

vermont
psychiatric
survivors

Counterpoint

Vol. XXXI No. 3

From the Hills of Vermont

Free!

Since 1985

Winter 2016



CHEERS FOR THE YEARS — A group of guests and visitors celebrate the fifth anniversary of Alyssum, a peer-run crisis respite residence in Rochester. The program held an open house in October to mark the event. (Photo Courtesy of Alyssum)

Police Responses Get New Focus In Mental Health

by ANNE DONAHUE

Counterpoint

MONTPELIER — When Andrea Stefani called the police in Worcester to help her get her daughter to the hospital, the last thing she expected was to see her taken away in handcuffs.

Then, in court the next day, “there was my poor daughter in chains.”

Chi Chi, her daughter, is 23. As Stefani told their story one evening at the Another Way peer drop-in center, Chi Chi was nestled quietly against her on the couch, occasionally nodding in agreement.

She was frightened by the experience of prison, she said. “I was just trying to make it through the day.” Her mother says Chi Chi has autism and epilepsy, and occasionally gets “revved up,” as she did that night.

“I did not call them to have her arrested and charged,” Stefani said. “I called them to help me get her to the emergency room safely.”

Since that experience three years ago, “I’ve gotten more and more terrified of calling the police” for assistance, she said. “You never know who’s coming” and whether the officer will help calm things down or be aggressive, like the “Rambo-style” officer who responded that night.

If her daughter had not been compliant, the police “might have wrestled her to the ground” or “tasered her” — which could have been fatal because of her epilepsy. “That’s what scares me.”

It is a fear expressed by survivors like Chi Chi that *Counterpoint* interviewed for this article.

That concern has also gotten the attention of Vermont advocacy groups that are trying to address what steps the state can take to prevent deaths like that of Ralph ‘Phil’ Grenon, the 76- (Continued on page 6)

Confidentiality at Risk in New Approaches to Integrated Care

by ANNE DONAHUE

Counterpoint

BURLINGTON — The University of Vermont Medical Center is debating the need to limit access to mental health records to preserve patient confidentiality versus the need to provide full access to such records to members of a health care team to improve patient care.

The issue is also popping up in other health systems in the state, but psychiatric survivors aren’t necessarily aware or asked what they think. When asked, psychiatric survivors still strongly oppose information sharing, primarily because of the discrimination they experience in the health care system, *Counterpoint* learned in interviews.

Bob Pierattini, MD, the chair of psychiatry at UVMMC, asked for input recently from the inpatient psychiatry’s Program Quality Committee,

which includes several survivors. The UVM health network system includes several hospitals and many outpatient providers, and its electronic health records include all patient diagnoses and prescriptions, but the system was created to have a “sensitive notes” default that blocks general access to mental health provider notes.

“I was one of the privacy proponents” when the system was first set up, Pierattini said. Now, there is increasing pushback from other physicians who believe they need full access for optimal care.

Other Health Systems

The state’s centralized electronic health information exchange has a work group that has been reviewing how to get patient records that have special protections under federal law into the sys- (Continued on page 8)

For Little Boy, a Six Day Emergency Room Wait

by ANNE DONAHUE

Counterpoint

BERLIN — He could not see the outdoors even through a window.

The lights were kept on, 24-hours a day.

At least twice, he was restrained by two or three staff and sedated.

He was confined to one small room.

For six days, he was held in a hospital emergency department, waiting for admission to the Brattleboro Retreat.

He was 11 years old.

It was “the most epic kind of torture” that could be imagined for the boy, his father said later, because with his nonverbal autism, he did not have the ability to understand that anything might change.

“From Tommy’s point of view, he was stuck there forever, for the rest of his life.” Although Tommy rarely expresses visible emotion (“we’ve never even seen him cry before”), several times he was “sobbing uncontrollably.”

At other times, he tried to pull the door open or get away while being escorted to the bathroom.

“He wanted to escape. He could not believe what was happening.”

“No one has the right to treat someone the way Tommy was treated. You do not torture the most vulnerable,” his father said.

Tommy’s plight underscored how children, too, are being caught up in a mental health system that lacks adequate resources for those who need it, including leaving persons in crisis trapped for days in emergency rooms. The nightmare for Tommy ended only after days of negotiations be- (Continued on page 4)

Peer Leadership and Advocacy

Meeting Dates and Membership Information for Boards, Committees and Conferences

Peer Organizations

Vermont Psychiatric Survivors

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

Counterpoint Editorial Board

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

Currently Recruiting New Members

Alyssum

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

Disability Rights Vermont PAIMI Council

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

Hospital Advisory

Vermont Psychiatric Care Hospital

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

Rutland Regional Medical Center

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

Brattleboro Retreat

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

University of Vermont Medical Center

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

Save the Dates!

2017 Alternatives Conference

The National Empowerment Center (NEC) will organize and host the 2017 Alternatives Conference at the Boston Park Plaza from Friday, August 18, through Monday, August 21, 2017. The Alternatives Conference 2017 website is in development and will have further information at www.power2u.org.

Hearing Voices Conference

The Ninth Annual World Hearing Voices Congress will be held at Boston University August 16-18, 2017. The Hearing Voices Movement will be celebrating its 30th Anniversary. The Hearing Voices Movement consists of over 30 national networks from around the world joined by shared goals and values, including a fundamental belief that...hearing voices is not, in itself, an indication of illness. More information at <http://www.hearingvoices-usa.org>.

State Committees

Adult Program Standing Committee

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

Local Program Standing Committees

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

Facebook and Web Sites

Wellness Workforce Coalition

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

Mad in Vermont

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

Advocacy Organizations

Disability Rights Vermont

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

Mental Health Law Project

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

Vermont Center for Independent Living

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

Vermont Family Network

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

Adult Protective Services

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

Vermont Client Assistance Program

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

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

Vermont Federation of Families for

Children's Mental Health

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

Counterpoint

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Mission Statement:

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

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The Editorial Board reviews editorial policy and all materials in each issue of Counterpoint. Review does not necessarily imply support or agreement with any positions or opinions.

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

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Counterpoint Deadlines

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Summer (June delivery; submission deadline April 7)

How to Reach

The Department of Mental Health:
802-241-0090

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

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

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

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Back Issues can be accessed at www.vermontpsychiatricsurvivors.org

Advocacy Coalition May Evolve From 3-Group Peer Conference



MONTPELIER — Three organizations are planning to build on their common ground after a day-long conference in September titled “Towards a More Authentic Coalition: Uniting Three Statewide Peer Networks for More Powerful Advocacy.”

