Spring Is Back!

Counterpoint Returns To Four Issues a Year

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

# Counterpoint

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# Bill To Speed Up Medication Orders Passes Senate, 26-4

Wendy Fuller of Montpelier testifies at the public hearing.

**by DONNA OLSEN**
**Counterpoint**

MONTPELIER — Changes that would allow a court to set a faster time schedule for some involuntary drug hearings passed the Vermont Senate in February on a 26-4 roll call vote after a short and low-key debate by legislators. The vote was an anti-climax to passionate testimony from witnesses in the weeks before.

The proposed bill, S. 287, will next be considered by members of the House.

"I am here to talk about the great potential harm for anything that aims to reduce an individual's voice in actions that are done against their body," Laura Sisson said at a public hearing on the bill. She called it a "vicious cycle of retraumatization."

But Vicki Mednick, a psychiatric nurse for 17 years, said that "putting a person in the hospital and then not being able to treat them, among my colleagues and I, is unconscionable."

Parents of one man who waited in an emergency room for a bed for 14 days said he did not know he was ill, so he refused medication.

"After being transferred to a psychiatric ward, he continued to refuse treatment and it took 52 days before a judge approved a clinician's application to have him involuntarily medicated," Ron Powers said. "When injections were finally allowed to commence, my son's psychosis began to ease. He's home now, calm but not cured."

The bill is focused primarily on expediting the commitment and medication process for two groups of persons: those who, despite being in the hospital, were creating a "substantial risk" of "serious bodily injury" to self or others, and those who had received medication under an order within the past two years, and improved from it.

It would shorten time frames for any involuntary patient through a limit on continuances to a single, 7-day delay; allowing petitions for commitment and medication orders to be heard on the same day; and placing limits on when an appeal can result in holding off the start of the involuntary medication.

There was contradictory testimony throughout weeks of hearings before two Senate committees.

Psychiatrist Craig Van Tuinen said it took time for patients to develop a therapeutic relationship.

"They have to deal the with the trauma of being handcuffed and then [are] asked to trust the people who hold the key to freedom."

Judge Amy Davenport said she worried that "if you push too hard you increase the number of

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# *Insurers End Mandate For Preauthorizations*

**by DONNA IVERSON**
**Counterpoint**

The state's largest insurance company, Blue Cross Blue Shield of Vermont, dropped all preauthorization requirements for therapy this winter after challenges about whether the practices of its new mental health managed care subsidiary, Vermont Collaborative Care, violated federal parity law.

A second insurer, MVP, is also dropping its prior approval requirements, citing compliance with the federal regulations.

Blue Cross Blue Shield's Vice President for External Affairs, Kevin Goddard, told *Counterpoint* that it came to the decision because a review of data and conversations with clinicians convinced the company that the change would improve the management of care.

The shift to drop prior approval requirements also came after meetings with state regulators and legislators, and after a series of letters from the American Psychiatric Association charging that Blue Cross Blue Shield was in violation of the federal parity law.

In 2008, Congress passed the Mental Health Parity and Addiction Equity Act (MHPAEA). The federal parity law bans management of care that created differences in the way people could access mental health care, when compared to the majority of other health services.

Those seeking mental health therapy describe "preauthorization" as a dreaded word that conjures up a picture of a faceless bureaucrat sitting at a desk deciding if coverage is deserved, working for a system determined to restrict coverage.

Although in recent years prior approval for initial visits were gradually dropped by insurers, preauthorization continued to be required for continuation of visits. That meant persons requiring long term therapy had to repeat the process regularly.

Because advance approval is not required for medical visits in similar situations, Vermont mental health advocates said they believed the requirements violated the federal law, and began putting pressure on Blue Cross Blue Shield.

Although the law passed in 2008, final regulations were only enacted in 2013. Vermont's own longstanding parity law has never addressed differences in management of care.

The American Psychiatric Association (APA), working closely with the Vermont Psychiatric Association "met with leaders of Blue Cross Blue Shield in early October of 2013 for the purpose of trying to come to accord over several important aspects of the federal parity law," according to Ken Libertoff, a consultant for the APA.

The first area of concern was the preauthorization requirement, Libertoff said.

The second area of concern was to "have nondiscriminatory reimbursement rates for mental

*(Continued on page 3)*

# Opportunities for Peer Leadership and Advocacy

## Meeting Dates and Membership Information for Boards, Committees and Conferences

## 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. The committee is the official body for review of and recommendations for redesignation of community mental health centers and monitors many aspects of the system.

**Adult Standing Committee Needs New Members!**

The Adult Program Standing Committee has issued a news release to recruit new peer, family and provider members. It is a "very intelligent, exciting committee," the release from member Marla Simpson said.

"We meet the second Monday of every month, from noon to 3 p.m. at 26 Terrace Street in Montpelier," she said. "The Commissioner of Mental Health and other experts in the field meet with us and we hear the latest and most innovative news regarding mental health matters in Vermont.

"We also review and help re-designate Designated Mental Health Agencies. Duties include attending all meetings, reading relevant materials for the meetings, and/or making site visits to Designated Mental Health Agencies. It is an honor and a pleasure to be a part of this important committee."

The news release said that the Committee is looking for two provider members, one peer member, and one family member. Based upon the desire to have members from different counties across the state of Vermont, the committee is especially interested in adding members from the Northeast Kingdom, Chittenden County, Southeastern Vermont, Bennington County, and Addison County. There is reimbursement for mileage.

Those interested in applying can contact Melinda Murtaugh (Melinda.Murtaugh@state.vt.us) or Clare Munat. Marla Simpson, M.A Member of the VT Standing Committee

### *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).

## CORRECTIONS

### Obscenity Not Used in Poem

A poem by Ocean Chance published in the fall 2013 issue of *Counterpoint* included an abbreviation for an obscenity within the poem. The abbreviated word did not appear in the original poem as submitted. *Counterpoint* regrets the error.

### Combining Topics Was Error

Two articles were combined into one in error in the winter issue of *Counterpoint*. One topic addressed the Youth in Transition grant, while the second one reported on a meeting of the Mental Health Transformation Grant's advisory committee. The subject of the MHTG meeting was the work being done on making programs welcoming to young adults. Although the populations of focus — young adults — are very similar, the two grants are separate and the grant advisory committees are separate. *Counterpoint* regrets the error.

**How to Reach**
**The Department of Mental Health**
**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

## 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 under development with expansion from the current advisory group for Green Mountain Psychiatric Care Center. 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.

## CONFERENCES

The New York Association of Psychiatric Rehabilitation Services (NYAPRS) is presenting its 10th Annual Executive Seminar on Systems Transformation April 24-25 at the Hilton Albany in Albany, New York. Information is available at www.nyaprs.org. The Psychiatric Rehabilitation Association is hosting its Recovery Workforce Summit: PRA 2014 Annual Conference at the Renaissance Hotel in Baltimore June 22-25. Information can be found at www.uspra.org/


# *Counterpoint*

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


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## Have News To Share?

**Send It to**

***Counterpoint!***

***Your* peer newspaper**

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

***Counterpoint* Deadlines**
Fall (September delivery; submission deadline July 7)
Winter (December delivery; submission deadline October 7)
Spring (March delivery; submission deadline January 7)
Summer (June delivery; submission deadline April 7)

# Insurers End Mandate for Preauthorizations

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health and substance abuse treatment providers," he said. Colleen Coyle, general counsel for the APA, exchanged several letters with Blue Cross Blue Shield last summer, urging it to drop the preauthorization requirement as a violation of the federal Mental Health Parity and Addiction Equity Act.

After the unsuccessful October meeting, she wrote again, saying that "the lack of interest does not reflect well on BCBSVT's professed interest in treating patients with mental illness in Vermont... in a fair and reasonable manner." Coyle flew to Vermont in October to testify to the legislature's Mental Health Oversight Committee.

Blue Cross Blue Shield did not acknowledge that its changes were based upon pressure from the AMA or others.

"We changed our preauthorization requirements because our discussions with providers and analysis of data convinced us that the change supports our goal of improving care management and support," Goddard said.

Peter Albert, CEO of Vermont Collaborative Care, said VCC took over managing mental health services for BCBS on July 1, 2013, and that BCBS began holding hearings and talking with mental health professionals, state regulators and state legislators about how to manage its mental health coverage.

"We agreed that before any major changes would be made we would first need to review prior practices, analyze data and assess how other health plans approached this work," Albert said about the new managed care company.

He said the company "recognized that a key to any possible success was the importance of listening to our clinical community," and "spent several months meeting with representatives of professional organizations along with a great number of individuals in private and group practices."

Albert said company officials also met with regulators from the state's Department of Financial Regulation, the Green Mountain Care Board and the Mental Health Oversight Committee.

The company then hired an independent clinician to hold a series of independent meetings with clinicians from around the state "to get front-line advice from those actually doing the work."

Albert said that "the more we spoke with people and looked at the data the clearer it became that to make real change we needed to focus attention and resources on those individuals who needed better coordination of care and increased communication between clinical disciplines.

"With that goal in mind, removing prior authorizations for routine outpatient services was a logical step," he said. Albert said that clinicians were notified of the change in mid-December.

The letter stated that preauthorizations would no longer be required for outpatient treatment. It said that BCBS would be collaborating on developing a "more effective method for reviewing quality and outcomes, thereby creating a system to better identify 'high risk' members to ensure that they receive the coordination of care they need."

Other services, such as "inpatient, residential (such as substance abuse rehabilitation), partial hospitalization, intensive outpatient programs, electroconvulsive therapy, and psychological testing" will still require prior approval, it said.

### Other Insurers Are in Compliance

The two other Vermont health insurers, Cigna and MVP, were not a target of the advocacy efforts last year. According to spokesperson Mark Slitt, Cigna was the "first managed health care organization to remove preauthorization requirements for routine outpatient mental health care.

"We believed then, and continue to believe now, that individuals should have easy access to mental health care. Cigna was a very early supporter of mental health parity," Slitt said.

"We advocated for the federal law before it was passed and we have actively worked to implement it in Vermont. We have also put a great deal of energy and effort into compliance with the state's parity law."

MVP, like Blue Cross Blue Shield, had required preauthorizations. It, too, contracts with a separate company, Primeralink, to manage the mental health benefits for its members. Primeralink is owned by the Brattleboro Retreat.

Susan Gretkowski, Senior Government Affairs Strategist for MVP, said that its leadership met with Primeralink to review the federal regulations after they became final in November. That led directly to its decision to drop the requirements for prior approval for continuation of mental health care visits, she said.

### More Parity Work To Be Done

Several Vermont mental health advocates say there is more to be done to assure that Vermont companies are in compliance with the federal parity law. Alice Silverman, MD, of the Vermont Psychiatric Association, said that although the law is complicated, "my sense is that the continued presence of 'carved out mental health benefits' as represented by VCC [Vermont Collaborative Care] as well as under-reimbursement is still a violation of parity."

She added that although prior authorizations have been eliminated for in-network providers, they continue for out-of-network psychiatrists.

She said that because there are insufficient numbers of psychiatrists as a result of the aggressive managed care policies of the past 10 to 15 years, "I would like to see proactive efforts to correct this problem."

APA General Counsel Coyle raised the same issue, identifying it as a result of compensation for psychiatrists that was not at an equal level with medical physicians for the same treatment codes.

Reimbursing psychiatrists at a lower level "discriminates against mental health patients by limiting access to care," Coyle wrote in one of her many letters of concern to BCBS. Libertoff also referenced the unequal reimbursements.

Silverman's criticism of the separate management of mental health benefits relates to the longstanding practice of insurance companies to subcontract mental health management, while directly managing other health benefits.

### New VCC Manages Care Separately

Vermont Collaborative Care is a new company created jointly by Blue Cross Blue Shield and the Brattleboro Retreat to manage mental health care for Blue Cross Blue Shield. It replaced the contract that Blue Cross Blue Shield had with Magellan Behavioral Care for many years.

Goddard said that Vermont Collaborative Care was created "to improve management and support of mental health and substance abuse care" by moving it into Vermont, since Magellan was an out-of-state company. In addition, through the co-ownership with the Retreat, Goddard said it was "partnering with a like-minded Vermont organization that has decades of experience in supporting Vermonters with mental health or substance abuse problems."

"Most importantly," he said, was "beginning the integration of mental health and substance abuse and physical medical care management."

# *Third Death Within Past Two Years At Brattleboro Retreat Is Reviewed*

BRATTLEBORO – An investigation into the suicide death of a 13-year-old girl at a Retreat residential program is not yet complete, but a state official said there are "no allegations of any kind of wrongdoing… or negligence on the part of the program."

The death on January 3 was the third suicide or drug overdose death on Retreat program premises in less than two years.

Jim Forbes, LICSW, MPA, Director of Residential Licensing and Special Investigations at the Department of Children and Families, said that although he could not comment on the specifics of an open investigation, there was not a basis to be "concerned about the safety of any of the children [currently] in the program."

He also said that the "program responded very appropriately" in meeting the needs of the other youth in the program in the aftermath of the death.

Forbes said that he believed the collaborative investigation by DCF and the local police would be finished by mid-March. The medical examiner's full report is not yet complete, and "with a situation like this [you] don't want to close the door without having all the information."

He said that the Retreat reported the death to DCF as would be required for any critical event, in this case, "a serious and tragic event." DCF licenses all such children's residential treatment programs.

The girl was a private patient from New Hampshire, not a youth in the care and custody of the state, he said. According to reports in January, the girl had been admitted to inpatient care last November. In December, she was moved to one of four group homes on Linden Street, a step-down residence with less intensive oversight than in the Retreat's inpatient, 24/7 treatment facilities.

The teenager was last seen in a common room on Friday evening 10 to 15 minutes before she was found dead in an upstairs room, according to Retreat officials. Staff at the adolescent residence hall called her for dinner, and realized she was missing when she didn't respond.

Forbes said that a review process involves interviewing relevant staff and youth, reviewing the expectations regarding supervision and the care plan in place in light of the licensing regulations, and finally, whether there was a link between anything the program had not been doing and the critical incident. AD

## *Awareness Rally Planned for Spring*

**BRATTLEBORO — Pathways is planning a Mental Health Awareness Rally in late spring on the town common, featuring live art, music and speakers. The rally has been scheduled for May 17.**

**Further details can be obtained by contacting Matti Saliman at at matti@pathwaysvermont.org.**

**PASSIONATE VIEWS — Members of the public pack a hearing room to listen and to testify to two Senate committees about a bill under consideration to expedite the time frame for the court process for orders of involuntary psychiatric medication. At left end of photo, around the**

# *Bill To Speed Up Court Drug Orders*

*(Continued from page 1)*

cases being heard and decrease the number of cases being resolved in a consensual way."

Davenport, who is the chief administrative judge for the state, shared a flow chart with legislators from the Judiciary and Health and Welfare Committees at a joint hearing that opened review of the bill.

The chart showed that in the 455 cases of patients being held for a commitment hearing in 2013, 316 were dismissed before the hearing and 90 were resolved by consent. After that, only 42 applications for involuntary medications were filed. "If we increase medication filings, that gain may be lost," she said.

Davenport supported an addition to the bill requiring a judge to find that there was a valid legal reason to hold a person involuntarily within a week of an admission. That requirement was included in the bill that passed the Senate.

