER director to appeal to the governor to address the danger to staff and other patients by admission delays.

In Guildhall, Judge Robert Bent simply ordered that sheriffs take Adam Chartier to the state-run temporary hospital in Morrisville the next day after finding him "insane at the time of the alleged offenses," despite knowing there were no beds available.

Before the transport occurred, a bed opened at the Brattleboro Retreat. Otherwise, Paul Dupre, Commissioner of the Department of Mental Health, said he assumed "we would have had to take him to an emergency room and had the sherriffs sit with him" until a bed became available.

Both men differed from others in the past two years who have faced emergency room waits — sometimes for many days — because they were already under a 90-day court-ordered commitment.

"My understanding is that this has been a very rare situation," said Dupre.

The ongoing emergency room crisis has revolved around persons being held for an emergency examination to determine the need for potential commitment. Persons charged with crimes but referred for an inpatient evaluation of sanity, on the other hand, have frequently been held in Corrections for weeks to wait for an open bed.

The Director of the Emergency Department at Springfield, Rick Marasa, MD, wrote in an email to Governor Peter Shumlin that the delays for admissions were causing a "clear and present danger."

Sending a person to sit waiting in an open emergency room bay after just having criminal charges dropped because he was psychotic was "ludicrous and dysfunctional," he said in an initial email to colleagues that became a part of the email sent to the governor.

"Although, the circumstances of receiving this patient are unique, the intrinsic danger to our staff and the lack of appropriate psychiatric care for this patient are glaringly evident. I am praying hard that no harm comes to my staff, my community, or this patient. I pray, because prayer is all I have," he wrote.

Shumlin responded through a letter from the Department of Mental Health Commissioner, Paul Dupre, who outlined the steps the state has been taking to rebuilt the system of care since Tropical Storm Irene forced the closing of the Vermont State Hospital.

Using a commitment order as a way to put pressure on the system to provide a hospital bed was seen as a victory by Essex County State's Attorney Vince Illuzzi.

"We forced their hand," he told *Counterpoint* after Chartier was admitted to a hospital. Illuzzi said that Chartier had spent 19 days "being kept in solitary confinement" in Corrections when he was supposed to be receiving inpatient care. "It's not right," Illuzzi said.

Dupre said that the Department was "trying to work with the judges [about] what is realistic and what is not" in light of the shortage of inpatient beds while a replacement hospital is under construction in Berlin.

Dupre told a legislative committee in November that the Department now moves ahead with the psychiatric competency evaluations while defendants who were found to need inpatient care are waiting in Corrections. That makes it more possible for a person to be found incompetent and commitment ordered when not yet in a hospital.

Chartier's criminal charges stemmed from a truck stolen in Brattleboro on October 23, after he was discharged from the Retreat. He returned to Essex County, where he told a Northeast Kingdom Mental Health worker that he was going to kill people at random, the affidavit said. It said he was stopped by police in Concord, and was crying and asking police to shoot him when taken into custody. When Chartier appeared in court on October 29, a screener told the court that Chartier was suicidal and homicidal, Illuzzi said. According to the later Order of Hospitalization, he was evaluated for sanity by a psychiatrist while in Corrections. On November 18, the court signed an Order of Hospitalization that directed that "Mr. Chartier will be transported to the Green Mountain Health Care facility [sic] in Morrisville, Vermont on November 19, 2013."

Doctors Plead for Help from the Governor

Between Monday, November 25 and Wednesday, November 27, a series of emails from the state's Emergency Department directors eventually ended up being directed to Governor Peter Shumlin, with copies to legislators. The conversation was initiated by an invitation by Mourning Fox, the Department of Mental Health's Care Management Director, and Elliott Benay, Director of Psychology at the Department, to bring up topics for discussion that would be of help "in dealing with psychiatric patients... waiting for significant times in your ED." Rick Marasa, MD, of Springfield Hospital, responded with a detailed case history from the prior week. The emails, which are public documents, are reproduced here chronologically, with edits to remove some of the more sensitive details about the patient that were described, as well to remove some tangential or repetitive comments in order to reduce overall length.

From Dr. Rick Marasa, November 25, 2013:

Dear Norma [D'Anca] and Elliott [Benay][DMH],

I wanted to follow up the communication I wrote you last Wednesday with information on our current saga of unsafe, dysfunctional psychiatric care that has been imposed on us by the "system" of care for psychiatric patients in this state. DMH and the corrections system are primarily involved. Here's the story:

At 4:15 on Thursday 11/21, I received a long voice mail from Mourning Fox who gave me the courtesy of telling me about an imprisoned patient that was being sent to our ED until a Level 1 bed was available. [Patient has] ...the diagnosis of anti-social personality disorder and schizophrenia. He has committed at least one very violent crime and has been incarcerated from time to time. Apparently, he had been arrested for some reason recently... and was in Springfield Prison awaiting trial. According to Mr. Fox, he went to trial and was apparently psychotic, mostly due to his unwillingness to take his regular medications and apparently there was no court order to give them.

The judge ruled him unable to stand trial and made a ruling that he needed commitment to psychiatric therapy. The prison then essentially ruled that since he can't stand trial he is no longer under arrest and shouldn't be in prison and refused to house him until a Level 1 bed becomes available. As such, he was being ordered to come to the "closest ED," which is Springfield Hospital.