Kathy Holsopple of the Vermont Federation of Families for Children’s Mental Health and one of the organizers said that “an overwhelming number of people want to move ahead” in working together in some way.

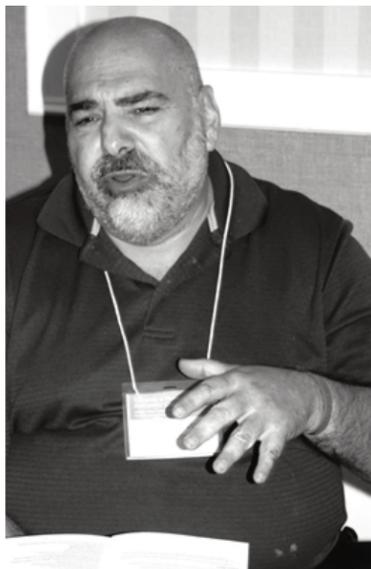
The other two groups are Vermont Psychiatric Survivors and the Vermont Recovery Network.

What is less clear, Holsopple said, is what form the next steps will take. The leadership of the three groups “want peer voices behind it” in identifying where to move forward.

The desire to continue collaboration was heard during discussion groups at the conference, and supported by 48 of the 52 responders to a survey of participants. Among them, 32 of the 52 want to see more joint advocacy, and 20 identified an interest in working together on resilience, Holsopple said.

She said the three groups are considering creating regional groups “to continue these conversations.”

“Having listened to each others’ stories” a next step towards joint advocacy would be to identify, “What is our common ground?” and where would the members be a “stronger voice together.” AD



Hospitals Face Cut In Federal Funding

MONTPELIER – The state may eventually lose \$64 million in federal matching funding for costs for inpatient and some residential mental health programs under revisions to an agreement on how Medicaid funds can be used.

Five million dollars in lost federal funds will need to be made up in the budget this year, according to testimony by Sara Teachout of the legislature’s Joint Fiscal Office.

Vermont has had an agreement with the federal government since 2005, which permits much greater flexibility in how Medicaid is spent by the Department of Vermont Health Access. Under the agreement, called a “Global Commitment,” DVHA must keep costs below the growth rate in costs that would otherwise be expected.

Until this year’s renewal, that agreement has allowed for federal matching funds to be spent on the Vermont Psychiatric Care Hospital and the Brattleboro Retreat. In the absence of the agreement, under existing law, Medicaid funds may not be spent on standalone psychiatric hospitals that exceed 16 beds.

Under the new agreement signed in October, the state must build a transition plan over the next five years to bring the state into alignment with federal policy on that and other residential care that includes “room and board costs,” according to testimony by Teachout to the legislature’s Joint Health Oversight Committee in October.

That would include programs such as the secure residence in Middlesex and the Valley Vista substance use treatment program.

Federal funding for Woodside, the youth detention facility in Colchester, has been terminated effective immediately, according to Frank Reed, Commissioner of the Department of Mental Health.

The legislature had purported to “repurpose” Woodside from a detention center to a psychiatric treatment facility several years ago to claim Medicaid funding.

The VPCH and the Retreat’s current Medicaid expenditures are \$34.5 million. The match rate changes each year but is above 50 percent, so that alone would be a loss of more than \$18 million to the state’s mental health budget.

The transition timeframe “allows the state time to plan appropriately for needed capacity, which could include downsizing these existing facilities so that they are not over the bed limit [of 16], adding capacity elsewhere, or developing new facilities,” Teachout said.

The state’s Medicaid budget as a whole is \$1.6 billion, and Sen. Jane Kitchel, who chairs the Senate Appropriations Committee, said of the future financial losses, “Yes, there are dings on the cash register,” but it was a small percentage of the overall budget. This year, the changes in the Global Commitment agreement will mean a shortfall of \$5 million to be made up in the mid-year budget adjustment in January, and another \$6.5 million shortfall in the budget for fiscal year 2017-18, Teachout said. AD



Crisis Text Line Available 24/7

WATERBURY – The Department of Mental Health has announced a partnership with the national organization Crisis Text Line to enable Vermonters to access a trained crisis counselor within five minutes of sending a text message on their cell phones when help and support are needed. The service is available 24/7.

“The counselors are not therapists, but they are trained to help with active listening that is empathetic, understanding and respectful,” states the media release from Crisis Text Line.

To access the crisis line, a person can send a text message from a cell phone to the number “741741” and type the letters “VT” in the message box.

There will be an automated text followed by a response from a trained crisis counselor through a secure platform. The counselor will stay in text communication until the crisis is abated and there is a plan for next steps.

“Crisis Text Line will help make a difference for people to get support in the moment, especially for those individuals who may feel more comfortable sharing difficult thoughts and feelings through text messaging,” states Dr. J Batra, Medical Director of DMH.

“This is an important complement and gateway to the state’s mental health services, such as face-to-face crisis response at Vermont’s community mental health centers,” he said.

The service is free. Crisis Text Line states that nothing will appear on a person’s cell phone bill if the plan is with AT&T, Verizon, Sprint or T-Mobile. The system has a limit of 140 characters in one message.

More information is available at www.crisistextline.org. This is a privately supported, nationwide nonprofit organization that receives donations from individuals, corporations, and other donors.

Six Day Wait

(Continued from page 1)

tween the Department of Mental Health (DMH) and the Brattleboro Retreat, Vermont's only psychiatric hospital that has a children's unit.

The Retreat had beds, DMH said, but there were too many other patients on the unit that needed intensive care to admit one more.

That is the same issue that often faces adults in the system: hospitals that have beds but refuse admissions, saying that they do not have the resources to address individuals with the most severe behavioral symptoms.

Kathy Holsopple, of the Vermont Federation of Families for Children's Mental Health, said that the emergency room issue is "our number one priority for advocacy right now."

The Federation has been "hearing about it all over the state," with the numbers rising over the past year and no relief in sight. "It's getting worse," she said.

Holsopple said the Federation will be advocating with hospitals for more beds. There is a particular need for complex combined medical and psychiatric care, she said.

That does not exist at the Retreat, since it is a stand-alone psychiatric facility not attached to a medical hospital. It is both the only psychiatric facility in the state that admits children, with 24 beds, and the largest of those serving adults, with 89 of the 188 adult beds among six hospitals.