At the start of the first hearing in January, Sen. Jeanette White, who introduced the bill, said that she understood that involuntary medication addressed issues that were "highly personal [and where] the stakes are high."

She said that it was "not a bill that weighs the benefit of medication... [or] whether medication should be used," but about "timely access to judicial review of [a person's] case."

The Judiciary Chair, Sen. Dick Sears, said that "what is happening to that person" in the interim, while the case is pending, is "a critical point."

The risk of violence in the hospital during that delay was stressed by the Medical Director of the psychiatric inpatient unit at Rutland Regional Medical Center. Gordon Franke, MD, told the committees that one staff member suffered a traumatic brain injury after an assault by a patient.

"He appeared to be working well with staff but one day without warning he walked up behind a staff member who was sitting at a table, talking with another patient, and he, with a closed fist, hit that staff member on the side of the head as hard as he could.

"He knocked that staff member to the ground, nearly knocked him unconscious, picked him up by the hair and hit him again before other staff could intervene. There was no warning, he didn't threaten anyone, he didn't state he was going to hurt anyone. He just did this."

After the assault, there was no way to speed the process of getting a hearing for involuntary medication, Franke said.

"This is in direct opposition to the best interest of the patient. The current process is not working."

The Commissioner of the Department of Mental Health, Paul Dupre, said one question to consider was how long a person was suffering. "I believe we can move forward and expedite the process while protecting rights of patients."

However, Jack McCullough, director of the Mental Health Law Project of Vermont Legal Aid, said there was a "moral and legal obligation to listen to the patient."

"We have serious problems with this bill. We think it is a rush to judgment and will deprive people of their due process rights."

The two committees also heard from a medical bioethicist from Fletcher Allen Health Care in Burlington. Robert Macauley, MD, said it was an "emotionally charged" issue with no perfection solution in the effort to respect individual rights, help patients in need, and protect others from harm.

He said "a core of the debate" is what it means to be mentally ill, with many patients believing that "the 'mentally ill' version of themselves is truer to who they really are than the 'medicated, healthy' version."

At the public hearing several weeks later, individuals described their own experiences with forcibe administration of psychiatric drugs.

Margaret Bennett testified that she had been in the mental health system since 1989 and was humiliated as she was restrained and forced to have medication.

"Treat people with dignity," she urged the legislators. "Please listen to the patients."

Sisson said that her multiple diagnoses failed to identify the real issues and what treatment might be appropriate.

"What none of these diagnoses could tell you is that I had experienced early and repeated sexual trauma that was deeply connected to all the symptoms that the mental health system was insisting be treated with medication." She said that the involuntary medication created an "entrenched message of no power or control."

Marla Simpson testified that her own experience with forced medication was "very traumatizing... more traumatizing than being a victim of domestic abuse."

"I believe in positive psychology. Forced medication creates dependency on the system," she told the Senators.

"I understand I was a danger to myself but the doctors were not looking at me as a person," said Erica Reil, who described being involuntarily medicated at age 14. She said that at 36 she now suffers from post traumatic stress disorder as a result.

Parents who testified at the hearing described the effects of long waits for medication hearings. Kate Faust said her son was hospitalized for six-and-a-half-months before treatment was administered.

She also testified about her hope that the bill would address emergency room delays, saying that her son experienced a six-day wait before his first admission and a 10-day wait the second time. Each time he was in full restraint and guarded by sheriff, she said.

Faust described her son as a gentle person and said she realized he was not in control. She said he told her, "I would not hurt anybody," and that he just wanted to go home.

Irena Smironva said that her son had multiple hospitalizations and each time the length of stay increased. It took months to get him the drugs he needed for treatment, she said.

One witness provoked a recess after her emotional testimony about being hospitalized for five-and-a-half weeks before being able to appear before a judge.

"I fought for my rights and I'm out of there. No one should ever have to endure what I've gone through, it's has been hell," Kristen Schumacher said. She told the legislators that she was shackledand locked up the day her son was murdered by former husband, who then killed himself.

According to a news article in the Burlington *Free Press*, the court ordered her released after finding that she was not "a person in need of treatment" under the law either when she was first held or at the time of the hearing.

## Committee Reviews TBI Commitment Bill

MONTPELIER — A bill allowing court-ordered treatment for persons with a traumatic brain injury charged with a crime is under review in the legislature. The House Judiciary Committee has been working to finalize a bill addressing persons who are accused of committing a crime, but who are not able to stand trial or cannot be charged because the behavior was a result of a traumatic brain injury.

Under current law, a traumatic brain injury can be considered in the same way as a mental illness or a developmental disability in determining whether a person can be held responsible in a criminal court. If criminal charges are dropped, however, a person with a mental illness or a development disability can be committed to the state for treatment. Since a traumatic brain injury is neither a mental illness nor a developmental disability, no treatment can be required under those laws. The bill would allow a similar system for court-ordered treatment, including secure treatment, for persons with a traumatic brain injury charged with crimes. AD

**hearing table are Senators Dick Sears, Clare Ayer, Alice Nitka, Anthony Pollina, Dick McCormack, Jeanette White and Ginny Lyons. (Counterpoint: Anne Donahue)**

# *Is Approved by Senate*

## *Vote Was 26-4; Bill Now Moves to House*

In contrast to the intensity of witness testimony in committee hearings, the Senate had only a few exchanges in floor debate before voting on the bill.

Even one of the four Senators who voted "no," and who had voted "no" as a member of the Health and Welfare Committee, said that only the weight of a feather tipped him against the bill.

"I barely came down on one side," Sen. Richard McCormack said.

McCormack said that based upon the testimony he heard, it was clear that some people "have a really horrible time as a result" of involuntary medication, but often, it "does good."

"What autonomy are we protecting" if people are in a state where they are unable to think for themselves, he asked, if medication "actually gives their autonomy back?"

His decision, he said, was based upon whether speeding up a process that already exists would reduce protections.

McCormack said that the testimony from Legal Aid that attorneys would have less ability to prepare cases led him to believe that a faster process "will result in less judicial oversight."

"Let's give them the maximum protection of their rights," he concluded.

Sen. Claire Ayer said that for many patients, doctors "can and do wait" before seeking a court medication order.

"That is the gold standard," she said. "Gaining trust is the best way to get a therapeutic relationship."

However when violence is an issue, waiting is sometimes not an option, she said.

"They're not all violent, not by a long stetch," Ayer emphasized.

She told the other legislators that "getting a person who is incapable... to the point they can make a decision" is the purpose of an involuntary order. Ayer is chair of the Senate Health and Welfare Committee, which voted 3-2 to send the bill to the Senate Floor.

The other committee member who voted "no," Sen. Anthony Pollina, said he believed there would be more petitions for drugging orders under the new law, because it expedited the process but added no resources "to make [the process] fair."

It "affects people's civil rights; people's human rights," Pollina said. "We need to be super careful if we're going to do this... and I don't think it does."

Sen. Dick Sears, the chair of the Judiciary Committee, said that "luckily it is a relatively few people" who are affected, but that the committee found that "most other states have moved beyond Vermont... in [the process] for timely decisions."

His committee had voted 5-0 to move the bill forward.

Sen. Diane Snelling voted in support of the bill but said that her concern was that legislators might think this took care of addressing problems with the mental health system.

"We need to make a solemn vow," she said, to examine all the options for treatment, to look at the effects of medication, and not to have emergency room wait times that leave patients for days.

Sen. Joe Benning, who is a criminal defense attorney, addressed the part of the bill that would require a judge to review whether a person is being held legally within several days of an involuntary admission.

He described the recent "horrific example" and "heart-wrenching testimony" of Kristen Schumacher, who waited weeks before being able to access a judge to make her case.

The other Senators who voted against the bill on the Senate floor were David Zuckerman and Mark McDonald. AD

# Patient Injured In Corrections Wins Lawsuit

MONTPELIER — The Agency of Human Services has agreed to pay $35,000 to settle a disability-based discrimination charge filed by a man who said he was jailed instead of being placed in a court-ordered psychiatric bed.

Randall Corkins, who was experiencing a mental health crisis, said he was "subjected to segregation, uses of force and pepper spray, and sustained injuries because his disoriented state prevented him from complying with commands, all while not receiving the level of care that would have been provided in a hospital setting."

The allegations were made in a Vermont Human Rights Commission complaint filed for Corkins by Disability Rights Vermont, a federally mandated advocacy system

After spending a week in prison, Corkins was eventually placed in a psychiatric bed, a news release from Disability Rights Vermont said.

DRVT said mentally ill patients are sometimes placed in prison because AHS has not maintained enough beds to provide inpatient psychiatric evaluation for everyone ordered into them by a court.

In addition to the $35,000 payment, the Agency of Human Services is required "to institute new policies and procedures to protect the rights of people with disabilities ordered to inpatient evaluation but who are instead placed in prison," the release said.

The Agency did not admit liability for the incident in the settlement.

The settlement also requires the Department of Corrections to use best efforts to avoid the use of force against patients held in prison.

"DRVT continues to advocate for the immediate allocation of resources to fulfill capacity and assure that no person with a disability be unnecessarily secluded, restrained or harmed simply because the State of Vermont continues to fail to provide appropriate placements for people held in State's custody," the release said.

# House Considers Taser Law

MONTPELIER — The House Government Operations Committee took testimony in February on a bill that would set statewide standards for police training and use of electronic control devices. The bill was introduced after a Thetford man was killed by a Taser used on him by a state police officer in 2012 after he had called a mental health provider for crisis help.

The Chief Executive Officer for Taser International, Rick Smith, flew in from Arizona to testify to the committee. Taser is a name brand for the device. It is a pistol-shaped weapon that fires two probes into a person, delivering a strong shock that causes full-body muscle contraction. Smith said Tasers reduce the number of times an officer has to use a gun or even a kick or a punch. Those types of force often result in more injuries, he said.

The bill asks the Criminal Justice Training Council to ensure that officers receive appropriate training, beyond that from the manufacturer, before they are issued a Taser. It also asks the council to coordinate training with the Department of Mental Health in order to better understand how to respond to mental health emergencies. The bill also lists the circumstances in which an officer may deploy a Taser.

Approximately half of law enforcement officers carry Tasers, according to the state's Law Enforcement Advisory Board.

# Crisis House Survives Appeal by Neighbors

LYNDONVILLE — Opponents of a mental health crisis home lost a zoning appeal in February. The home is operated by Northeast Kingdom Human Services to provide temporary shelter for one or two people who need support but not hospitalization. Neighbors said Zoning Administrator Justin Anderson should not have allowed it in a residential zone, and they appealed his decision, but the Design Review Board let it stand.

"Our zoning has to be adjusted to allow for certain uses so we're not discriminating against a particular [group] of people," said Anderson.

The neighbors could appeal the Design Review Board's ruling further to the state's environmental court. *From Vermont Public Radio*

**HONORED — Rep. Ann Pugh of Burlington was recognized as the Legislator of the Year on Mental Health Advocacy Day at the state house in February. Awards were also given to Linda Corey, Executive Director of Vermont Psychiatric Survivors, and Patrick Flood, former Commissioner of the Department of Mental Health. (Counterpoint Photo: Anne Donahue)**

# *Soteria Residence Funding Is Deferred To Next Year*

MONTPELIER — The state's first effort at a peer-led alternative residence that helps those who want to avoid medication had been delayed for another year. Soteria Vermont, intended for persons with a first psychotic break, is now budgeted to begin in January of 2015, according to the proposal presented to the legislature.

Paul Dupre, Commissioner of the Department of Mental Health, said that two things led to his decision to delay the funding. First, he said, the process of approval required for new health care projects from the Green Mountain Care Board had already delayed the target opening date from January of 2014 to sometime next summer.

That delay occurred because instead of an expedited process, the project has been required to go through the full Certificate of Need process because of the interested party status received by HowardCenter, Dupre explained to the House Appropriations Committee. Renovations cannot begin until approval is received, and Dupre said that based on his own experience in developing new community programs, it always takes longer than projected to get a program ready to open.

Because of those uncertainties about when the program might be ready to open, it made it a logical choice for budget savings by not approving an actual start until next January, he said.

Soteria was a program authorized as one of the community programs to help reduce reliance on the use of hospitals under Act 79, passed by the legislature in 2012. AD

# *CMS Approval Still Pending For Green Mountain Center*

MORRISVILLE — An interim, 8-bed hospital scheduled to close when the Vermont Psychiatric Care Hospital opens in Berlin in July is still awaiting word of approval by the Centers for Medicare and Medicaid Services.

The Green Mountain Psychiatric Care Center opened in January of 2013, and has received its state license, as well as approval from the Joint Commission for hospitals.

However CMS, which authorizes approval for federal funding, has reviewed the hospital in two stages and found different areas in need of attention, according to Executive Director Jeff Rothenberg. The Center corrected problems with privacy (camera monitoring) and restraint last fall, he said, opening the way for the second step, which is a psychiatric care review.

That evaluation occurred in February, and Rothenberg said that he expects a plan of correction will be required to address one item of physician documentation before receiving final approval.

The planning timeline for the Vermont Psychiatric Care Hospital includes a two-week period between the final stages of construction and a July 27 date for receiving "approval and licensing" from the state certification of CMS.

The Joint Commission will allow the GMPCC approval to carry over to the new hospital for six months, and Rothenberg said DMH is negotiating with CMS to agree to do the same. AD

# All Five Hospitals Receive Designation For Psychiatric Care

MONTPELIER – All five hospitals providing psychiatric services in the state were approved for a two-year re-designation by the Department of Mental Health last year. All were praised for the quality of their work.

The review of Fletcher Allen Health Care in Burlington noted a seclusion and restraint workgroup initiative "to improve safety for staff and patients," with initial data reflecting significant reduction in use of emergency procedures. Wristband bar codes for medication identification are now in place as part of a hospital-wide change. FAHC has two units, with 12 beds and 16 beds.

Rutland Regional Medical Center has a 23-bed unit, including its six-bed acute wing. The hospital has implemented electronic health records. The report said that the unit was in the process of creating an indoor exercise room.

Central Vermont Medical Center, which has a 14-bed unit, reported that it is seeing an increasing trend in patients who also have medical conditions and a need for medical responses. A new sensory modulation program initially implemented in the psychiatric unit is now being practiced hospital-wide.

The Brattleboro Retreat has five adult units, an adolescent unit, and a children's unit in its inpatient program. A new Violence Prevention Protocol is used to assess for risk of violence at intake, linked to a medication plan with an "order set" for the prescribing practitioner. The protocol is to ensure medication is available for management of violent behavior, the report said. The Retreat also reported an increasing trend of admission of patients with co-morbid medical conditions, and has initiated a new quality project for addressing "medically vulnerable" patients.

The Windham Center, in Bellows Falls, a 10-bed unit of Springfield Hospital, described problems that arose after the start of a new smoke-free campus policy, and how they were addressed. It was the last psychiatric inpatient facility in the state to transition to a smoke-free campus. AD

# *ECT Data Show Reduced Use And Safer Treatment Practices*

MONTPELIER — Annual data show a decrease in the use of ECT in the state since a peak in 2009, according to a report from the Department of Mental Health.