I trust that you both can see how ludicrous and dysfunctional this is! This individual was in jail because of criminal behavior and is no less dangerous to society than he was when it was felt necessary to incarcerate him. Now he is not only criminally dangerous, but even more dangerous because he is psychotic...

What is more appalling from a personal and professional standpoint is that this man... is in an open room in the Springfield Hospital ED. I feel powerless to provide protection to my staff or myself in this matter. He is already hoarding items whenever he can and he managed to get his mother to bring him in razors in some toiletries, despite him telling us she is bringing in food...

Because CMS has sternly directed us (with the threat of essentially closing the hospital down) not to confine these patients, he has direct physical and eyesight access to staff and all children and other people that walk down the public corridor where the door to his room is adjacent to...

Although, the circumstances of receiving this patient are unique, the intrinsic danger to our staff and the lack of appropriate psychiatric care for this patient are glaringly evident. I am praying hard that no harm comes to my staff, my community, or this patient. I pray, because prayer is all I have. The system and the circumstances are not protecting or serving the needs of any of these endangered people I have listed.

Please help! Dr. Rick Marasa

Response from George Terwilliger, MD, Brattleboro Memorial:

What a difficult position you and your staff are in. This very dangerous situation is precisely the sort that could result in a disastrous sentinel event which could force the Supreme Court to rule that the legislature, agencies and executive branch have been negligent in their duties to care for mentally ill patients and to protect the public. I'm convinced that only such a ruling will have enough force to effect necessary changes.

George Terwilliger, MD, ED Site Director

Response from Amanda Young, MD, Porter Hospital:

There is nothing that makes a manager feel more powerless than this exact situation. We are prisoners of laws, rulings, and lack of high administration support to change things, so we are reduced to venting on email streams to each other the injustice of this clinical event...

We too, recently had a boarder who was psychotic, anti-social, and a scary physical presence in our ED. We put up moveable screens outside his room to reduce the amount of eye contact and verbal threats he could make to other patients. We had two sheriffs present at all times for safety and administered IM meds when he absolutely refused the PO medications (which only happened once after mountains of documentation for CMS purposes). He stayed for 13 painful days and the highlight was him standing at his doorway screaming the demands of scrambled eggs and sausage from the nursing staff, who happened to be 10 feet away assisting the MD with the placement of a central line in a critically ill patient. The image is almost laughable, and then it makes you want to cry.

No one wants to be the one to shoulder the sentinel event that is destined to happen - why does this seem so difficult to understand? Does the governor deserve a (polite) earful from us? Should he be privy to these emails that so accurately describe the true tragedies of this situation? Does anyone else feel like something more decisive from us needs to happen and what is our avenue? The folks at DMH are on our side but they are constrained by the realities of higher administration. I am new to this group, so perhaps a little naïve as to what power we might have, if any. Rick, my sympathies go out to your staff and the patient. The reality is that while this guy will eventually go, there is a great cost you have incurred, but perhaps the biggest ticket item is the assurance that it is only a matter of time before it will happen again.

Amanda Young, MD, ED Director

Reply to Dr. Young from Dr. Marasa:

Thank you so much for your heartfelt message and your support... I hope our desperate cries for help will be heard and considered by the following individuals and organizations: Dr. [Harry] Chen as a serious Public Health issue since these patients are the only ones in Vermont that are systematically being forced to receive substandard, inappropriate care; the State's Attorney's office as these patients are being denied proper care just by the nature of their diagnosis and their disabilities, which if probably were any other group would be considered a civil rights violation; by [the Vermont Association of Hospitals and Health Systems] because this extraordinary effort by the E.D.'s and hospitals not being paid for and even worse is putting all our staff at risk of harm and even death; by DMH so that they can redouble their efforts to carry out their duty to care and comfort these patients: and finally the Governor to create the resources needed to get these patients the proper care, like they had before the hurricane shut down the state psychiatric Hospital.

Maybe we can make a difference and maybe we can't, but it seems like the right time to try. Again, thank you so much for sharing your experience and speaking up. Rick

[An additional email was then sent from Dr. Marasa describing an incident involving the same patient, when still waiting in ED, alleging inappropriate actions visible to the spouse of another patient.]

Cover letter from Dr. Marasa to the Governor:

Dear Governor Shumlin,

I hope this letter finds you anticipating the Thanksgiving Holiday with your family. After much time and consideration, it seems to be clear how important it is to share with you the comments from myself and other ED Medical Directors regarding the lack of appropriate care for the most ill psychiatric patients in Vermont and the clear and present danger they are creating for our community and health care workers. I can be witness to the fact that the comments below are an excellent representation of the overall sentiments regarding this crisis. All our efforts to date have not made anything better and your current plan is doomed for failure. I can only hope and pray that with this knowledge you will promptly take the steps necessary to give proper inpatient care to psychiatric patients instead of leaving them in Emergency Departments where they cannot get proper care and they impose an ominous threat and sometimes create serious harm to health care workers and our community. Respectfully, Dr. Rick Marasa

The regular *Counterpoint* referrals page was suspended for one issue as a result of this late-breaking story on new impacts on the emergency room crisis. It will return to our back page in the spring issue.