The Federation has been on a work committee that also includes the Vermont Family Network and the Howard Center in Burlington, and has been reviewing national models of care, Holsopple said.

Too Sick for Admission

Tommy's parents said they were told they needed to wait until one of the four beds in the "low stimulation area" on the children's unit at the Retreat became available.

If Tommy had not been "as sick as he was," there would have been a bed for him, they were told; because his behaviors were so disruptive, he was nonverbal, and he had co-occurring medical symptoms, he was considered to be in need of the highest level of care.

In "State of Emergency," an article that ran in *Counterpoint's* summer 2016 issue, this newspaper reported on the long Emergency Department waits that adults in emotional crisis face. However, the system backup has worsened in the past several months, and DMH is trying to come to grips with the pressure points and a response, according to Commissioner Frank Reed.

Reed acknowledged that the problem was worsening for children, as well. There are "more children with difficulty getting admitted," he said. The data for June through August show 28 cases of youth waiting in the emergency department for an inpatient bed, with delays between 5 hours and five days.

Reed said that children were also remaining in the hospital longer because of greater complexity of their situations, and there was added pressure through referrals from the Department for Children and Families as a result of the opioid crisis.

While the issue of which resources are lacking may differ, the stressors in the adult and children's systems are similar. Holsopple said that Reed told her DMH policy favors care in the community over inpatient hospitalization, but she said community resources are also inadequate.

The children's system was not included in the review at the time that the adult system's community resources were enhanced after Tropical

Storm Irene closed the Vermont State Hospital in Waterbury, but the balance and overall adequacy are the same issues being identified for the entire system of care.

New System Pressures

Reed told the legislature's Joint Health Oversight Committee in October that one of the Department's concerns is that a recent Vermont Supreme Court case that increases potential liability if a person who has been receiving services harms others appears to be having an impact on the number of emergency room referrals. That decision – *Kuligoski vs. Brattleboro Retreat* – corresponds with the sudden spike in numbers of involuntary holds (emergency examinations) being requested, he said.

The *Kuligoski* decision involved an adult who was discharged from the hospital to his parents, and both the Brattleboro Retreat and Northeast Kingdom Human Services were sued for their failure to warn the parents of his potential dangerousness. The court's ruling that such a failure could be a basis for liability created a duty to warn caregivers, and it was not limited to adult patients.

Reed said that the connection between the "surge" in involuntary emergency room holds and the court decision is "all speculative" but it seems to be affecting the "risk tolerance" in the community, based on concern over being held responsible if something goes wrong.

He believes that increased public awareness of "bad outcomes" that are perceived to be related to persons with unmet mental health needs and the law enforcement response to those persons are also factors in providers' desires to reduce the risk of leaving individuals in the community.

Reed said this greater concern about risks may be causing the increase in the number of individuals being screened and held for involuntary admission, adding to the emergency room backlog.

A work group of providers and advocates is attempting to draft a consensus approach to legislation that would revise the "duty to warn" obligation created by the Supreme Court ruling, Reed said.

Reed acknowledged that similar new pressure could also develop based on a perception that a deadly car crash on I-89 in October could have been avoided if the driver who killed five teenagers had received more responsive treatment in the University of Vermont Medical Center emergency room earlier that day.

There are no facts that have been disclosed, but news media reports said that the wrong-way driver had been seen entering and exiting the emergency room three times the morning before the crash, and there has been widespread speculation that he failed to receive adequate services, reflecting a lack of resources in the system.

"No one wants to be in the position" of feeling responsible if something goes wrong, Reed said.

Does System Lack Capacity?

At the legislative committee meeting, referring to the adult system, Sen. Jane Kitchel said that, "We really need to take stock" of the system that was developed five years ago after Tropical Storm Irene closed the Vermont State Hospital in Waterbury. "Are there parts of the system that need more capacity?"

Reed responded that "we believe when there is the right flow in the system" — when there is appropriate movement to crisis diversion beds and discharge placements — there are enough inpatient beds. That flow is disrupted when patients are in the hospital longer than is necessary, he said.

He said that DMH is also evaluating whether a children's crisis bed program in southern Vermont would help alleviate the emergency room delays for children.

In terms of issues for the adult system, Reed said there is a need for more capacity in the secure residential program that is currently in a temporary facility in Middlesex.

It has seven beds, and was designed for persons who were deemed to need a secure setting for longer-term care after no longer needing a hospital level of care.

Reed also said that there is a discussion about whether an expanded secure residential program could also serve inmates from the Department of Corrections who need a higher level of treatment than what they receive in prison.

Another identified gap for adults is for nursing home beds that will accept a person who is being discharged from a psychiatric hospitalization.

Designated hospitals, including the Retreat and its two children's units, can refuse any patient that it feels it cannot appropriately treat, Reed pointed out.

Only the inpatient programs reimbursed by the state for 100 percent of cost on "no refusal" units, called "Level 1," can be required to admit patients as long as there is an available bed. There are no such beds for children.

The problem is not unique to Vermont. Hospital emergency rooms are a "mental health dumping ground," according to a recent *MedPageToday* article reporting on an online survey of 1,716 emergency physicians nationwide. Rebecca Parker, MD, president of the American College of Emergency Physicians, told *MedPageToday* that "...almost one-quarter of our poll responded that they have patients waiting two to five days for a psychiatric bed."

Reed said he is working to develop proposals for the legislature when it reconvenes in January.

No Services for Tommy

None of that will happen in time to help Tommy. He spent two-and-a-half weeks at the Retreat in September and was "doing well", according to his parents, at the time of the *Counterpoint* interview in early November.

"We're still traumatized," his father said.

Like most of those who have tried to understand the emergency room crisis in the state, whether for adults or for children, Tommy's parents believe the problem goes much deeper into the system than at the point something has reached a crisis: it starts long before the point of crisis.

For Tommy, it was nine years in the making.

His autism includes dysphasia — an inability to communicate — and from a young age he would have rapid emotional changes with what his parents called "behavior fits."

He also had many medical challenges, and the combination meant there were fewer resources available to him. Sometimes providers were even unwilling to treat him, thus he was unable to get treatment.

His autism was an excuse for medical professionals not to do their jobs, Tommy's father said, citing an Ear, Nose and Throat specialist who refused to look into the boy's ears — yet still got paid for the visit.

"People [who witnessed it] were horrified at how unprofessional" doctors were when Tommy was present.