A significant change in the new data for fiscal year 2013 is the reduction in the use of bilateral ECT (the use of electrodes on both sides of the head instead of one side) at Fletcher Allen Health Care in Burlington, DMH Medical Director Jay Batra reported.

"This is an important trend since memory problems are most closely associated with bilateral ECT, although they can occur with other electrode placements as well," he said.

The largest reduction in the number of persons receiving ECT came after the Brattleboro Retreat discontinued its program in 2010, the report showed.

In fiscal year 2013, 88 persons received ECT at Fletcher Allen, seven at Central Vermont Medical Center in Berlin, and 14 at the Veterans' Administration Hospital in White River Junction. The departure of a psychiatrist at CVMC affected its program.

There were no instances of patients starting with bilateral ECT at FAHC or CVMC, and FAHC also had fewer patients switching to bilateral after beginning with unilateral, Batra said in his summary of the data.

More than two-thirds of patients received only unipolar ECT for the entire course of treatment, he said.

Of the 109 patients who received ECT treatment, around 30 percent reported no memory problems. Bilateral treatments, and thereby patients in the combined group (receiving both unipolar and bilateral), show a higher chance of memory problems, Batra noted. "Of note, nearly all patients who had 'combination treatments' reported memory problems."

In the past year more than 95 percent of patients receiving treatment with ECT reported at least some benefit and fewer than five percent reported no change, while there were no patients who reported a decline in their condition, Batra said.

Fletcher Allen and Central Vermont Medical Center are the only hospitals under DMH jurisdiction currently providing ECT. CVMC began its program in 2009, overlapping with the last year that the Retreat provided ECT.

The Veterans' Administration Hospital is supervised federally. It has voluntarily shared its ECT data with the state, although it did not do so in 2011 and 2012. AD

## 2015 Budget Proposal:

# Housing Faces Major Losses

MONTPELIER — The budget proposed by the Department of Mental Health to the legislature for next year has a large increase to pay for operating the new hospital in Berlin, but no resources to make up for lost federal funding for housing.

The budget will be voted on by the House in late March and then moves to the Senate for review.

In a memo to the Appropriations Committee, House Human Services Chair Rep. Ann Pugh said that her committee was "distressed to find that two years after passage of Act 79, the financial commitment to community-based psychiatric care is not consistent with the goals of that Act."

Act 79 outlined a shift to expanded community services to help reduce the use of hospitalization.

Pugh's memo said that because of the financial pressures of "higher than anticipated overhead costs" for the new hospital, there was no room in the budget to make up for lost federal housing funds, "the opening of Soteria House will be delayed, seven authorized intensive residential recovery beds in Chittenden County are on hold indefinitely, and the [peer] warmline is not operating on a 24/7 basis."

### Federal Housing Funds Cut

Federally funded transitional housing programs are facing cuts ranging from 10 to 26 percent of their funding in Addison County (Hill House), Orange County (Safe Haven), Franklin County (174 North Main), Orleans County (Newport Housing Project) and Chittenden County (Safe Haven.)

In addition, a $373,000 federal grant for Pathways to Housing has ended. That will eliminate the housing support services of the Housing First program for dozens of persons, according to the Department.

The housing voucher programs run at community mental health centers and funded by DMH are continued in the budget, with enough money to add about two to three per month, DMH said.

### Hospital Costs Are Higher

Hospital costs for Level 1 involuntary care will increase from $19.3 million to $27.8 million with the opening of the 25-bed Vermont Psychiatric Care Hospital.

It will add a total of 10 new beds to replace the Vermont State Hospital level of care, since the eight beds at the interim Green Mountain Psychiatric Care Center in Morrisville will close and the temporary use of seven beds at Fletcher Allen Health Care in Burlington for Level 1 care will end.

The Department said it hopes the additional beds will end the need to use emergency rooms and prisons to hold an average of six persons waiting for beds every day.

It should also reduce the need for patients who need Level 1 care to be hospitalized in overflow beds on regular units in Rutland and at the Retreat, DMH told legislators.

The new, state-run hospital is budgeted to cost about $2,250 per patient per day. That contrasts with about $1,450 per day for the 14 Level 1 beds at the Brattleboro Retreat and the six beds at Rutland Regional Medical Center, according to the numbers presented by the Department.

DMH Commissioner Paul Dupre told the House Appropriations Committee that the much higher cost to run the Vermont Psychiatric Care Hospital in Berlin is primarly due to the level of staffing required because of the new hospital's design and its small size.

Dupre said a higher ratio of mental health specialists per patient was necessary because the openness of the design makes it more difficult to oversee patients, the private bathrooms add to supervision needs, and the greater number of separate activity areas require more staff coverage. "Mental health specialist" is the new staff title for positions similar to psychiatric technicians at VSH.

### Youth Transition Grant Reduced

In addition to the housing cuts, another program reduction will occur with the end of the 3-year federal Youth in Transition grant. The budget proposes to add state funds in order to continue the program at half of the sites. AD

# New Hospital Is 'On Track' for July

BERLIN — Construction is "on track" and advertising is underway for the first staff hiring cycle for an opening of the state's new psychiatric hospital in July, Executive Director Jeff Rothenberg has reported.

The ability to meet that target will depend on a number of challenges, Commissioner Paul Dupre told members of the legislature.

A total of 106 new employees will need to be recruited, trained, and retained; a contract for psychiatric services needs to be completed with Fletcher Allen Health Care; a collaborative agreement must be established with a hospital for pharmacy services and for medical consult; an operational health record system must be in place; and there must be no construction delays, he said.

Under the current schedule, DMH will receive the building keys to begin its use for training on May 15.

### Sculptors Developing Art

The new hospital has been approved for the state Art in Public Buildings program, and five granite sculptors are collaborating on a theme of animals from nature, according to Judy Rosenstreich of DMH. A tree stump alive with small sculpted animals will be outside near the front entrance, and a "water feature" will include two otters. A beaver dam design has been selected for the courtyard, and there will be outdoor benches that continue the animal theme, she said.

Advertising for staff began in February, first by sending notices to the Vermont State Hospital staff who were laid off in 2012. The expectation is that staff will be staggered to begin on three dates, with orientations from April through July, matching the three phases of opening of the hospital, Rothenberg said.

The first eight patients are projected to transfer from the Green Mountain Psychiatric Care Center in Morrisville on June 29 with the next eight-bed unit admitting patients beginning on July 15 and the nine-bed unit opening on August 15.

Staff orientation is still being refined, he told members of the Transformation Council in February. Member Kitty Gallagher asked whether peers would be involved in part of the orientation. "That's an excellent suggestion," Rothenberg responded.

The greatest challenge is expected to be in filling nursing positions, he said. A contract for "travellers" (temporary nurses) is on a planning list.

### Record System Incomplete

The Department announced in February that it "does not plan to open the doors... in 2014 with a fully integrated [electronic health record] as originally identified..."

While the original plan envisioned a "fully functioning" electronic health record, the higher projected cost requires a formal bidding process, explained Frank Reed, Deputy Commissioner, at a Transformation Council meeting.

Instead, an extension of the current system that combines partial computer and partial paper records will need to be used in the short term, "possibly a year." The Department said it learned that the system it originally intended to use would not provide all of the functions needed.

### Forgotten Furniture

An unexpected discovery was the fact that a furniture budget had been left out of the plans, creating a shortfall of $750,000. That difference will be resolved by using some money from the construction budget and some money available because Soteria House did not open when projected, the administration told the legislature.

Staff also evaluated all of the furniture currently in use at the Green Mountain Psychiatric Care Center in Morrisville to determine what furniture could be reused when the temporary hospital there closes. AD

**TAKING SHAPE — Most of the exterior of the new, 25-bed Vermont State Psychiatric Hospital in Berlin is complete, as this photo from late February shows. On the left end of the photo is one of the three patient wings, in the center is the ambulance bay, and to the right is the main entrance. The target date for completion of the building is June 15. (Counterpoint Photo: Anne Donahue)**

# *The Debate Over Involuntary Medication:*

# A Case Against Force

To the Editor:

It is with rigorous honesty and vulnerability that I write this article.

I have been on the Vermont television news, testified at the legislature, and have been on Vermont Public Radio voicing my concern about Act 114 and Senate bill 287. I am very much against forced drugging and stripping away a person's rights when the judicial process orders involuntary hospitalization.

In my case I was forcibly drugged in emergency rooms without any judicial review or process whatsoever. I have also been forcibly drugged and involuntarily hospitalized at the former Vermont State Hospital (VSH), other hospitals around the state, and decades ago in Chicago.

*All* of my experiences with forced drugging were traumatic, horrifying. I entered the hospitals nonviolent, in distress, in need of a kind ear and compassionate care.

I had committed no crimes, and I will repeat, was nonviolent. What happened to me in those situations was a nightmare, and I wouldn't wish it on anyone.

I was restrained, terrified that I was going to be murdered. In some cases six or seven people would tackle me, leaving bruises all over my legs and arms for weeks and months at a time from various assaults in the hospital, in order to "treat" me.

At VSH I was put into solitary confinement where I was not allowed to use the bathroom, and was forced to pee on the floor. I know of another patient who was forced to defecate on the floor there because he was not allowed the simple human right to use a bathroom.

Many times I was so heavily and forcibly medicated that I lost memory for days. I woke up in VSH thinking I'd been kidnapped to Nazi Germany. It seemed like a prison to me, with evil energy running throughout the place. I had been so heavily forcibly drugged that I lost control of my own bowels at one point.

Restraints, seclusion, and forced meds were used as a form of punishment there. One night I felt happy because I had made friends at the hospital, and I was laughing a lot. Laughing. The next thing I know about 7 staff were on me, bruising and holding down my body, and forcibly medicating me with an unknown mind-altering drug. I'm guessing it was Haldol. Nobody ever told me what the drug was.

I spent all summer at VSH covered in bruises from these assaults. One time I was assaulted by another patient there, who slapped me hard across my face and left a bruise. After this experience I experienced three instances of domestic violence in my own home at the hands of a man I was dating. I equate restraints, forced drugging, and being assaulted in hospitals with the same level of psychological terror as domestic violence. I thought I might be killed in all instances.

There are many alternative treatments and options open to people. I have noticed that everyone who talks out about being for Senate Bill 287 about speeding up the judicial review process for forced "treatment" has *never personally* experienced it themselves. I have, many times. *Every* time it was a traumatic psychological event.

And as for the "judicial review" process that the state is talking about speeding up from 30 days to five days I will honestly tell readers this: *nobody* ever, ever once told me what my judicial review was about.

At VSH I was taken in chains and shackles to a courtroom, where I remained calm. I had not committed a crime, yet was before a judge like a criminal.

Would society do this to a cancer patient? Handcuff them, shackle them, take them away by cop car, ambulance, and then force them to go to court after being assaulted by a hospital because they had cancer? No, of course not.

But when it comes to rights of people in mental health distress, like myself in the past, I was never even told that I was going to an involuntary commitment hearing.

At two hospitals, including VSH, I had a list of grievances about the bad treatment of me while there. I had to drop them in order to get out. Hurricane Irene saved me from having to spend any more time in cell 14 at VSH. They did not seem like hospital rooms, they seemed like "cells."

I will write that there are some nice and caring staff at these hospitals. However, forced drugging and making someone an involuntary patient (I had even requested to several staff that I be permitted to become voluntary and was denied) is a violation of my human rights, my mind, my body, my very soul.

Nobody really talks about the hard core truth of what it feels like to go through these things. Terms like "treatment" and "medication" are tossed around. My stories and experiences with forced drugging, seclusion, and restraint were living nightmares.

I am also a professional, as well as someone with lived mental health experience. I have a Master's Degree in Clinical Mental Health Counseling from Antioch University New England, and an undergraduate degree from Middlebury College.

I am a bright, caring, compassionate person and professional. The public deserves to hear the truth about what happens to some people like me in the mental health system.

Currently I receive good care. I voluntarily take meds and am nice to all those around me. I go to therapy and work in the field of mental health at a job I love.

I shared these stories to shed light on a topic that is hot in Vermont right now, and a topic that deserves full attention. All people interviewed about forced drugging in a study found it "coercive." I found it to be the nightmare of nightmares.

Please, Vermont, and state government and treatment facilities, consider kind and compassionate care when dealing with all people.

We don't need to be stuck in 19th century archaic modes of treating people. This is an article with a strong theme about basic human rights.

MARLA SIMPSON, M.A.
Randolph

# A Parallel to Slavery

To the Editor:

There was a time when large numbers of people in the US thought slavery was needed for the economy to function. Some argued, and some even believed, that it was good for the slaves.

The argument was made that slaves had better living situations than most workers in Europe and in the Northern states. John Calhoun said, "Never before has the black race of Central Africa, from the dawn of history to the present day, attained a condition so civilized and so improved, not only physically, but morally and intellectually."

The laws also supported slavery, including the Fugitive Slave Law of 1850 and the Dred Scott decision. It is amazing to contemplate that there was a time when people said, and even believed, these things.

Well, sort of.

A similar type of thinking is prevalent in public discourse today, on a different topic. Forced psychiatric drugging is a horrendously inhumane and harmful practice.

I just finished my Bachelor of Science degree, and in my final project, I looked in depth at the research on the effects on the brain and body and on people's functioning over the long term of psychiatric drugs.

The recent, credible, honest research is very clear: the drugs do a large amount of physical damage to the brain and to the body, and on average, the long-term outcomes of taking psychiatric drugs over five, ten, and fifteen years are much worse in all measures of quality of life, cognitive functioning, relapse rates, employment rates, and so forth, than the outcomes when people with the same problems do not take the drugs.

People who never take any drug to begin with do better long-term than people who are given drugs in the hospital, then either continue to take them or stop taking them at some point. People who take the drugs die an average of about 25 years younger than people who do not, mostly due to adverse effects of the drugs, including diabetes, heart arhythmias, abnormal clotting, and extreme weight gain.

We now know that the "research" that "showed" these drugs to be effective was fraudulent in its design and the data was then fraudulently reported, often simply neglecting to report all of the data that didn't reflect well on the drugs.

In addition, the experience of forced drugging is compared to the experience of rape by many who are subjected to it. It is intensely traumatic, adding to the mental health struggles a person already has.

Yet we keep hearing arguments for why it is

*(Continued on page 13)*

**An Exchange Of Viewpoints**

Letters do not represent the opinion of the publisher.

***Point →***

# *Bill To Speed Court Process Sparks New Protest*

# It Is Better To Work *With* Patients

To the Editor:

I truly enjoy reading your paper and usually pick up a copy at the local library.

I was interested in a few articles in the winter 2013 edition, one of them on the bill addressing expediting forced drugs. Upon reading this I was a slight bit dismayed as no person should ever be forced to take medications.

As a certified peer support specialist from Pennsylvania, I worked on the extended acute unit of a privately funded hospital, with a lot of the patients coming from state facilities that had been closed down.

It was sometimes difficult to get a patient to understand the reasoning behind taking certain medications, however once they understood completely, and were aware of side effects and how the medication may help, we were often able to be successful in getting patients to at least try the medication for a period of time.

Understanding that space is limited and that there is always someone else looking for a bed in the facility, it is still important to work with each individual as much as is needed to help them feel comfortable with the medications.

Also, I took note that at one point a statement said some of the patients feared coming out of their rooms because of the atmosphere caused by other clients.

When a situation like this occurred, we had a standard procedure of warning to the disruptive individuals. As adults they are all responsible for their behavior; if they cannot manage then they may spend that time in their room so that others may come out of their rooms.

If they are offensive still in their room then we have a quiet room they are taken to which has simply a mattress in a fully carpeted room with a soundproof door. They may have their tantrum in there and when they are able to be calm for at least 45 minutes, they may come out and go to the milieu.

The staff, all staff, is required to have quarterly training in handling various behavioral situations both in a verbal manner and if needed in a manner of a physical hold.

We would have a designated team for each shift for the whole hospital should any one person become extremely out of hand, called the green staff, which consisted of five staff members to bring an extreme situation under control.

There have been very few times when police have been called for an out-of-control situation unless the individual was not going to be staying at the facility any longer.

There is always a need for more people to serve and understand the mentally ill. And there are never enough facilities to house them. In PA, it seemed that if there was going to be a budget cut that mental health took the brunt of that cut.

The place where there is never enough understanding is in the criminal justice system. Police officers, prison guards, and the like, have no understanding and act as if they really don't want to understand.

Addictions and mental health also go hand in hand.

What can I say, as a consumer, and repeat-user patient, and someone who now is in her own mental health continuing recovery? I have an avid desire to keep learning more and passing it on to others.

We need many more peer supports, and forensic peer supports, for a system with few inpatient facilities for people who need help, where they can get it.

DEBRA ZIPP
Bennington

# Questionable Intentions

To the Editor:

It is merely an observation, however apparently these days all one has to do is to suggest they are working for the greater public good as well as mention about how everyone around the table has the best of intentions and this appears to be enough to absolve them and everyone else who might be in agreement from any possible unintended or adverse consequences.

This even when certain agendas and motivations are actively at play, including potential political and financial ones, oftentimes going unnoticed, unstated or understated.

Whether it be within the medical, psychiatric, legal, business or political communities or society at large, it makes one wonder about whether higher ethical standards are in place and are being properly practiced as well as enforced when, how and where it counts.

Sometimes it can seem as if morals and ethics have been completely tossed overboard in favor of whatever some of those in power and authority have decided is best as well as most expedient for the rest of us, not to mention being better and possibly more profitable for them or for those they are employed by or are aligned and associated with.

When it comes to societal or personal dilemmas and seeking solutions to these, no matter what the supposed problem(s) or the causation(s) might be and whomever might be involved as well as what field of expertise might be called upon for help, and no matter how complex the nature, the standard for addressing these matters should be, first and foremost, not to do harm.

It is one thing to know and to recite, however, it is yet another thing to put these type of morals and ethics into meaningful as well as enduring practice. One of the ways to not do harm in the first place is never to treat any person involved as being the problem and therefore as an object, as if they were less than human, whom others should be doing something to or about.

Throughout the history of humankind, it rarely if ever has done human society — nor any person living within it and subject to such — much if any good to institutionalize societal or personal dilemma(s) or supposed solutions to these either.

Whatever supposed good or betterment might be perceived as resulting is usually rather short lived as well as overshadowed by problems arising from unintended and adverse consequences.

For example, even when one might mean well in attempting to come to the aid of someone else experiencing a personal crisis no matter what the nature or cause and in terms of civil commitment and non-emergency psychiatric treatment in general, as well as forced drugging more specifically, when a person is treated in a fashion that involves using force and coercion in one manner or another, whether it be enforcing the will of someone else or the state against another, this quickly evolves into a dehumanizing process for each and every party involved.

Whenever force or coercion is employed within any healthcare or other type of setting, it is no longer truly medical treatment being delivered, save only being the worst and most dehumanizing sort.

Good intentions never improve on ill treatment or the outcome from such, nor make these better, at least not for the person on the receiving end.

Ironically, among the questions that rarely gets asked, let alone answered, is if using force and coercion in terms of providing mental health care truly did work as effectively as some try to claim it does, then why do many people who have undergone it either end up going through the revolving institutional door over and over, thus having it be done to them again and again in one form or another or, after being (re)traumatized, they attempt to avoid health care and mental health care providers like the plague?

The fact is when a person is treated with dignity and respect as well as making sure their choices or otherwise what they might have wanted if they could make their own choices are the priorities adhered to when decisions are being made about how to proceed, there is less of a risk and danger of doing harm.

The standard of care and top priorities concerning the same certainly should never be about ease or expediency, nor about the needs of mental health care providers or the system.

In addition, those who try to suggest this is only about forty or so people on an annual basis are either missing the point or hoping the rest of us will.

When violence and harm is visited upon one, particularly when it is made easier and quicker to do so, it only brings harm to us all.

Calling the use of forced drugging mental health treatment does not make it so, nor does it mean it is for the best.

As a society, we should not be making it easier and faster to obtain non-emergency forced psychiatric drugging orders against someone. If anything, we should be making it much harder and extremely rare, if ever, to be able to do so.

MORGAN W. BROWN
Montpelier

*Morgan W. Brown describes himself as a concerned citizen, writer, blogger and political observer.*

***Counterpoint***

# Editorial Page — Opinions and Letters

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

## Editorial

# Is Silence on Suicide a Kindness?

As *Counterpoint* went to press in December and finalized an article about a woman who had died of suicide at a program at the Brattleboro Retreat, it received this email from a Retreat spokesman: "My only request is that when you write your article that you please leave the name of the individual out... I think it would be an act of kindness to her and her family if they were left out. Thanks for your consideration on this."

*Counterpoint* replied our policy opposes contributing to stigma by treating a death by suicide as something shameful and secret, and somehow different from a tragic death from cancer or a car accident. "The more we treat mental illness as something shameful and in need of being hidden, the more we reinforce the shame," our reply stated. "[T]he act of kindness is to treat all persons the same way, and not to act differently based upon a social taboo, sending the message to her family that *Counterpoint* joins in the belief that they should be feeling shame."

*Counterpoint* has published editorials in the past criticizing this practice of withholding names. The fight for equality will only be won when we are considered and treated as full members of society, entitled to the same rights and privileges, whether that means access to health care or equal treatment in matters of public record.

Almost every year in Vermont, there are double the number of deaths from suicide than from motor vehicle accidents. Most people are unaware of that simple fact. For each car accident death, there is a name and face attached: a real person is recognized. Is the lack of attention to suicide partly because its victims are so often left nameless and faceless?

*Counterpoint* asks our readers: Do you agree? Is withholding the name of a person who has died from suicide an act of kindness, or an act of stigma?


## LETTERS TO THE EDITOR

# Airports Fail To Give Equal Accomodations

To The Editor:

I live with anxiety, agitated depression, and PTSD. I realize that a mental or emotional handicap isn't something that one sees, necessarily, but it should be recognized as existing and accommodations should be provided for our emotionally handicapped as well as our physically handicapped.

This prejudice is everywhere. It most affects me on trips using air flights, changing terminals. My anxiety is such that I am on the verge of a "freak out" when having to go from one terminal to another. I am sure there are others that live with this sort of thing.

All I need is an airline employee to escort me to my next terminal and show me where to check for my boarding pass. Well, they do not provide this service but they will provide this service if you are physically handicapped: wheelchair and accompaniment of an airline employee.

Now I am not saying that the physically handicapped shouldn't have this accommodation but I am saying that emotionally handicapped individuals deserve at least an escort. Why won't the airlines provide this accommodation to emotionally handicapped individuals, sans chair?

So many organizations and committees and associations try to create a world where the handicapped have their necessary accommodations to be able to live their lives as fully and as comfortably as any normal person. Well, the emotionally handicapped have been overlooked and I for one want the world to know, so please pass this on to the world and try to band together to ban this kind of prejudice.

We have rights too!

I am hoping to send copies of this letter printed in [*Counterpoint*] to all the major airlines so hopefully something can and will be done to rectify this serious situation. I thank all of you who support this change. I also hope that you will send letters with this same concern to major airlines.

It is the squeaky wheel that gets the grease so let's squeak loudly and in numbers.

Let's make a positive change for what should be our equal right!

LAURA LEE SAORSA SMITH
Cabot

# State Misled Morrisville

To the Editor:

The Department of Mental Health has flat out lied to the residents of Morrisville, Harrel Street, and the Lamoille County CRT consumers, Not only has the state lied to Morrisville and the CRT consumers, they're going against their promise.

Morrisville is not designed or structured for a full time state hospital. Savi Van Slvytman, Paul Dupre [DMH Commissioner], Christine Oliver [former Commissioner], have taken away from the consumers and families of Lamoille County. A full time state hospital connected to CRT is totally inappropriate and unacceptable.

If Christine Oliver, Paul Dupre and DMH had paid attention to this 3-to-5-years ago, before Irene when their decertification first took place, we wouldn't be here. Secondly, the old Vermont State Hospital had 54 beds! Why are you thinking of building a VSH with so few beds, knowing the number is higher? Their way of thinking is hurting a lot of people and destroying our CRT program, and any possible affiliation with the community.

DMH and Paul Dupre owe CRT and Harrel Street a bigger thank you than what they ever know. Morrisville helped you all. The Vermont State Hospital is making problems for all except for Paul Dupre and DMH. SCOTT THOMPSON
Morrisville

*The writer is refering to the state's use of half of the Lamoille County mental health agency's bulding for the interim hospital in Morrisville, which has resulted in the loss of the CRT consumer group space. It was promised that the use would end when the new hospital opens in Berlin. The state has not changed this agreement, but the writer is concerned that it will. Ed.*

## Shout It Out!

Have an Opinion About Things Going Right or Wrong? That's What the Letters Pages Are 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.

# When Suicide Strikes Close to Home

by DONNA OLSEN

Suicide. That word and act that no one wants to talk about. I am going to talk about it, though, because it has been in my life a lot. That final act that is so permanent. My dad died by suicide when I was three. It destroyed my family.

Over the years I have had a few friends and co-workers who died by suicide. It was upsetting but nothing came close to my friend Warren Hardy's suicide.

Warren.

One of my favorite people and I loved him so much. I had not seen him in some time but I knew if I needed him or wanted to see him I could. Now I can't and I am just left with my memories. And that makes it so hard to accept. In my eyes he was larger than life and such a funny guy. He was a person that I could tell anything to and he genuinely cared about me.

This is for you, Warren. This is for all those people out there lost and alone and contemplating suicide. Don't do it. Please. No matter how low life is, it is temporary and there are definitely people who love and care about you. Keep reaching out until someone listens. Do not give up!

You were my boss at the nursing home washing, drying and delivering laundry to the wards. I liked you instantly. You were so genuine and just and just a nice guy. I was slow at my job but you never criticized me and always encouraged me to do better. I hated that job but I loved coming to work because of you and worked hard. I never called in sick and you showed your appreciation every time I showed up to work. I remember you backing out the exit bowing to me all the way. You made me feel special. Although the job was awful you made it fun and we goofed around a lot.

I remember singing the song "you are making me crazy" in a high pitched voice and you really thought I was crazy. I remember the day you and Carol came to my rescue on I-89 as I got pulled over for speeding and found out my license was suspended. I remember the night you and Carol had to come in to catch me up and we worked together all night. It is one of my best memories. You so loved her and it was written all over your face.

Carol is one of the nicest people I know and my heart breaks to know that she is heartbroken; so devastated and grief-stricken over your death. And that's where I am so angry at you. You may be at peace but you left behind many people that are just broken now. Carol, Olivia, Kris. They did not sign up for this. I did not sign up for this. When you shot yourself it caused so much pain and grief. Why? Because you were a good guy who was loved and cherished by your friends and family. How dare you do this to us. It's been three months since you died and people who loved you are still devastated. I am still devastated.

I feel guilty because I always meant to contact you and let you know how I had overcome all my hurdles. How I was clean and sober and writing for a newspaper. I know you would have been proud of me. I was so lost when we worked together. You kept track of me as I went in and out of rehab. Now I have made it and I cannot share it with you and I am so sad.

My tears come every time I see Olivia post something on facebook in memory of you. She is struggling and I want to be there for her. You would like that. I want to reach out to Carol and Kris but they are too devastated. So I am doing the only tribute I can. I am writing this article. For Olivia, for Kris, for Carol and all the friends you left behind.

I will miss you, Warren, and maybe someday the image in my head of you killing yourself with a gun will diminish. I hope so because it is not the Warren I want to remember. I want to remember my friend who made me feel good about myself. I wish you had reached out but you didn't and now you are gone – forever.

Rest in peace, my special friend, and keep watch over all of us who are mourning a great loss. I love you. I will stay in touch with your family.

As Garth Brooks would say,

*"And now I'm glad I didn't know*

*The way it all would end the way it all would go*

*Our lives are better left to chance*

*I could have missed the pain*

*But I'd have had to miss the dance"* [The Dance]

Donna Olsen is from Randolph, and is a writer for *Counterpoint* and for *The Herald* of Randolph.

ROSES IN REMEMBRANCE — As they entered the House chambers on Suicide Awareness Day in February, state representatives were each handed one of 117 roses representing the 117 Vermonters who died of suicide in 2011. Many were placed in vases at the podium of Speaker Shap Smith. A moment of silence was shared to reflect upon lives lost, and to recognize those who work to prevent suicide in Vermont through their compassion and support. (Counterpoint Photo: Anne Donahue)

# A Personal Experience

# Life in Hell: Suicide Attempt Leads to Time in a Tennessee Jail

This story about jail was shared in the third person to keep the writer's identity confidential.

*Prelude*

*Rex was getting intoxicated as he watched the game. It was the night of the Super Bowl and Rex Peters was without a wife. He had been simmering for a month in self pity. Receiving divorce papers with lies in them made the hurt worse, and the restraining order against him hurt his pride: He had never threatened her or anyone else in his entire life.*

*He had been getting inebriated off and on that month, knowing where the drinking would eventually take him: Madness and suicidal thoughts and efforts. The alcohol certainly didn't mix with his medications and were assured of driving his blood sugar up.*

*It all felt like a triple whammy, as his parents had died a couple of years earlier. Then his grandson, Jack, had drowned while attending a rock concert the previous summer. Finally Susan left him.*

*Rex had come to long for his Dad's old shotgun, and he pressured his brother to give him. The night of the Super Bowl he shot the gun twice. Once was on property near the apartment, testing it out. Then Rex ended up at his brother's apartment with it, planning to shoot himself in front of him. It terrorized his brother, who shut the door and went to call the police.*

*The police came. Rex had just tried to shoot himself in the head. He knew it could be done with the shotgunbut it was awkward and he moved the gun up too fast and mistakenly pulled the trigger.*

*The barrel of the shotgun was by his left ear when it went off. Next thing he knew he was running back to his apartment but the police were already there shouting for him to throw down the shotgun and get on the ground. Rex did throw the shotgun down but didn't get on the ground himself.*

*He ran towards the cops, hands in the air, and hollered, "Shoot me!" He fully expected to get shot. Then he was Tased and surprised at the shock, and didn't realize what had happened to him. He just remembered being on the ground.*

*He had an epiphany of sorts. He began to grieve the loss of his parents and his grandson. It seemed to him that he hollered for them in anguish and he knew at that moment he had never properly grieved them.*

*When the police tried to get his arms behind his back he lay on them so they couldn't. He was a fool not to cooperate, but felt the cops had no need to Tase him again: He heard them laughing as they did it. He knew they enjoyed it. All they had needed to do was overwhelm him and grab his arms.*

*The cops finally had him and threw him roughly into a backseat of one of their cars. They had enjoyed themselves: how can one ever trust a cop again? They put his cap on his head and pulled it down roughly as far as they could on his forehead, laughing all the while. And it was on to the jail.*

Part 1

There is little kindness in a county jail in Tennessee if you are in your late 50's and you have never been there before. What kindness there is, is usually from other inmates, though these guys are mostly watching out for themselves. Rex knew this instinctively. Who would blame them?