As his condition worsened, Tommy began to hurt himself or others more often, yet his parents were still unable to find help. For years, they had resisted having him go on medication, but last

(Continued on page 5)

Six Day Wait

(Continued from page 4)

January they agreed to the recommendation of a psychiatrist to try. It didn't help, they said.

In the crisis building over the prior couple of months, he had started to bite himself and kick himself in the head; he also bit others. In one absolutely terrifying moment for his mother, he almost darted across a busy I-89 because he saw a tree in the median he wanted to climb.

By this past September, "it's hard to imagine how exhausted we were" living in constant crisis management. "It was getting impossible."

"We had no choice" but to turn to the emergency room on September 3, his mother said. When they arrived in the emergency room that day his parents had decided, "we have to stay here until they actually help him."

They had no idea how long that would end up being, and each day would go by with promises of progress, followed by new delay.

"It was that false hope" that was so draining for Tommy's parents, according to his mother, never knowing, hour-by-hour, whether a plan would fall into place or would fall apart, again.

A caseworker from Washington County Mental Health made multiple efforts to find a temporary place for him while waiting for an opening at the Retreat — "some bed, anywhere in Vermont" — but there was no room, anywhere, his mother said.

The usually physically active boy spent the days mostly sitting on the bed. Washington County staff and teachers from his school visited and brought some toys.

There was constant "white noise" to help reduce outside disturbance. Tommy slept quite a bit, under the influence of sedatives.

Although Central Vermont Medical Center has a new, separate section of the emergency room with three rooms, a hallway, its own nursing station and a bathroom for mental health patients waiting for admission, it was not made available to Tommy.

Nor could his mother recall any "comfort items" from that area being offered to him.

Central Vermont Medical Center told *Counterpoint* that "the safety and well-being of the person coming to our Emergency Department is our primary concern when determining where to care for them." At times people already in the new Transitional Care Area "may be experiencing symptoms" and the area "would not be therapeutic or safe for a child."

Nonetheless, regardless of a patient's location, "they have access to the same sensory and comfort items," the hospital said.

Tommy's father said that professionals "think that they're doing the right thing" with rules such as not allowing a self-harming child near a window, or keeping lights on for constant safety monitoring.

What they are missing is respect for "the patient's point of view."

"They've got to look at the patient's point of view" — in this case, the point of view of a nonverbal, 11-year-old boy.

News Briefs from Around the Country

Report Recommends Solutions On Segregation in Prison

A report by the AVID (Amplifying Voices of Inmates with Disabilities) Prison Project, published on September 8, focuses on the work of the protection and advocacy (P&A) system to promote the rights of individuals with mental health conditions in solitary confinement, including both non-litigation and litigation strategies. The report, *Locked Up and Locked Down: Segregation of Inmates with Mental Illness*, includes "federal and state recommendations to build on the momentum gained by the P&As and their partners." For the free report, go to <http://www.avidprisonproject.org/index.html>

New Zero-Risk Treatment Is Described for Mania

A Norwegian study reported in *Psychiatric Times* notes that people who experience mania may benefit from darkness. More than 20 years ago, the National Institute of Mental Health found that, in a very small sample — one person — darkness was able to replace the need for medication as treatment for mania.

Subsequently, researchers found that it is "blue light" that needs to be blocked in order to get the darkness effect. Wearing amber-colored safety glasses is one way to accomplish the effect.

For the *Psychiatric Times* story, with links to more information, see <http://www.psychiatric-times.com/bipolar-disorder/new-zero-risk-treatment-mania>.

Website in United Kingdom Addresses Recovery Principles

Recovery in the Bin describes itself as "non-religious and unassociated/unaffiliated to any mental health organisation. We'd like to keep it that way."

Among the other statements on the group's home page is the following: "We believe that there are core principles of 'recovery' that are worth saving, and that the colonisation of 'recovery' undermines those principles, which have hitherto championed autonomy and self-determination. These principles cannot be found in a one size fits all technique, or calibrated by an outcome measure."

The website's home page, which includes a link to the group's 20 key principles, is <https://recoveryinthebin.org/>

Not Too Late To Urge Senators Not To Amend Bill S. 2680

Several advocacy groups are continuing to urge constituents to contact their U.S. Senators and ask them to support S. 2680 (the Mental Health Reform Act of 2016) without amendments or changes. Congress is expected to meet for a brief session after the November elections and before the start of the new term in January.

H.R. 2646 (the Helping Families in Mental Health Crisis Act of 2016) passed the House of Representatives nearly unanimously.

The Senate bill is better than the House bill and it is important that it pass "as is," according to the National Coalition for Mental Health Recovery (NCMHR).

NCMHR notes that, among its provisions — and unlike H.R. 2646 — S. 2680 does not expand forced treatment; includes representation of people with lived experience; does not mention "anosognosia"; incorporates mental health recovery language throughout the bill; and calls for better

education about the Health Insurance Portability and Accountability Act (HIPAA) rather than providing a path to relaxing HIPAA confidentiality protections, as does H.R. 2646.

Numerous other advocacy organizations support S. 2680. These include the Consortium for Citizens with Disabilities, the National Association of State Mental Health Program Directors, and the Autistic Self Advocacy Network.

For the most recent text of S. 2680 that is available online, <https://www.congress.gov/bill/114th-congress/senate-bill/2680/text> and then scroll down past Sec. 608 of the version that is largely crossed out until you get to the clean text.

Contacts for Vermont Senators are:

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

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

Transgender Not a Mental Disorder, New Study Shows

Although some influential sources continue to categorize being transgender as a mental disorder, a new study has found that "the social rejection and violence that many transgender people experience appear to be the primary source of their mental distress, as opposed to the distress being solely the result of being transgender," *Time* magazine reports.

"Stigma associated with both mental disorder and transgender identity has contributed to the precarious legal status, human rights violations and barriers to appropriate care among transgender people," said the study's author, quoted in *Time*.

The study, involving interviews with 250 transgender people, was published in *Lancet Psychiatry* in July. For the *Time* article, see <http://time.com/4424589/being-transgender-is-not-a-mental-disorder-study/>

New Rules on Outdoor Access Spark Massachusetts Resistance

Despite rules recently issued by the Massachusetts Department of Mental Health requiring hospitals to allow people with mental health conditions access to the outdoors, up to 20 hospitals (about a third of psychiatric hospitals statewide) plan to seek waivers, citing lack of space.

"The rules present a tug-of-war over patients' rights, doctors' judgment, and the logistical demands of running a hospital in an urban environment," according to a news article.