It was like a country boy being dropped into the middle of streets of Calcutta: pure culture shock as he could never have imagined. He was thrown into the drunk tank, where there was a stainless steel toilet in one corner and no privacy.

The following morning Rex was officially booked. It was horrifying to him that he was charged with the felony of reckless endangerment. He had no idea what that meant.

He was given his call and he called the only person he knew to call... the only person Rex could get a phone number for, his youngest brother who was a county cop in another city.

Barry was merciless but he did at least relay a message to his sister to bring Rex's medications down to the jail. After this first and only arrest he was thrown out of Barry's and his sister's family. It hurt some. They were blood but it didn't seem to really matter.

Rex quickly began to learn the poor man's options in jail. The man or woman without money in any jail in the world is just out of luck. The only way someone with money stays in jail is if he or she has done something heinous such as murder, and even then, the wealthy seem to keep out of jail.

And so Rex was photographed and fingerprinted. He was taken into a little room and was told to strip. After a short shower he was given underwear, way too small, and another pair that were too damn big. "Shit, I can't wear these," he said to the guard.

"It's all we have. We are short on clothing. I'm sorry about that."

Rex was then taken to what was supposed to be a one-man cell with a senile 72-year-old man. The guard called him Ace.

What was very confusing to Rex was that the man obviously was suffering from some form of dementia — perhaps Alzheimer's. What was he doing here? He didn't belong here.

Hell, Rex felt like he didn't belong here either as he had been trying to blow his head off, but here he was anyway and there was no escape.

Everywhere in the jail, the walls were gray. Some of the sliding, clanging metal doors were brown and the bed was brown. The only other colors were the white tiles of the ceiling and the metallic silver of the stainless steel sink and toilet.

There was no time in this place. The lights were on at all times and his sleep was unpredictable and ragged. The sensory deprivation kept him from knowing what time it was and what day it was.

At times he couldn't remember the most simple of things... peoples names, places, and more — and Rex thought he would forget his name and be completely insane. Somehow he survived this early time in in jail.

With the fantasy of hell eroding, Rex began to think of being in an alternate universe. It was the only way to explain this hideous state, this hideous jail with slamming metal doors.

How the guards seemed to like to slam them after delivering the foul meals! Most of the guards were pretty decent people, giving respect as they received it, just doing their jobs. But some took it too far and acted gung-ho, as if in the military, when ordering inmates about.

So the alternate universe theory was born, and how could Rex disprove it?

"Christ, I am nuts for sure but how can I be sure in such a situation?"

Part 2

After a couple of days a guard came to get him and took him to the booking area where a group of others waited. The guards began to handcuff them with their hands to the front. Then they had to get on their knees on a chair while their legs were shackled.

They were put into a couple of waiting vans and were taken to be the courthouse. The vans parked in front and Rex and his cohorts were unloaded. What embarrassment! If anyone saw Rex he would be seen handcuffed and being led to the courthouse in an orange suit.

Even those with relatively minor offenses were in handcuffs and leg chains. It was a method of shaming and for Rex it worked. Shame crept into his soul and he couldn't stop it. Despite it, Rex refused to look down and held his head up.

He saw his appointed lawyer who told him, "Your case will be carried over for a couple of weeks so they can get you to a psychiatrist that is court appointed."

That was it. He would be sent back to hell and he didn't have any idea for how long.

Thoughts roared through Rex's mind.

"Just as worthless as most court appointed lawyers. The cogs in the legal machine are rolling and unless I can come up with some money I am screwed, plain and simple."

"What did you do?" he heard one fellow whisper to another.

"Oh broke into some goddam cars for some stereos to sell."

"How much time you getting?"

The guy started getting weepy and we stared at him. It didn't matter. The tears rolled down and he was able to moan out, "I'm afraid I'll get one hell of a lot of time, man."

Some guys tried to comfort him. Rex was too shook up to say or do anything. After everyone's case was addressed, they were returned to the prison.

Rex didn't know how much longer he was in that jail cell with Ace. It seemed like forever. Ace would eat the food that Rex didn't want. There would be white rice for breakfast that was overcooked. There would always be a couple of sandwiches for lunch. Dry peanut butter on white bread was almost inedible. Burned beans for dinner. The food was always cold.

Ace was rambling on as usual one day when he said, "Y'know it doesn't matter if it is a woman's mouth or a man's mouth sucking you. It's all the same."

Rex freaked and got up off of the floor to look outside of the tiny window in the steel sliding door. The guards were there almost immediately.

He was taken to a cell with another guy who had no place to go, though he had served his time for whatever crimes he had committed. He was waiting for an opening in a nursing home.

Rex was only in that cell for an hour before they pulled him out and put him in the "medical" pod.

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*Life in Hell* will continue in the next issue of *Counterpoint.*

# Personal Reflections

## Why Self Harm?

by BONNIE L. MACHIA

It's interesting when people ask why I self harm (cutting). Self harm isn't just cutting one's flesh and has nothing to do with attention. Attention is the last thing I seek.

There are many reasons why someone engages in self harm. For myself, I may engage in this behavior as a way to escape from a profound sense of hopelessness and I may lack a foundation, building blocks in life, so as to develop filters, tools, coping skills and boundries to help me better manage the emotional intensities that I experience.

I may be numb and engage in this behavior so as to feel something, anything. I may engage in this behavior because I lack the ability to say what I am feeling or as a way to punish myself. When people see my scars or cuts and I hear comments that I must be "mental or seeking attention," I want to scream.

Smoking, drinking, drugs, reckless driving and many other things can be considered self harming behaviors and yet I have discovered that these are not viewed as harshly as my form of self harm.

Why is it no one ever asks: Why did the abuser abuse? Why was a child neglected? Why is it acceptable for me to be harmed by others and yet when I use self harm as a coping skill, it is considered unacceptable?

The question should not be why I did as I did, but why others do as they did so that I feel a need to self harm in order to cope, or to ask why I do not have the proper tools, skills, etc needed in which to cope. My behaviors are my tools, my coping skills that have helped me survive a life of trauma, abuse and neglect.

*Bonnie L. Machia is from Burlington*

## I Am a Classic Victim of Stigma

by RICHARD L. WILLIAMS

On December 4 I had a very traumatic experience with my local senior center regarding a bus trip to Holyoke, Massachusetts. I was at my destination on time for departure, but the bus was not there!

It was apparent that I was left behind, so I left the parking lot and a few minutes later I discovered the bus on West Main Street. I began running frantically in desperation to catch up with the bus and trying to flag the driver down, to no avail.

So I frantically ran around the block and cut crosslots to get back to the parking lot. The bus was there and I got on. But I was shaken up, and I decided I was taking no more trips. Plus, I nearly stumbled and smashed my face and nose. That was the worst trip that I ever took!

Instead of staying in the parking lot to let people get on, the bus was running all over town. To get to the core of the situation, the activities director does not like me, and she does not want me around. I'm shown no compassion; no understanding.

I'm being involuntarily forced into social isolation and oblivion just because of mental illness. As a result of the December 4 incident, I will have several fewer social connections. Several other incidents have occurred on other trips, even in the distant past.

Three years ago, I was driven out of the pavilion at Lake Shaftsbury, where I was yelled at loudly. I left instantly in disgust without finishing my meal. All this is gross, cruel and unprofessional. Down with this organization for good!

*Richard Williams is from Bennington.*

## LETTERS TO THE EDITOR

### A Parallel to Slavery

*(Continued from page 8)*

not only an acceptable medical practice, but for why it is needed, why more different kinds of less-trained health care practitioners should be able to do it, and why it should be able to be done more easily and quickly in the absence of an emergency.

This is absurd. The discussion should be about how and when to abolish this practice altogether. The underlying assumption seems to be that there are no other options of how to conduct mental health care in situations in which forced drugging is used, and that in non-emergency situations, people with certain diagnoses just deteriorate if they are not force-drugged.

This is far from the truth. For example, people with psychosis are shown to improve with cognitive psychotherapy in the absence of "medication." In the study about this published in May, 2012, in *"Psychological Medicine"* in the UK, no participants deteriorated; they only varied in the speed of their improvement.

There is similarly promising research about psychosis and daily aerobic exercise, published in the *Archives of General Psychiatry*, Feb., 2010. MRIs showed huge positive physical changes in the brain that tended to reverse schizophrenia.

For a psychotic person to deteriorate when not on drugs requires a large degree of neglect of these kinds of needs. The absence of medication does not cause it. Neglect causes it. In the absence of neglect, no unmedicated psychotic research participants deteriorated. Perhaps one way to look at it is that neglect "causes" the "need" for medication.

There are approaches to mental health care that make forced drugging unnecessary. It bothers me that the people who argue that expanding forced drugging is necessary are not trying very hard to find other, more humane ways to conduct mental health care. When I attend conferences about alternatives to psychiatric drugs and when I attend conferences about specific mental health modalities other than drugs that tend to reduce the reliance on drugs, I don't see them there.

How do they "know" that forced drugging is "needed" when they are not making much (or maybe any) effort to learn about other treatment approaches?

We do not need any expansion of emergency or non-emergency forced drugging. We need to require mental heath facilities to make the effort to get the training to be able to offer other modalities of mental health care that are shown in research to be safer and more effective, and that are practiced successfully in other places. Some of these modalities, such as Open Dialogue in Finland, are so effective as to make forced "medication" nonexistent in the entire mental health system where the modality is practiced. Some are effective enough that the rate and extent of "medication" use is a tiny fraction of what it is here, and the mental health outcomes are much better. Empathic Therapy, as practiced in Juneau, Alaska, comes to mind.

It's time to stop arguing to expand an inhumane, harmful and outdated practice. Anyone who is paying attention and making an effort to keep up with the field knows that change is afoot, and it's ridiculous to try to go backward into expanding a practice that the field is moving away from for good reasons.

How long are people going to cling to an inhumane and harmful practice because it's what has been done in the past and it's more convenient to perpetuate it than to learn a new way of doing things? When will people be willing to do what's hard, because it's what's right? Change is hard, but the alternative is evil. It's time to work toward abolishing forced psychiatric drugging, not expanding it.

HEIDI HENKEL, Putney

*The studies on cognitive therapy and aerobic exercise can be found at the following weblinks: www.ncbi.nlm.nih.gov/pubmed/2191425 www.ncbi.nlm.nih.gov/pubmed/20124113*

## DEATHS

### Darlene Manning, NAMI Volunteer

RUTLAND — NAMI announced "with deep regret" the death of long-time volunteer Darlene Manning, 62, on December 30, 2013. "Darlene gave so much of herself to other people," the NAMI press release said. "NAMI Vermont was extremely fortunate to have her as one of our key volunteers for our programs."

**Darlene Manning**

NAMI said that Manning was actively involved as a Provider Education teacher and Connection Recovery Support Group facilitator in Rutland in the community and at Rutland Regional Medical Center on the psychiatric unit.

"Her involvement with the Connection Support Group meant so much to her and she always looked forward to facilitating the meetings. She was an inspiration to so many people," NAMI said.

"Her resiliency and courage was so evident in how she always found a way to be at the support group meetings in spite of her medical challenges in the last year."

### Sally Fox, 2013 Legislator of the Year

BURLINGTON — Sen. Sally Fox, honored with the outstanding legislator award at Mental Health Advocacy Day in 2013, died this January after a two-year battle with lung cancer. She was a Democrat serving Chittenden County.

Fox, 62, was in her second term in the state Senate, where she served on the Senate Health and Welfare and Senate Appropriations committees. She was also the chair of the Mental Health Oversight Committee.

From 1977 to 1988, she ran the Developmental Disabilities Law Project for Vermont Legal Aid. She was elected to the House of Representatives in 1986 and served seven terms.

Fox is survived by her husband, Michael Sirotkin, and two sons. Sirotkin was appointed by Governor Peter Shumlin to fill Fox's Senate seat until next fall's election.

# Arts

## Poetry and Prose

*Book Review:*

# *Lost in Schizophrenia*

**by DONNA OLSEN**
**Counterpoint**

BETHEL — Van Bennett is 43 years old and lives in Bethel with his wife, Margaret. He works full-time, goes to church, takes classes at Community College of Vermont and pursues his dream of becoming a Doctor of Osteopathic Medicine. He also has schizophrenia.

Schizophrenia.

The word can conjure up a vision of a person who is violent and commits criminal acts. Bennett has recently published a book about his journey being a schizophrenic for over 20 years entitled *Lost in Schizophrenia, The Memoirs of a Schizophrenic.*

"I started to write about myself and the things that had happened to me. I thought it would be a good way to process what had happened to me. But as I continued to write I realized I could help a lot of people," said Bennett.

After nine nervous breakdowns and countless hospitalizations, Bennett is stable and actively in recovery, he reports.

He came to Vermont in 2003 to enroll in Community College of Vermont to begin the process of getting his undergraduate degree in science. He has an associate's degree in architectural engineering.

He met his wife, Margaret, during a brief stay on the psychiatric floor at Fetcher Allen Medical Center. Margaret, who also has a type of schizophrenia, was impressed with Van's goals and his commitment to his faith.

"He kept pursuing me. I was in a month longer but he kept in touch. When I left the hospital, I was in transitional housing and then in women's shared housing. I invited Van over and he proposed to me."

Margaret turned him down that time but two months later he proposed again. She accepted. Margaret says she knew some of his history but not a lot of it. "I have personal experience with that. I have a mental illness. I did not date a lot. People were scared the more I was honest about my diagnosis," she said.

According to the American Psychiatric Association, news and entertainment media tend to link mental illness including schizophrenia to criminal violence.

Dr. Kevin Buchanan, a psychiatrist at the Clara Martin Center in Randolph and Bennett's doctor, told *Counterpoint*, "Though some individuals with schizophrenia are prone to violence because of their symptoms, in general, folks with schizophrenia are not violent. In fact, they are more likely to be victims than perpetrators."

Buchanan is a fan of Bennett's book saying, "Schizophrenia from the inside."

Bennett attributes many things to his recovery and his stability.

"My treatment team at Clara Martin, my friends and family, my medication and my strong spiritual faith," he says.

His marriage to Margaret is also a big part of his stability.

"She saved my life. Part of my life was lonely and I needed to love someone and care for someone, I needed someone to love and care for me. And that someone was Margaret."

It helps that both of them are in recovery, he says.

"I don't get judgmental when he gets upset and I understand what he is going through. I know it is the mental illness. He does the same for me," said Margaret. "It is just part of the path."

More than 2.2 million people in the United States have a diagnosis of schizophrenia, according to a report by the British Broadcasting Corporation. The Department of Mental Health states that as of 2011, the number of people with a diagnosis of schizophrenia in Vermont was 1,554.

Bennett hopes to help those people by writing about his experiences and showing that recovery is possible.

"It took me ten years to accept my diagnosis. My advice is to listen to your doctor," he said.

For information on how to purchase *Lost in Schizophrenia, The Memoirs of a Schizophrenic* contact Bennett at vanb1970@yahoo.com.

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*This article was first published in the Randolph Herald. Donna Olsen of Randolph, who began her work in journalism by reporting for Counterpoint, now works for the Herald as well.*

# Either Side of the Door

by John S. Caswell

The floor, although carpeted, is hard; and cold too, but not to the extreme of that at the loading dock where I tried to sleep one night. That floor is made up of cement. And it had rained that evening, an early May rain that left the floor damp, a contributing factor to the cold that found its way to the marrow of bones no longer young, but aged almost 60 years.

I found no sleep there on the dock, but was fourtunate enough to learn the entryway to President Obama's campaign headquarters was unlocked.

I was able to doze off and on there in the entryway for probably the short side of an hour before the sky opened up to daylight pushing the darkness into its daytime hiding spot located on the other side of our planet Earth. But the entryway floor was hard and cold too, as it also was constructed of cement.

I'm thankful for the thin carpet that covers the floor; however it provided little cushion for my tired old joints.

It's strange what goes through the mind when I'm destitute. I sit here wrapped in my son's childhood blanket and I think of my family living so far away from what was my childhood home. This was my home, where now I'm alone, cold, tired and hungry.

But I have faith that things will work out. I'm in hope of going through boxes of my belongings my sister was able to rescue from the apartment I lived in for 14 years, but recently gave up.

The rescue of some of my things amounts to the extent of assistance I receive from a family whose members tell me I'm mentally ill, but yet don't take that into consideration in regards to my current life situation. Without their knowing the facts, I'm told it was my choice; I have options, and to keep the faith… yet here I am.

Many people don't understand why I gave up the apartment; it's simple really. With the death of my best childhood friend occurring so near to the property, and my attempting to end my own life a number of times in that apartment, I just couldn't stay there any longer. And there remains the fact that I experienced a number of psychotic episodes while living there.

When I'm destitute I find it very hard to ask for assistance from family and friends. I like to believe they'd assist if they knew of my needs. One friend allowed me to nap at her house a few hours one day. She also gave me a number of rides. And while I was in the hospital she brought me a backpack full of my belongings she had been holding for me. Another friend offered the comfort of her home for up to two weeks; I have yet to accept the offer. In the case of family and most friends, I think they believe there are services enough to cover everyone and every situation; the reality is, there are not.

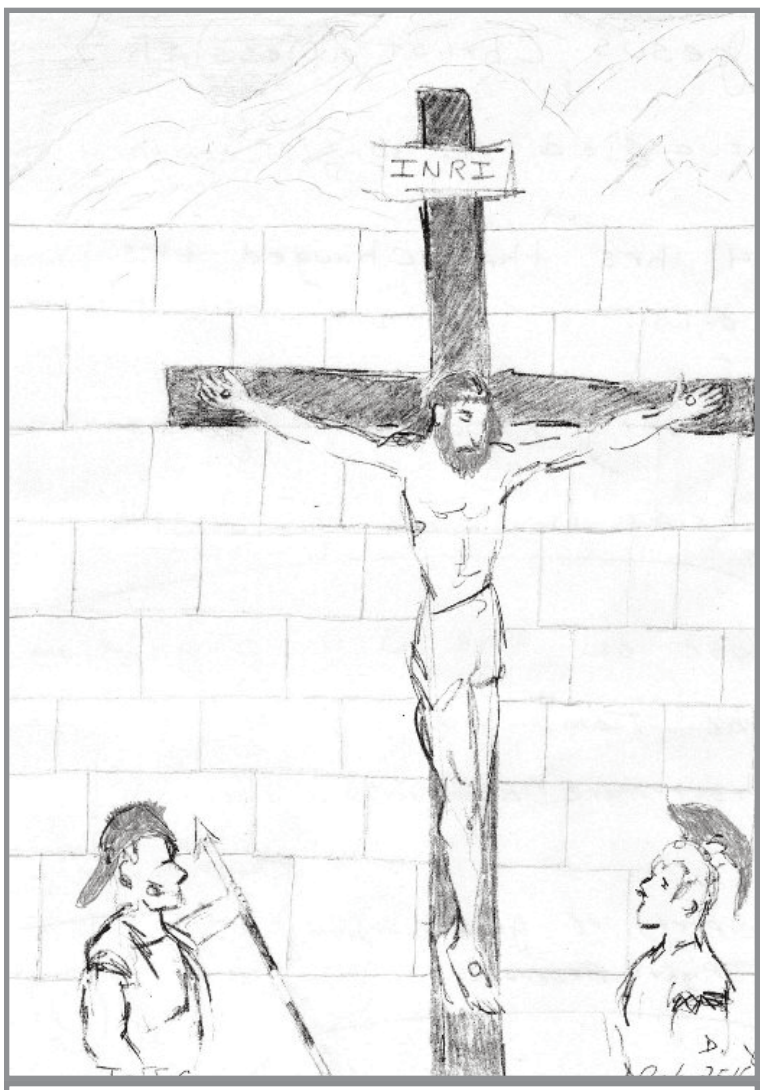
I lived alone in my apartment for 14 years. It was rare that anyone would visit, let alone spend the night. It was also rare that I'd spend a night away from home.

While "residentially challenged" I spent some time in our shelter. However, I find it very challenging being around other people after spending 14 years most often alone. This challenge was evident while I was with my children too, as I'd spend most of my time alone in my room. But I have a light heart; forever believing there is good life to experience on either side of the door.

*Winter* by Bonnie L. Machia, Fairfax

# Arts

# Poetry and Prose




Jesus Christ, Messiah, crucified. He rose on the third day from his tomb and is alive forevermore (Revelation 1 Verse 18). Pencil sketch by Jeff Gargiulo, of Central Islip, N.Y., freehand reproduction of "Jesus Christ on the cross outside the north wall of Jerusalem, AD 30, 1rst century," from *"24 Hours That Changed the World."*

## Hello ... What's Wrong?

To test and repair
my connection to life
I was to picture her face
receiving news that I chose to hang up.

She would open with a perky 'Hello',
deconstruct 'Hi',
and panic.
My daughter's face has an expressive range
that could not be matched
by the cast of Rent.

Neurological wires had quietly crossed.
Cutting and alcohol borrowed a glow of healthiness
that belonged with exercise and vegetables.
Suicide felt warm and happy.

Genetics deals different hands to siblings.
My superstar sister inherited perfect pitch,
played college sports, graduated from a top medical school,
married Prince Charming, and gave birth to
Five happy, loving, healthy, fun, interesting kids.

Skype reconnected me.
"Hello Daddy"
"Hi"
"What's Wrong?"
"Your Aunt"

by Alfred George Brier

Author's Note: In therapy I was asked to picture my daughter receiving news that I killed myself. I later watched her receive this news about her friend, my sister.

## The Happiness of Being Among Others

We sat in a circle

And I pretended that

I was not here.

I've never been a part

of any group.

He nods to me,

and I think about shape.

My shape won't fit

in any of these

spaces,

these holes.

Oh, how I wish to be left alone!

by OCEAN CHANCE
Morrisville

## On The Stoop

Sitting here on the stoop day after day, week after week...
I wave at the young woman across the street
If she really knew the loneliness in my heart she'd come say, "Hi!"
She must suspect, though. Her husband rarely even waves.

All these people walk by and I begin to recognize faces
There's the old couple... I mean old, but not old
They jog, yes jog, and I wonder what their old bones feel like
They always sing "hi" as they go by, but they don't stop

I'm on the stoop slowly, too slowly, getting to know people
Christ, it's sad not even being able to say "hi" to a child
You may be an old pervert
Just look at that coach in Pennsylvania

I get stoned on the stoop smoking a gentleman's pipe
It has my own mixture and I have no worries
Sometimes Ralph stops by, the only one to stop and talk
And he talks about nothing really, but I listen for something

Something is always there to listen if you listen
Something is always there to see if you watch
Oh, the fucking feelings are the hardest
When you feel them from a homeless stranger on the stoop

by JOHN PACE
Barre

**Arts** **A Short Story**

# This Good Book

by LAURA LEE SAORSA SMITH

Yellowed pages nearly brittle with age but still holding their own, the leather binding cracked and yet there still seemed to be a strength emanating from the book along with a musty smell. The Good Book as some call it.

Inside the front cover, ever so detailed, the family tree, marriages, births, and deaths. It was all there for anyone to see should they be fortunate to open the book and breathe in deeply its spirit, its essence. History is so important; it makes us who we are, after all.

The book was now in the hands of Betsy Donovan. She inherited it from her Grandmother, being that Betsy was the only grandchild. What Betsy did not know was the secret hidden in the pages of the book, a secret that made this Good Book even more of a treasure.

With a morning cup of freshly brewed coffee in hand, Betsy had picked up the book from her kitchen table, where she had left it last.

A letter came slipping out from between the pages to settle on the linoleum floor. She gingerly picked it up, and carefully unfolding it she began to read it as she sauntered into the living room to put her feet up.

*My dearest Helen,*

*How I miss you. I miss your warm laughter, the loving light in your eyes whenever you look at me.*

*When the war is over will you marry me? I will propose to you in the most proper way, and ask your father for your hand when I get home but please, say yes. It would mean so much to me and it would help to know I have someone to come home to.*

*The war is not a thing to be talked about with someone of your sensitivities and concerns, just know that I love you now and always no matter what your answer.*

*Lovingly yours, Brett*

The letter was short and romantic. Betsy sighed just thinking what it would be like to be so loved. The letter brought about questions, such as who the lovers were, and whatever became of them.

A mystery soon solved, thought Betsy, as she turned to the front of the book and the family tree. She ran her finger down through all the names but she found no Brett, and the closest name to Helen was Marta Helena Schmidt who married a Joseph Peter Donovan. They had only one son, Stephen John Donovan.

Mystery not so easily solved. The oldest living relative was Grandma's sister Agnes, who was an old spinster but who might shed light on this increasingly interesting and romantic mystery.

Grand Aunt Agnes was in a nursing home and Betsy hadn't seen her in a very long time. So Betsy brought a lovely bouquet of fragrant flowers, some scented soaps and expensive shampoo.

Aunt Agnes was up in a wheel chair, tiny and fragile looking. Her hands were gnarled like old pieces of wood. Her face full of creases cracked to show yellowed teeth, but there was no mistaking the pleasure she had at seeing Betsy come.

Aunt Agnes had very bright eyes, intelligent, deep and thoughtful. Betsy found it easy to talk to her. She felt guilty for not seeing her sooner.

Betsy finally came to the questions she wanted to ask. She pulled a nondescript white envelope containing the yellowed paper from her purse. She unfolded the letter carefully and read it to Aunt Agnes. Aunt Agnes closed her rheumy eyes to better look into the past.

"There was a story, a family secret that has not been told in so long, but it doesn't need to be kept a secret any longer," she said as she opened her eyes to the present.

"Your Great-Great Grand Uncle was not the biological father of his son, Stephen. Stephen was the child to Marta Helena Schmidt and Brett MacDonald. But Brett died in the war without ever knowing he had a child. Marta went by Helen because it was more American. Helen was devastated by Brett's death and she did all she could do to keep her baby and a roof over their heads. She relied on charity and the love of her parents. They were ahead of their time for the era, most parents would have been ashamed of Helen and shunned her.

"But Helen was a charmed child in many ways. Joseph Peter Donovan fell in love with both Helen and Steven. Steven was only a few months old so he never knew any different and the family decided to write him in the family tree as a Donovan."

Betsy and Agnes had a good long talk. Betsy had to leave to get on with her day but she hugged Aunt Agnes and gave her a light kiss on her dry, papery- thin cheek. Betsy thanked her and went on her way, with her treasure of a single love letter tucked in an envelope safe in her purse.

There were other treasures, but Betsy first found the relatives of Brett MacDonald. They were very forthcoming and dug about in their boxes of memories stored in their attic and discovered a smaller box with many envelopes tied with a string. They were all faded and yellowed but nonetheless legible.

They just gave them to Betsy and offered for her to come any time, as she was family. Just like that. They were kind, generous, and loved Betsy.

The letters she was given by the MacDonalds' were all from Helen. Brett had saved every one. The last letter answered Brett's request to wed in the most affirmative way. The letters were in amongst his personal effects when the military sent his body back to be buried in American soil.

Some of the other treasures in the old Bible were pressed flowers and ribbons, pieces of the past, which were all explained by Aunt Agnes through stories.

Betsy and Agnes spent much more time together and found they had quite a lot in common, such as a shared love of the author Jane Austen, so Betsy brought in some of the movies that were made from the books.

They watched the movies together with micro-waved popcorn. The nurses envied the culinary delight as the popcorn's buttery fragrant smell wafted through the halls. They sometimes shared their popcorn with staff and residents.

A relationship was forged and it brought Agnes back to life at least for the time she had left. Betsy's life was enriched for knowing her. It was odd that it took an old Bible filled with memories and secrets that got them together in the first place.

Betsy never regretted getting to know Grand Aunt Agnes. She cried at her funeral. She had so many memories of her that she often smiled at one or another of them at like doing dishes or when she curled up to read a Jane Austen book in her wing-backed chair with matching ottoman and a warm blanket on a cold day.

Betsy decided a few months after Agnes had died that she would write a letter about her Aunt and put it amongst the leaves of the Good Book. Should she find a serious boy friend as romantic as Brett MacDonald, she hoped she would keep the love letters amongst the pages of this Good Book, along with a special pressed flower or two, the bits and pieces, the little things that make up our stories.

*Laura Lee Saorsa Smith is from Cabot.*

## A Broken Mirror

As the mirror dropped to the floor

It felt as though it opened up a healed sore

All the shattered glass

Reminds you of the turmoil from your past

Each tiny broken piece

Seems to hold a memory at least

As you peer into each broken section

You witness an unfamiliar reflection

You gaze deeper into each broken part

And it reminds you of your shattered heart

The mirror demolished so fast

That it seemed more was breaking than just the glass

In one of the pieces you can still make out your face

But what you are seeing is a disgrace

It's as if you're standing on a ledge

As all the pieces surround you with a jagged edge

The shiny pieces that surround

Call out a sort of danger sound

The broken pieces will cut you open like a knife

And is ironically symbolic of your life

Say goodbye to your mirror

Maybe it will allow you to see things clearer

by Nikita Laferriere, Lyndonville

# Arts Photography

## Portraits of Music

by Donna Iverson, Burlington

ME2 Orchestra members Sara Weisman, above, of Shelburne, and Liam John of Essex.

## A Survey for Mental Health Consumers in Vermont: Your Experience of the System

This idea generated from a long-time consumer in the Vermont Mental Health System. She wanted a way to give feedback. She wants a way for you to give your feedback too. An advocate helped her come up with this survey.

*The System!*

1) In your experience, does the mental health system help clients meet their essential health needs?

A) If so, what in the system works for you? B) If not, why not?