An interviewee who had been confined on a psych unit and had repeatedly been denied outdoor access said, "I feel like my stay would have been cut in half if I had had access to fresh air."

In related research, scientists have found that contact with nature has a positive physical impact, resulting in better mental health. See a report on the research at <http://well.blogs.nytimes.com/2015/07/22/how-nature-changes-the-brain/>

News briefs are from The Key Update, the free monthly e-newsletter of the National Mental Health Consumers' Self-Help Clearinghouse, <http://www.mhselfhelp.org>

Police Responses

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year-old man who was shot in his shower in Burlington last March.

Another police response that drew broad news media attention occurred in Hinesburg in May after police body camera videos captured an officer bursting into a home where a woman was sitting at a table and in emotional distress. The officer forced her to the ground and handcuffed her.

In the Grenon death, Chittenden County State's Attorney T.J. Donovan found that criminal charges were not justified, because the officer who fired the fatal shots met the legal criteria of whether, in the immediate moment in time, a reasonable person would have believed that Grenon posed an imminent threat of death or serious bodily injury.

In the Hinesburg case, Donovan's office said in November — six months later — that the case had been closed.

Assistant State's Attorney Bram Kranichfeld said the results of a Vermont State Police investigation were reviewed and "no further action" would be taken regarding the actions of Officer Cameron Coltharp. He said that because "Vermont law prohibits us from disclosing certain information," he could say nothing else.

The Hinesburg Police Department had stated that its own internal review would be deferred until after the state's investigation was complete. Town administrator Trevor Lashua said in mid-November that "an internal investigation is planned but has not commenced."

In the meantime, paid administrative leave for Officer Coltharp has been extended to December 7, he said.

A lawsuit claiming excessive use of force was filed in federal court in June by the victim, Lori Ann Carron, and is still pending. According to the lawsuit she suffered a broken rib, elbow damage and a concussion.

Groups See Need for Change

At least four groups, both formal and informal, have been discussing what changes can be made in the responses to a person in crisis:

- The "Act 80/79 Committee" of stakeholders, which includes survivors and which helps to develop police training, will be considering whether to endorse a Crisis Intervention Team model at its December 9 meeting.

- A group of advocacy organizations have met under the leadership of the ACLU to discuss what proposals it could promote.

- An informal group brought together by a retired judge and the former Executive Director of the Howard Center in Burlington has been meeting to discuss initiatives.

- The Burlington Police Commission drafted ideas for improving crisis response for further consideration.

Wilda White, Executive Director of Vermont Psychiatric Survivors, was invited to participate in both of the advocacy groups, but expressed reservations about the discussions taking place.

"My concern is that the people who have taken it upon themselves to advocate for change are not psychiatric survivors and they unknowingly make assumptions about what changes are necessary that perpetuate the same biased and oppressive attitudes about people who've been labeled by psychiatry that I think contributed to Phil's death," she said in an email.

She said that the cause of his death "started well before the police were even called. There is

a bias and oppression against people labeled by psychiatry that must be acknowledged if we are going to prevent the series of events that led to Phil's death at the hands of the Burlington Police Department."

White said that although she was "heartened" by the fact that people were motivated to make changes, she believed "the people who have been labeled by psychiatry and who are at risk of being shot and killed by police need to play a greater role."

She cited as an example of misinformation a person "who is not a psychiatric survivor" who "testified at a public hearing that a person who is psychotic is unable to communicate. This is a gross generalization and is flat out wrong. If police rely on such wrong information, it will only make the situation worse."

White said Vermont Psychiatric Survivors "is committed to convening meetings around the state with psychiatric survivors to bring more voices to the conversation and more innovative solutions to this multifaceted challenge."

Robert Appel, a Burlington civil rights attorney who is the former director of the Vermont Human Rights Commission and has participated in several of the groups, said the traditional approach for police work is to "react, control, clear, and go on to the next case."

That approach can provoke a worse response when someone is in crisis.

"It's what we've always done. What we've always done doesn't seem to work too well. Let's try something different, something more humane."

That message is starting to be understood among leaders in law enforcement, he said.

"The conversations are beginning, which is good, but we're not there yet," he said. It will take a major culture shift and demand strong leadership with clear policies and with accountability for officers who do not follow them, he said.

Jim Leddy, the former Howard Center director, said the group he helped organize was "loose-knit" but committed to improving how law enforcement responds to and interacts with people experiencing a mental health crisis."

He said by email that the group was looking at training of both police and mental health providers "as key to change and improvement," and also to "reach out to legislators to explore whether legislation may be helpful or necessary to address this issue."

Leddy said he knew Grenon for nearly 60 years and he was "a friend, a good father and a loyal brother who overcame many challenges in his life," including a struggle with mental illness.

He shared frustration over the events that led up to Grenon's death, "killed in his apartment after creating a disturbance upon receiving an eviction notice from his 'landlord', the Burlington Housing Authority."

"In the aftermath of Phil's death, and even acknowledging the challenge his mental illness presented, I can only ask -- what did the Burlington Housing Authority expect when they posted the eviction notice on his door? Where was he to go? What was he to do? Go quietly and homeless onto the streets of Burlington!"

He said the group was working to coordinate efforts "and find common ground — where possible — with other organizations, such as the ACLU, who are addressing the issue of 'use of force' by Vermont police agencies."

Leddy said the group currently includes retired judge Michael Kupersmith, Appel, White, the Director of NAMI-Vermont, a retired psychi-

atrist, the Director of Training at the Vermont Police Academy, several parents/family members, and survivor and legislator Anne Donahue (who wrote this news article.)

Jay Diaz of the American Civil Liberties Union said the ACLU has a concern regarding unnecessary use of force as a whole, but has gathered advocates on the specific issue of persons with disabilities. He said that changes in policy needs to be a driver, but has to be followed by training, accountability and oversight. "Those four pieces are the key."

"We want to take a much broader view," he said, to look at what "led to these situations in the first place." That includes "more innovative and workable models" for police interactions with persons who may have a mental illness or other disability, including "professionals and peers" working with police.

There need to be "coherent policies" that focus on protecting life and maintaining people's dignity as a primary goal, even if force is needed, he said. Diaz said that one challenge is the number of small town police forces, with "each department doing its own thing."

The Burlington Police Commission was asked by the City Council to "perform an independent review of the strategies and tactics deployed by the Burlington Police Department in the events leading up to the shooting of Ralph 'Phil' Grenon, with the goal of identifying potential improvements to future policies and practices."