C) Most important: how SHOULD the system change to be more oriented to delivering the help that individuals need?

*Communication!*

2) Which best describes your experiences with the mental health system:

A) Misunderstandings are worked out at the time they occur

B) Misunderstandings stay unresolved so long that the people involved experience stress and possibly even physical illness

C) Misunderstandings stay unresolved so long that it becomes too late to remedy things, as too much has changed.

3. If your answer was B or C:

i) Please describe a situation you experienced or witnessed where misunderstandings stayed unresolved.

ii) How could it have been approached in a more positive way?

iii) What factors in the mental health system would you see as barriers to communication?

iv) What do you think might help improve communication?

v) What can you suggest to make the system better at resolving misunderstandings?

[*Marj's Survey Ends here.]*

<u>Another question: Involuntary Treatment</u>

The Governor and Department of Mental Health are trying to make it easier to commit people faster and give them psychiatric medications against their will.

Do you agree with this? Yes___ No___ Not Sure____

Has this ever happened to you? ? Yes___ No___ Not Sure____

If it happened to you, was any part of it helpful? Yes___ No___ Not Sure____

What was helpful?

If it happened to you, was any part of it hurtful? Yes___ No___ Not Sure____

What was hurtful?

Do you have any suggestions to make things better for you or other people?

If you want to respond, please send your responses to Sarah at skknut@gmail.com. Sarah is collecting the information. Thank you for your time. Sincerely, Marj and Sarah Sarah Knutson, Mental Diversity Consultant

https://www.facebook.com/neurodiverseuniverse.org

https://www.facebook.com/HumanRightsRecovery.org

## Share Your Art, Your Poetry and Your 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**

# Lost and Refound:

*In September of 2013, research by Counterpoint Editor Anne Donahue on the cemetery at the Vermont State Hospital [originally named the Vermont State Asylum for the Insane]was presented at an event commemorating Vermont Archeology Month, sponsored by Vermont Psychiatric Survivors and the Office of State Curator, and hosted by the Waterbury Historical Society.*

*This chronology and the information memorializing those believed to be buried there are excerpts from that presentation.*

Key Dates:

August 8, 1891 — Vermont State Asylum for the Insane opened with 25 patients transferred from the asylum in Brattleboro.

November 25, 1884 — Bill passed for the "Advancement of Anatomical Science" for use of unclaimed bodies for medical education.

1960s, State Hospital staff reported 19 grave indentations still visible; Herbert Hunt reviews patient records to create list of persons buried there.

1990 – old map found and used to track location of "the knoll" by Deputy Commissioner of the Department of Developmental and Mental Health Serives; state archeologist determines "most likely" boundaries.

1991 – rededication ceremony held.

2011 – Tropical Storm Irene: State Hospital closed; old patient records destroyed by flooding.

2012 – Closure ceremony; New research began, to honor the memory and dignity of those buried in the cemetery.

2013 – Legislature passed Resolution and repealed law permitting donation of bodies without consent.

From the Joint Resolution relating to the history and legacy of the Vermont State Hospital and the preservation of its cemetery:

*"Whereas, with the closure of the historic Vermont State Hospital Waterbury campus, it is important to remember those individuals buried at the hospital's cemetery in use from the hospital's inception until 1912…, and*

*"Whereas, the preservation of this cemetery and of the memory of those individuals is of lasting importance, and*

*"Whereas, the names of those buried there have been gathered in the past, and may still be able to be located and preserved so that these individuals will not be left unknown…*

*"Resolved by the Senate and House of Representatives:*

*"That the General Assembly… requests the State to maintain and preserve perpetually the hospital's cemetery, and be it further*

*"Resolved: That the Department of Mental Health is requested to seek to identify from past records those individuals who were buried at different locations.*

## Information on 28 Deaths: Who Is in the Hospital Cemetery?

Although the graves were once marked with wooden crosses, those decayed and disappeared, and Herbert Hunt, author of the first section of the *History of the Vermont State Hospital,* wrote in 1965 that "all that remains today are the depressions in the ground which are covered by the forest that has grown uninterrupted since the last patient was buried there over 50 years ago." The depressions, he wrote, "can be seen in two parallel rows."

A hospital patient log lists 13 as buried in "asylum cemetery" (1892-1896);

Plus two in "state cemetery" (both 1896);

Plus two in "upper meadow" (both 1909);

Plus two in "hospital burying grounds" (1909, 1911)

These 19 are the likely source of the count that Hunt used as his estimate.

Four others are listed as "probable" hospital cemetery burials: one, "by the state" (1899); three, "Waterbury cemetery" (1893, 1898, 1906)

Two are described as being buried on grounds of the hospital other than the cemetery itself, in 1908 and 1912; three listed as unspecified "hospital grounds" burials (1908, 1911, 1913)

This would make the best guess between 19 and 27 actually in the cemetery and between one and five elsewhere in unknown locations on hospital grounds.

## Rumor of a Lost Second Cemetery

Some mysteries remain. Howard Hunt's history says that "[i]t was reported by an elderly resident of Waterbury who remembered when the patients were buried there that because of the crowded condition of this asylum cemetery it was necessary to start burying the patients in the meadow between the Winooski River and the dump road... the last patient to be interred by the hospital was buried in the meadow about 50 feet north of the large elm tree that now stands in the middle of the field, This patient was buried about the 20th of December 1912."

In 1896, a special Joint Committee of the Legislative investigated the status of the state hospital and condemned the care provided there — only five years after its opening. Included in the report was this paragraph:

***Burial Place Neglected***

*The patients who have died at the asylum whose bodies have not been claimed by relatives... have been buried upon a plot of ground situated upon the top of a hill about one-half mile from the asylum. This is reached by an unused logging or wood road; it is situated in a clump of second-growth bushes in a pasture belonging to the asylum. The space occupied for the purpose is three or four rods square, where there is no growth of bushes. We think there are eighteen unmarked, untended graves and we cannot but feel that the decencies of civilisation require a more suitable place of burial and recommend that proper enclosure be set apart for that purpose.*

If there were 18 graves already present in the fall of 1896, it is a higher count than the 14 identified from the patient log as of that date.

It was Hunt's recollections that led the legislature's resolution to comment that *"there is evidence that at least two and perhaps more patients from the Vermont State Hospital were buried at different locations on the grounds in unmarked graves that are likely to never be identified which would be a grievous indication of past indifference to the lives of those individuals…"*

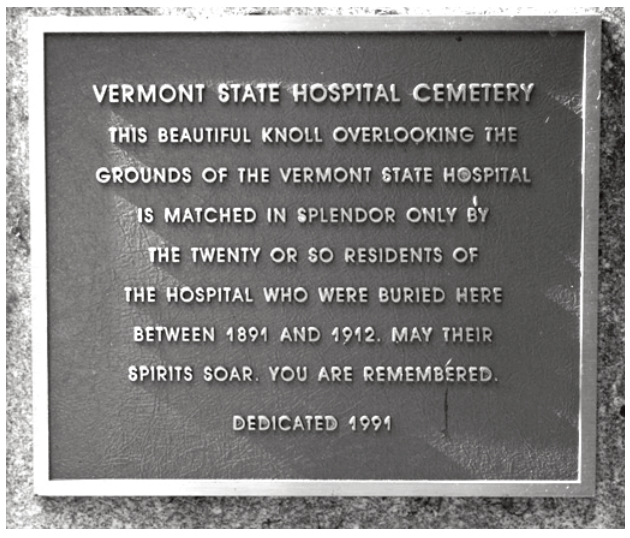
Unless further records are uncovered some day, those patients may never be known.

## Why So Few? Where Are the Others?

What happened after 1912? Biannual reports to the legislature in the state archives report that as of 1904, there had been 370 deaths.

Most were either claimed by families or sent to Overseers of the Poor in home communities and buried in cemeteries there, or buried in the Waterbury cemetery's pauper section.

However many were identified as being sent to the "Medical College." This includes seven listed as before 1913; of those admitted up to 1919, 199 transfers are registered between 1894 and 1954.




**A 1991 rededication stone pledged to remember those buried at the cemetery, but by 2012, it was at risk of being forgotten again, and there was still no identification of the patients buried there.**

The1884 Act for the Advancement of Anatomical Science gave the authority for unclaimed bodies to be requested by physicians for the purposes of education. It was intended to address the a serious problem with grave robberies caused by the lack of bodies for student learning. The act created strong penalties against grave robbery.

Although it was no longer used later in the 20th century, it was not repealed until 2013, when the old law was noticed during the cemetery research. [Act No. 32 Repeal of 33 V.S.A. § 2302 (use for advancement of anatomical science)].

In 2013, commitments for future preservation of the cemetery were made through its listing in the Putnam State Forest Management Plan, addition to the Vermont Archeology Inventory, and plans to include it on the State Register of Historic Places.

During the legislative attention to the cemetery, the Associated Press news services published an article about it which appeared in news outlets across the country.

One outcome was an email sent to Anne Donahue from a woman in Manchester, CT, that said, in part,

*"Dear Rep. Donahue:*

*"…I wanted to send you a note of thanks for your work...*

*"Sally Town, who died in childbirth at the hospital, was my fourth-great-aunt. All I knew of her before your story was featured on NPR was that she was born mute and hearing-impaired and that she had been "sent away" as a young woman…*

*"I have always been drawn to Sally's story in our family history, but I could never find a trace of where she went… [It is] a relief to know that she and her son are not forgotten…*

*"Thank you… for letting me know where a family member — now family members — I've been chasing for so long rest."*


**The only known photographs recording the last day of the Vermont State Hospital were taken by *Counterpoint* on August 29, 2011.**

# Remembering the Long-Forgotten Patients at the Cemetery of the Vermont State Asylum for the Insane

*"We cannot but feel that the decencies of civilization require a more suitable place of burial and recommend that proper enclosure be set apart for that purpose." 1896 Special Joint Committee of the Vermont Legislature*

*"... a grievous indication of past indifference to the lives of those individuals..." 2013 Joint Resolution of the Vermont Legislature*

## *"So that these individuals will not be left unknown…"*

*[from the Resolution of the Legislature, 2013]*

**Joseph Warren**, age 45, was the first burial listed in the "asylum cemetery." Although his death is listed as January 1, 1892, with burial on January 2, other history states that the first patient was buried there on August 1, 1892. No information for him could be located in the town death records, and his hospital record gives no diagnosis or cause of death.

**Kate Shamore**, who died May 27, 1892, had been in the first group of 50 women who were transferred from the Retreat on September 4, 1891. She was 72, and her cause of death was listed as a cerebral embolism. There are also no town records for her, and the spelling of her last name is in question.

**James T. Collins** died on March 23, 1893, at age 76, according to his death certificate, which also provides the names of his parents, John and Betsy [Eddy] Collins. Information drawn from the hospital records identifies a John Collins, admitted on the prior August 8 and dying on March 23, and lists him as "buried in Waterbury cemetery." The only Collins in the village cemetery is a "John," age 80, with no dates. There is no reason to assume other than that James was the patient and was buried in the hospital cemetery. His admission diagnosis was senile dementia, and cause of death, erysipelas and pneumonia.

**Pheoba Weller**, who died August 1 of that year, was 51 and had been admitted just a few months before, on April 10, with a diagnosis of "delusional mania, acute." Her cause of death was "exhaustion, organic disease of the brain." The hospital records indicate that a "son and his wife" were present for the burial. A vital records search turned up a husband, Edgar Weller, but only one child, a daughter, Mary Ann. Pheoba was born in Cambridge and Edgar was a farmer from Hinesburg. Their daughter was born in 1877 in Starksboro, and she and her husband, Danial Liberty, had their first child, Henry, the year before Pheoba's death. The last of her descendants traced were Geraldine Agnes Clark, who married Matthew Robert Thibault in 1947 in Burlington, and Barbara Ann Clark, who married Leo Louis Coutois in 1954.

**Sally Town**, listed as 30, died in childbirth on November 6 in 1893, and the newborn was buried with her in the asylum cemetery. She was admitted as a transfer from the Retreat in 1891. Her hospital record listed no admission diagnosis, but said she was "deaf and dumb" and "discovered she was pregnant October 20, 1893." Her death certificate lists paresis, a psychosis caused by destruction of brain tissue occurring in some cases of late syphilis. A Special Joint Committee of the legislature investigated her death in great detail in 1896, and found that she had received questionable medical care. Although one record said her parents were notified and did not respond to claim her body, another record acknowledged that they received no notice. Sally was born in 1832 in Pawlet to William, a farm laborer, and Jillian Town. They had five more children after Sally. The last of her brother William's descendants was traced to Richard James Bruce (1954-1975); but see letter, page 18, from her great-great-niece.

**Sarah Townshed**, also admitted on September 4 of 1891, died Nov. 21, 1893, at age 61. Her hospital record listed "uterine trouble" as the cause of insanity, with cerebral pressure causing her death. Death records list the cause of death as "acute mania."

**Patrick Waldrin** died the same day. Born in Ireland, he was 70 and was transferred from the Retreat in 1891 with "chronic dementia." His cause of death from the hospital record was Bright's Disease, an old term for undefined kidney diseases or chronic nephritis; in the death record, simply "insanity."

**Catherine Davies**, born in Burlington in 1824, died from a blood clot on May 10, 1894 at age 70. She had been transferred from the Retreat in October of 1891. The death record lists "fatty degeneration of the heart" as cause of death.

**Rachel Boynton**, 65, another from the first group of women brought from Brattleboro, died on September 1 of that year. Born in Wheelock in 1829, she had been at the Retreat since at least 1880. Her record stated that the cause of her insanity was "domestic trouble." She died from ulceration of the stomach. Rachel was the wife of Leonard Boynton, and they had two children, Mason, born in 1849, and Mary, born in 1850.

**Christopher Kidder** died June 15, 1895. He had been admitted in 1893 for "mania, chronic delusional," and died at 58 of valvular disease of the heart. Christopher and his wife, Emma S. Bassford, had two children, Elmer H., born in 1875 and Millie, born in 1877.

**Maggie Paro**, 34, died of epilepsy on May 16, 1896. She had been admitted from the Retreat in 1891 with "childbirth" as the listed cause of insanity.

**Annie Fuller** died May 25, 1896, of organic disease of the brain after having been admitted in 1894 for "mania, chronic delusional." Insanity was caused by "change of life which occurred last fall." She was born Anna E. Potter in Bennington, daughter of Benajah and Lucinda Potter, and in 1863 married Lemuel Fuller. There is no record of children. Depending upon the record, she was born somewhere between 1837 and 1846, making her between 50 and 59.

**Martha Taylor** was identified as age 81 but with no information about her death on July 3, 1896. She had been admitted on Sept. 4, 1892, and was listed as being buried in the "state cemetery."

**George Lyon** died of heart failure on August 12, 1896, just two months after his admission. He was 76 with "chronic dementia," and was buried in the "state cemetery."

**John Harwood** was at the hospital for nine days before his death from a "cerebral effusion" on Dec. 28, 1896. He was born in Bennington and a "laborer," but age unknown. He was the last death in which the term "asylum cemetery" was used to indicate the place of burial. His would have been only the fifteenth grave, however, among the nineteen grave impressions that witnesses have described.

**Amelia Platka** was another of the first women admitted in 1891, and died April 26, 1898, at age 63. She was born in Germany; insanity was caused by a "domestic affliction," but she died after three months with a "malignant disease of the liver." She was a widow, and was listed as "burial in Waterbury cemetery."

**Sheldon Pond**, who was admitted with "chronic dementia" in 1896, died on Feb. 25, 1899, at age 75, of "exhaustion of old age." His occupation was listed as farmer, and burial was "by the state."

**Josephine Paquette**, who died May 14 or 20, 1906, of "cerebral congestion," was identified as being buried "here in cemetery in Waterbury, VT. Her sister from Rhode Island to see to it." She is not listed in any Waterbury cemetery records. Josephine was admitted in 1902 and was 49. She was married to Charles H. Paquette, and her parents were Soloman and Amelia (Mosher) Pepin. The death record lists cause of death as "general paralysis," with a former attack of syphilis.

**Thomas Nason**, 80, committed suicide on June 25, 1908. He had been admitted the year before. The hospital records indicate that he eloped and was found the next day, "suicide by hanging at riverbank." The record indicated that the body was decomposing and "could not be moved from this place." Remains were "buried on hospital grounds."

**Adeline Smith** was admitted in 1896 for "chronic dementia" and died March 13, 1909 of a fractured femur; she has a cause of insanity listed as "disappointment in love." She was about 80. She is listed at "hospital burying grounds."

**Wlliam Burbank** was a 17-year-old with an unknown diagnosis who died from a scalding accident on July 6, 1909, and was "buried in the upper meadow." He was born in Burlington and admitted in 1908, but other information is listed as unknown. The description of the accident stated, "Was left standing near the tub while the attendant went to get a clean shirt. Attendant heard a scream, went in, and found Mr. Burbank half submerged and scalded. Shock of extensive scalding of body."

**Fred Phillips**, who died of suicide on July 21, 1909, at 48, is also listed as "buried in upper meadow." He was admitted in 1906. His death record lists a wife, Kate, and his father, Frank. The description of his death gruesome: "Absent when night watch did rounds. Body found in the weed on riverbank. Throat cut, knife on his abdomen." The hospital record said his family was present for a funeral service, held in the lecture room.

**Charles Tatro** was admitted in 1908 and died Nov. 10, 1910, at age 47 of "epilepsy, exhaustion, facial erysipelas (an infection)" and "since he died of a communicable disease the body was buried on the institution grounds this A.M."

**Philip Pitkin** died of tuberculosis at age 18 on April 24, 1911; he was admitted when he was 14. His mother is listed as Bertha Morian. He was "buried on the hospital grounds" after his body was refused by the overseer of the poor for his town.

**Joseph McCormick**, 36, died Oct. 29, 1911, of diphtheria. He had been admitted in 1896 for "chronic recurrent mania," with insanity caused by "heredity." He was the son of Cary and Ann (Corbett) McCormick, and his body was interred at the "hospital burying grounds."

**Frederick T. Sharp** was struck by a falling tree while on firewood duty on Dec. 20, 1912, and bled to death. He was 42, and had been admitted in both 1902 and 1903, with cause of insanity listed as "over study and mental work." He was the son of Alexander and Alice (Walker) Sharp. Several pieces of history conflict. One historical report lists the last burial in the hospital cemetery as being on Dec. 20, 1912; its marker says residents were buried there until 1912. The hospital record says "remains were buried on hospital grounds." Oral history recorded by Herbert Hunt indicated that he was buried in the meadow near where he died, about 50 feet from the foundation of an old farmhouse.

**Matilda Mineburg** died Feb. 21, 1913, at age 72 of "cardiac dilation – insanity." She had been with the first women transferred from the Retreat in 1891, and is listed as having been "buried on hospital grounds." If this refers to the cemetery, it would contradict the historical report that the last burial was in 1912. She was born Matilda Becker, the daughter of Meyer Becker, in Prussia and was married to David Mineburg, also of Prussia. It appears that they had seven children; the youngest was born in 1879 while they were living in Burke, and died a year later. The extended Mineburg family included his father Moses, who lived with his brother, Soloman, who was married to Rosa, all from Prussia.

# Resources Directory!

**Check Out the VPS website: www.vermontpsychiatricsurvivors.org**

## Vermont Psychiatric Survivors Peer Support Groups

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

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

**Central Vermont**
- Another Way,125 Barre St., Montpelier; every Monday; 5:30-7 p.m.

**East Arlington**
- Federalist Church, Ice Pond Road, East Arlington; every Monday, 6 - 7:30 p.m.

**Northwestern**
St. Paul's United Methodist Church, 11 Church Street, St. Albans; 1rst and 3rd Tuesday, 4:30-6:30 p.m.

**Rutland**
- Asa Bloomer Building, 1rst floor conference room; every Tuesday, 4-6:30 p.m.

**Windsor**
- Windsor Resource Center, 1 Rairoad Ave., Windsor; every Thursday, 5-6:30 p.m.

**VPS** is a membership organization providing peer support, outreach, advocacy and education; 1 Scale Ave., Suite 52, Rutland, VT 05701. (802) 775-6834 or (800) 564-2106.

If interested in helping develop a support group in your area contact George at VPS, 802-282-2267; vpsgeorg@sover.net

## Community Mental Health

**Counseling Service of Addison County**
89 Main St. Middlebury, 95753; 388-6751
**United Counseling Service of Bennington County;**
P0 Box 588, Ledge Hill Dr. Bennington, 05201; 442-5491
**Chittenden County: HowardCenter**
300 Flynn Ave. Burlington, 05401; 488-6200
**Franklin & Grand Isle: Northwestern Counseling and Support Services**
107 Fisher Pond Road, St. Albans, 05478; 524-6554
**Lamoille Community Connections**
72 Harrel Street, Morrisville, 05661
888-4914 or 888-4635 [20/20: 888-5026]
**Northeast Kingdom Human Services**
154 Duchess St., Newport, 05855; 334-6744
2225 Portland St., St. Johnsbury; 748-3181
**Orange County: Clara Martin Center**
11 Main St.,Randolph, 05060-0167; 728-4466
**Rutland Mental Health Services**,
78 So. Main St., Rutland, 05702; 775-8224
**Washington Cnty Mental Health Services**
P.O. Box 647 Montpelier, 05601; 229-0591
**Windham and Windsor Counties: Health Care and Rehabilitation Services of Southeastern Vermont,**
390 River Street, Springfield, 05156; 802- 886-4567

### 24-Hour Emergency Screener Lines

***(Orange County)*** Clara Martin (800) 639-6360
***(Addison** County)* Counseling Services of Addison County (802) 388-7641
***(Windham,Windsor Counties)*** Health Care and Rehabilitation Services (800) 622-4235
***(Chittenden County)*** HowardCenter
(adults) (802) 488-6400;
First Call – Baird Center:
(children and adolescents) (802) 488-7777
***(Lamoille County)*** Lamoille Community Connections (802) 888-4914
***(Essex, Caledonia and Orleans)*** Northeast Kingdom Human Servicse (802) 748-3181
***(Franklin and Grand Isle Counties)***
Northwestern Counseling and Support Services (802) 524-6554
***Rutland*** Mental Health Services (802) 775-1000
***(Bennington County)*** (802) 442-5491 United Counseling Services (802) 362-3950
***Washington County*** Mental Health Services (802) 229-0591

## LGBTQ Individuals With Disabilities

**Burlington,** Tuesdays, 4:30 p.m. at RU? Community Center, 255 S. Champlain St.,
- The Wellness Co-op, 43 King St, Thursdays, 3 p.m.

**St. Albans,** Northwestern Medical Center, conf room 4, Wednesdays, 5:30 p.m.
**St. Johnsbury,** Unitarian Universalist Church, 47 Cherry St, Fridays,11 a.m.
**Online** group through Pal Talk Monday nights 7-9 p.m. in the Vermont Chat GLBTQ And Disability chat room. Questions? Brenda@ru12.org / 802-860-7812 www.ru12.org

## Peer Support Lines

**Vermont Support Line (Statewide): 1-888-604-6412; every day, 3-11 p.m.**
Peer Access Line of Chittenden County: 802-321-2190, Thurs-Sun, 6-9 p.m.; for residents of Chittenden County.
Rutland County Peer Run Warm Line: Fri, Sat, Sun, 6-9 p.m.; 802-770-4248 or email at warm_line2012@yahoo.com.
Washington County Mental Health Peer Line Service: 802-229-8015; 7 days/wk, 6-11 p.m.

## Brain Injury Association

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

**DBT Peer Group:** peer-run skills group; Share materials, advice, information and activities. Sundays, 4 p.m.; 1 Mineral St, Springfield (The Whitcomb Building). More info at http://tinyurl.com/PeerDBTVT

## Advocacy Organizations

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

**Mental Health Law Project**
Representation for rights when facing commitment to a psychiatric hospital. 121 South Main Street, PO Box 540, Waterbury VT; 05676-0540;
(802) 241-3222.

**Vermont Family Network**
Support for families and children where the child or youth is experiencing emotional, behavioral or mental health challenges. 800-8800-4005; (802) 876-5315

**Adult Protective Services**
**Reporting of abuse, neglect or exploitation of vulnerable adults,**
1-800-564-1612; also to report licensing violations at hospitals or nursing homes.

**Vermont Client Assistance Program (Disability Law Project)**
Rights when dealing with service organizations, such as Vocational Rehabilitation. PO Box 1367, Burlington VT 05402; (800) 747-5022.

**Health Care Ombudsman**
(problems with any health insurance or Medicaid/Medicare issues in Vermont)
(800) 917-7787 or (802) 241-1102

**Medicaid and Vermont Health Access Plan (VHAP)** (800) 250-8427 [TTY (888) 834-7898]

## Peer Centers

**Another Way, 1**25 Barre St, Montpelier, 229-0920; info@another-wayvt.org
**The Wellness Co-op,** 279 North Winooski Avenue, Burlington, Mon and Wed-Fri, 10 a.m.-7p.m.; Tues, 10 a.m.-9 p.m.; 888-492-8218 ext 300; thewellnesscoop@pathwaysvermont.org/ More information at www.thewellnesscoop.org

## Peer Crisis Respite

Alyssum, 802-767-6000, alyssum.info@gmail.com; www.alyssum.org

## NAMI Connections

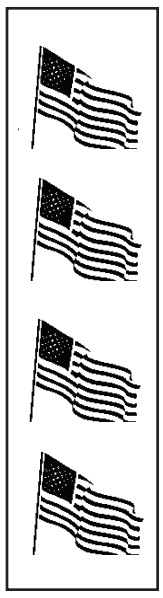
**Peer Mental Health Recovery Support Groups**
**Bennington:** Every Tuesday 1-2:30 pm; United Counseling Service, 316 Dewey Street, CRT Center
**Burlington**: Every Thursday 3-4:30 pm; St. Paul's Episcopal Cathedral, 2 Cherry Street (enter from parking lot)
Every Wednesday, 7-8:30 p.m., Turning Point Center, 191 Bank St., 2nd floor
**Rutland**: Every Sunday 4:30-6 pm; Wellness Center (Rutland Mental Health) 78 South Main St.
**St. Johnsbury**: Thursdays 6:30-8 pm; Universalist Unitarian Church, 47 Cherry St.
**Springfield:** Every Monday 11 -12:30 pm; HCRS, CRT Room, 390 River St.
*If you would like a group in your area, to be trained as a facilitator, be a Champion for a group in your area or have questions please contact NAMI 1-800-639-6480 or email us at connection@ namivt.org*
NAMI-VT proudly announces the Recovery Support Group is now being offered at the inpatient unit at Rutland Regional Medical Center, one of the first of its kind in the country.

**National Alliance on Mental Illness - VT (NAMI-VT)** provides upport, education and advocacy for families and individuals coping with the problems presented by mental illness. 1-800-639-6480, 162 S. Main St., Waterbury, VT 05671;www.namivt.org; info@namivt.org

## Vermont Recovery Centers

**www.vtrecoverynetwork.org**
**Barre**, Turning Point Center of Central Vermont, 489 N. Main St.; 479-7373; tpccvbarre@gmail.com
**Bennington**, Turning Point Center, 465 Main St; 442-9700; turningpointbennington@comcast.net
**Brattleboro**,Turning Point Center of Windham County, 112 Hardwood Way; 257-5600 or 866-464-8792; tpwc.1@hotmail.com
**Burlington**, Turning Point Center of Chittenden County,191 Bank St, 2nd floor; 861-3150; GaryD@turningpointcentervt.org or http://www.turningpointcentervt.org
**Middlebury**, Turning Point Center of Addison County, 228 Maple St, Space 31B; 388-4249; tcacvt@yahoo.com
**Morrisville**, North Central Vermont Recovery Center, 275 Brooklyn St., 851-8120; recovery@ncvrc.com
**Rutland**, Turning Point Center, 141 State St; 773-6010 turningpointcenterrutland@yahoo.com
**Springfield**, Turning Point Recovery Center of Springfield, 7 Morgan St., 885-4668; spfldturningpoint@gmail.com
**St. Albans,** Turning Point of Franklin County, 182 Lake St; 782-8454; tpfcdirecton@gmail.com
**St. Johnsbury,** Kingdom Recovery Center, 297 Summer St; 751-8520; n.bassett@stjkrc.org; www.kingdomrecoverycenter.com spfturningpt@vermontel.net
**White River Junction**, Upper Valley Turning Point, 200 Olcott Dr; 295-5206; mhelijas@secondwindfound.net; http://secondwind-found.org

**Please let us know if your group's schedule changes: counterp@tds.net**



## VA Mental Health Services

VA Hospital: Toll Free 1-866-687-8387; Primary Mental Health Clinic: Ext. 6132
**Outpatient Clinics** Bennington: 802-447-6913, Brattleboro: 802-251-2200, Burlington Lakeside Clinic: 802-657-7000, Newport: 802-334-9777, Rutland: 802-772-2300
**Vet Centers** (Burlington) 802-862-1806 (WRJ): 802-295-2908

## Vermont Veterans and Family Outreach:

Bennington/ Rutland Outreach: 802-773-0392; cell: 802-310-5334
Berlin Area Outreach: 802-224-7108; cell: 802-399-6135
Colchester Area Outreach: 802-338-3077/3078; cell: 802-399-6432
Enosburg Area Outreach: 802-933-2166
Lyndonville Area Outreach: 802-626-4085; cell: 802-399-6250
Vergennes Area Outreach: 802-877-2356; cell: 802-881-6680
Williston Area Outreach: 802-879-1385; cell: 802-310-0631
Windsor Area Outreach: 802-674-2914
**Outreach Team Leader:** 802-338-3022/ 802-399-6401
**Toll-free Hotline(24/7)** 1-888-607-8773

## Vet-to-Vet support:

**check for a group in your area at www.vtvettovet.org**

## Veterans' Services

Homeless Program Coordinator: 802-742-3291
Brattleboro:
Morningside 802-257-0066
Rutland:
Open Door Mission 802-775-5661
Rutland: Transitional Residence:
Dodge House, 802-775-6772
Burlington:
Waystation/Wilson 802-864-7402
**Free Transportation:**
Disabled American Veterans:
866-687-8387 X5394