The Commission heard from community members in two meetings over the summer, and reported to the Council in September that it was not issuing findings, but had gathered a "menu of proposals for improving mental health crisis response in our community."

Among the ideas were peer models of prevention, especially in housing/eviction situations; critical incident reviews; increased training; advocacy for supportive housing models; and looking at innovative models of crisis response elsewhere.

Burlington Chief Takes Steps

Burlington Police Chief Brandon del Pozo said he isn't waiting for recommendations. He said Burlington is one of five police departments in the country that is piloting new use-of-force principles written by the Police Executive Research Forum that place a first priority on the sanctity of human life. It focuses on de-escalation and "slowing a situation down" to allow for non-force solutions to be brought in, del Pozo said. (See sidebar article on the new principles.)

He also wants to have as many members of the force as possible trained in the Crisis Intervention Team model. "If we had a blank check" it would be all staff, he said. The CIT model includes a 40-hour training component for police.

There are never absolute guarantees against a death, but "you need to be able to say [it happened despite] using techniques formulated around trying to avoid it," del Pozo said.

Currently in Vermont all police are required to take a one day course in "Interacting with People Experiencing a Mental Health Crisis" developed by the Act 80/79 Committee and offered by the Police Academy.

A second training program, "Team Two," is offered by the Department of Mental Health to create links between first responders and local community mental health agencies.

Survivor Perspectives Vary

Counterpoint visited two programs to talk about how survivors view interactions with po-

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Police Responses

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lice, and had several conversations with individuals at Another Way. Responses varied, often based on how individual officers had interacted with the person.

Amiee Powers, who is the operations manager there, said the program itself sometimes has to call police as “our very last resort” when a client isn’t following rules for safety and refuses to leave.

“It makes me feel really horrible inside... I worry about whether things will escalate even more.” She said that most of the police in Montpelier were “pretty decent,” but “there are only so many skills you can impose on a police officer.”

What is needed is “a middle person to help de-escalate” who could be called in a crisis to reduce the need to call police, she said. She used the Burlington Street Outreach program as an example.

“It would help our community members out,” Powers said, because many are people who have been traumatized by past police interventions. “I see the rest of my community” when police have to be called in; “some are, ‘I’m out of here’ and some are really anxious.”

Keron Ascencio said that his encounters with the police in Montpelier while homeless were always “fairly decent.” If he was on private property, he was simply told he had to move his belongings.

“Anytime they’ve been called on me” by others, “they’ve been able to distinguish the facts and let me go my way.”

Another woman said that she had seen both calm, positive responses by police and aggressive, negative ones. “A cool head and a calm demeanor are absolutely essential” and aren’t always in evidence, she said. Sometimes if they know an individual from prior encounters, they “come in with an attitude” and have “got to be the tough guys.”

Although she says she would still call the police if she thought help was needed – “I think I’d feel I’ve got to do it anyway” – it makes her worry. “I would always be afraid it might go bad.”

David Callahan said that “usually my experiences have been very good,” but he sees the difference between police who are young and trained to be “overly self-defensive,” and those who have gotten to know the community.

“Some people will say threatening things but won’t really do anything,” and officers who know that can respond appropriately. He thinks there is a loss of that awareness when police “don’t walk the beat anymore” and get to “interact with people on a daily basis.”

Callahan recalls one Montpelier officer who was always able to de-escalate situations, while “others weren’t as talented.”

“I don’t know if [that] can be trained,” he said.

He does see a bottom line on two points.

“Killing people who are threatening to kill themselves doesn’t make any sense. Anyone trained as a police officer should be able to handle someone with a knife without having to shoot them.”

Sarah said the police had been called once to respond to her when she was upset about her pending divorce and was outside, “crying my eyeballs out.”

The police “made me get into the police car and made me go talk to the Washington County mental health screeners,” even though she didn’t want to. It worries her to think about it. “What

would they have done if somebody really didn’t want to go?”

In Barre, for example, she saw an incident involving a woman with a baby in a stroller arguing with a man. The police wanted her to leave and she was refusing, and “she was upset and yelling but wasn’t hitting anybody or being violent.”

Sarah said she was shocked as she watched and “several police officers wrestled her to the ground – they could have really hurt her.”

For Stefani, whose daughter was arrested, the crux of the issue is that police shouldn’t be the ones who have to respond to a mental health crisis.

“There is no mobile crisis team” serving her county, she said. “I wish I could just call my designated agency” and deal with the crisis right at home, possibly even avoiding a trip to the emergency room. A team like that existed nine years ago, she said, but was lost in budget cuts.

At times living in both Florida and California, she experienced that kind of support. After calling 911, police responded in California but explained, “we just came to keep people safe until the crisis team comes.”

In Vermont, Stefani said the interaction with local police began when her daughter, then 20,

got into one of her occasional “revved up” moods. Stefani didn’t feel she could safely drive her to the hospital alone. One of the officers who responded “decided [she] needed to learn a lesson.”

When Stefani protested that Chi Chi hadn’t done anything against the law, the officer replied, “Didn’t she touch you on the leg? That’s enough.”

That began a late night journey to the Middlesex police barracks, the hospital emergency room, and then a prison cell in South Burlington for a day until Chi Chi’s court appearance.

Chi Chi said softly that she was scared in the small cell she shared with another inmate, mostly because there was no toilet and she was afraid she was going to need the bathroom.

She didn’t eat or drink the whole time out of fear that she would “pee on the cell floor” and be in trouble. “I was just trying to make it through the day,” she said.

Stefani said Chi Chi could have died there if she had a major seizure, because she had no medication with her. She tracked down where her daughter was being held only with difficulty.

The next day, “the judge gave her back to me,” and seemed baffled by why she was there.

New Model Promotes ‘Sanctity of Life’

The Burlington Police Department is adopting a new model for the use of force by police, according to Chief Brandon de Pozo.

It follows the “Guiding Principles on the Use of Force” produced by the Police Executive Research Forum in Washington, DC, a police research and policy organization.

The report says that it “reflects the latest thinking on police use-of-force issues from the perspective of many of the nation’s leading police executives, focusing on police encounters in two categories:

“Subjects who have a mental illness, a developmental disability, a condition such as autism, a drug addiction, or another condition that can cause them to behave erratically or threateningly,” and

“Subjects who either are unarmed, or are armed with a knife, a baseball bat, rocks, or other weapons, but not a firearm.”

The PERF report says that in nearly all controversial, use-of-force incidents the officers should not be faulted, because their actions reflected the training they received, “but there needs to be a change in policies, training, tactics, and equipment.”

It notes that most existing policies are based on a Supreme Court decision that outlines what police can legally do, but does not provide guidance on what police should do.

The report quotes Chief Cathy Lanier of the Metropolitan Police Department of Washington, D.C., reframing the question:

“The question is not, ‘Can you use deadly force?’ The question is, ‘Did you absolutely have to use deadly force?’ ... And the decisions leading up to the moment when you fired a shot ultimately determine whether you had to or not.”

The report identifies 30 guiding principles for use-of-force policies. The first four are:

1. The sanctity of human life should be at the heart of everything an agency does.
2. Agencies should continue to develop best policies, practices, and training on use-of-force issues that go beyond the minimum requirements of [the Supreme Court].
3. Police use of force must meet the test of proportionality.
4. Adopt de-escalation as formal agency policy.

Another of the principles states, “Agencies should prohibit the use of deadly force, and carefully consider the use of many less-lethal options, against individuals who pose a danger only to themselves and not to other members of the public or to officers. Officers should be prepared to exercise considerable discretion to wait as long as necessary so that the situation can be resolved peacefully.”

“We initiated this policy in May 2011,” said San Francisco Police Chief Greg Suhr.

“You would think it’s a no-brainer, but we actually got push-back on this originally. This was designed for that type of situation where somebody calls the police asking for help, and the police end up using deadly force against a person who was threatening suicide or was in mental crisis.

“I believe that police officers like absolute rules, because they’re easy to follow. And so if they know going in that they cannot use deadly force against someone who is only threatening himself, then they’ve got to figure something else out. Since May 2011, we haven’t had a situation in which an officer used deadly force against a person who was a danger only to themselves.”

The full report can be found at <http://www.policeforum.org/assets/guidingprinciples1.pdf>.

Unreasonable Force in Baltimore Violated Disability Rights Act

The U.S. Department of Justice Civil Rights Division cited the Baltimore Police Department in August for numerous violations of civil rights, including using “unreasonable force against individuals with a mental health disability and those in crisis.”

On page 80 of the 164-page report, it said that “BPD officers routinely use unreasonable force against such individuals “in violation of the Fourth Amendment” and in those situations, “repeatedly fail to make reasonable modifications necessary to avoid discrimination in violation of Title II of the Americans with Disabilities Act of 1990.”

The full report is available at <https://assets.documentcloud.org/documents/3009376/BPD-Findings-Report-FINAL.pdf>

Confidentiality

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tem. Although that law – sometimes referred to by the federal regulation number, 45 CFR Part II – addresses only substance use records, it blocks all designated agency patient information because they are “CFR Part II” providers and the client base is intermixed.

The designated agencies themselves are struggling with how to support a more integrated health care system without “losing their clients’ trust and ultimately losing them to services because many clients don’t want their information shared,” said Mary Moulton, Executive Director of Washington County Mental Health Services.

Psychiatric Survivor Concerns

Counterpoint completed five interviews with survivors with different backgrounds, and most said they appreciated the potential value of shared information. The concerns, however, outweighed the value.

“The issue is the discrimination,” said Chris Hansen of Burlington, the director of Intentional Peer Support. “The reality is that [persons with a psychiatric label] get brushed off. They get ignored. They get inferior health care. They get sent to the psych ward.”

J.S., of Guilford, who was worried about stigma through being identified in this article, also emphasized that point.

“You become invalidated,” she said. “That to me is the biggest danger.”

That concern has a strong foundation. It was the subject of a *New York Times* article in 2013 written by a person who experienced stigma on the part of providers on multiple occasions.

“At least 14 studies have shown that patients with a serious mental illness receive worse medical care than ‘normal’ people,” Juliann Garey wrote. “[T]his particular kind of discriminatory doctoring has a name. It’s called ‘diagnostic overshadowing.’” The full article can be found at <http://www.nytimes.com/2013/08/11/opinion/sunday/when-doctors-discriminate.html>

The other major concern expressed by survivors was breach of trust.

“Many times the client only has their therapist as a ‘trust person,’ because their friends and family would rather not deal with them, [from] lack of understanding, or just not caring,” said Greg Burda, an advocate and survivor from Bennington.

If there is a fear that information might be shared, it would be a detriment to clients because “the total trust factor wouldn’t be there.”

Burda thinks the risks are significant. “[I]f what they tell their therapist is made accessible, then for that person greater hopelessness can or will set in which could escalate into distrust or a broken heart, the feelings of needing to avoid that person, and then easily lead to suicidal ideation.”

The thought that sensitive information might

be shared would be “the extreme end” of potential damage, Hansen agreed.

“I find that just abhorrent. My personal, vulnerable stuff that I finally got the courage to share?”

Even basic information like a diagnosis is a problem, she said. “Diagnosis [in mental health] is a judgment and it’s random,” she said. “It’s very arbitrary. People need to think ahead about information sharing and ‘be aware that the fact you have a psych history may be held against you,” Hansen said.

Sarah Knutson of Peerly Human in Plainfield said that the “problem is accuracy and whether you get added value for the information coming in, or whether it steers the treatment you get away from what is really going on with you.”

She agreed with Hansen that the vagueness of a psychiatric diagnosis was a significant part of the problem, and offered an analogy.

“Seeing a mental health provider is more like seeing your astrologer. They have a theory based on clusters of phenomena that seem to go together and seem to ring true and have a lot of intuitive appeal for some people.”

“Add prejudice around mind-related diagnosis to that and it gets even worse. It’s like your provider looking only at your horoscope and taking that as the end-all and be-all of what is happening in your life.

“All of your complaints are seen and interpreted through the lens of your horoscope. Other issues aren’t taken seriously, because, hey, ‘the moon is in the 7th house and Mercury is aligned with Mars,’ so what do you expect will be happening in your life...?”

J.S. is worried about how people with psychiatric labels are seen by health care providers.

“We’re living in a culture in which the medical profession has a lot of stigma,” J.S. said, with “medical providers throughout the spectrum who have very warped ideas of what a person with mental illness is like.” They aren’t acting with malice, she said, but they are ignorant, and “their ignorance is dangerous to us.”

She said that in her own experience, she has found that after a diagnosis is disclosed, “suddenly my concerns are invalidated” or “my symptoms are [seen as] psychosomatic.” Persons with a psychiatric label are “not to be taken seriously” and “aren’t intelligent.”

J.S. worked in the HIV-AIDS field in the early stages of the epidemic, she said, when, if a diagnosis were discovered, “suddenly they’d be double gloving for a broken arm.” There has been progress in that field, but not in the stigma of mental illness.

A person is suddenly “treated with kid gloves” – “the analogy to double gloving” – as though the provider is afraid of how the patient might act.

Burda made a similar reference. He said that if a physician was not accepting of a person’s mental illness, the physician might fear doing

something “that could set him [the patient] off in a way I [the provider] wouldn’t know how to deal with.”

J.S. had a recent experience even in primary care treatment after having been prescribed Xanax for anxiety. A short time later, she developed all the symptoms of an upper respiratory infection and called her doctor; he wasn’t in and a covering doctor talked to her.

“He said ‘it’s just anxiety, take your Xanax,’” she said.

Garey wrote in her *New York Times* article that a review of studies done by the Institute of Psychiatry at King’s College, London, demonstrates that “diagnostic overshadowing” happens a lot. “As a result, people with a serious mental illness — including bipolar disorder, major depression, schizophrenia and schizoaffective disorder — end up with wrong diagnoses and are undertreated,” she said.

Only one of the five interviewed told *Counterpoint* that mental health records should not be treated differently. The comment was made in the context of objections to all centralized electronic medical records.

Nicolas Nyirjesy of Milton, who described himself as both a psychiatric survivor and a provider said that policies that claim to address the “unique privacy needs” of mental health and substance use treatment are reinforcing both stigma and the “Us and Them mentality.”

He said that electronic medical records as a whole create significant risks of unauthorized access through negligence and digital crime. Nyirjesy said that such digital tools are “organizing and cataloguing information on a scale that has not been seen to date in healthcare.”

Provider Concerns

Providers who discussed the debate with *Counterpoint* focused almost exclusively on the issue of the tension between breach of trust and the need for a health care team to have better information about a patient.

At UVMHC, where diagnoses are already in the health record that is accessible to any other provider seeing the same patient, the question is full access to “sensitive notes” without the patient’s specific consent.

Pierrattini said that his guiding principle comes from a well-known psychiatrist who writes on the topic of professional responsibility, Glen Gabbard. “He said that ‘confidentiality is to the psychiatrist what the sterile field is to the surgeon.’”

Psychiatrists “rely on people being as honest as possible” with their doctors, Pierattini said. The practitioner’s role is to “help a person find a personal truth,” which requires that kind of trust.

The discussion about making notes more easily accessible is limited to providers on a patient’s inpatient team, not to access to mental health records from outpatient providers, he stressed.

Dr. Rick Barnett, of Stowe, who has been a

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Assault Charge Dropped, ER Patient Admits Disorderly Conduct

RUTLAND – A woman charged with assault after she struck an emergency room security guard has pled guilty to disorderly conduct for swearing in public and received a one-year, probation sentence. An assault charge was dropped.

“I was just adamant” about not pleading guilty to assault, said Mary Phelan. “I was defending myself.”

Phelan was being told she had to remove her clothing despite having explained a sexual trauma history, and believed the guard was about to remove them forcibly, she said.

“I’m pleading guilty to cussing,” she said she explained to the court. Phelan’s record will be cleared once she completes the one year of probation.

Phelan said she was offered the same penalty earlier in the fall for a guilty plea to simple assault, and refused it. That would have led to a trial on the charges, if the State’s Attorney’s Office had not reconsidered and agreed to accept the plea to disorderly conduct.

“I couldn’t live with myself if I did that,” she said, when she believed her response to the guard

was justified. However, as far as “the string of expletives,” she said, “that’s on me.” AD

Arts Evening To Mark Center’s 50th

The Clara Martin Center has announced an evening entitled “Celebrating Creativity in Mental Health, Wellness and Recovery” at Chandler Music Hall in Randolph on January 7, 2017. The event will celebrate the agency’s 50th anniversary at an art show, selected readings and a performance from the Me2 Orchestra.

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practicing psychologist and addiction counselor for over 20 years across multiple settings, said he believes the confidentiality of mental health and substance use records is of “utmost importance — professionally, clinically, ethically.”

He said he “would question why a provider may feel a need to be anything but extremely generic in their electronic medical record documentation around anything that might be even remotely sensitive. Sensitive notes can be kept in therapists’ own records.”

He said he knows from discussing consent with patients how important even basic information is for them, because in the informed consent process he finds that many are not comfortable in agreeing for him just to *look* at information in the state’s health information system — let alone to enter information.

Informed Consent Issues

Moulton said that the designated agency providers worry that patients give consent that is supposed to be “informed consent” to their primary care doctors for record-sharing “without really understanding what they are signing.”

The state’s health information system process for consent is better, she said, but the agencies can’t use that system because of the federal 42 CFR Part II restrictions.

She said she thinks the agencies need to have their own additional consent process for the use of a new electronic tool being set up by OneCare Vermont, an Accountable Care Organization. Such organizations have a primary mission of improving integration of care.

Moulton said the OneCare system will allow all team members working with an individual to communicate.

It “includes demographics, diagnostics, info on appointments, team members, etc., and everyone can leave messages and talk to one another. Great, right? Well — maybe,” she said.

“Due to our strong feelings about informed consent, for our WCMHS clients, we will explain this information sharing tool and seek an addi-

tional release. This gets to the heart of informed consent.”

Vermont Information Technology Leaders

Sandy McDowell, Ph.D., who heads the workgroup on 45 CFR Part II for the Vermont Information Technology Leaders, said its task is not to decide on the philosophical issue, but to look at technical solutions that will allow medical information to be entered into the health information exchange in a way that complies with the added federal consent protections.

The personal medical data gathered by that system has only basic diagnosis and medication history, not “unstructured” information such as clinical notes.

He sees importance in not having data missing from a person’s diagnostic history in an emergency room, where the state health information system is accessed. It is information that “is not necessary for all diagnoses [in the ER], but useful for some diagnoses,” he said. As to the risk of influencing a diagnosis in a negative way, he said, “there’s bias in every clinical decision.”

However, he said that by segmenting mental health out, it creates a barrier and “raises sensitivity” among providers. They feel, “why can’t I see it?” From a medical perspective, physicians are not supposed to be violating confidentiality and would not see their access as a reason for patients to perceive a breach of trust, he said.

Does Protecting Mental Health Records Perpetuate Stigma?

Bob Macauley, MD, head of clinical ethics at UVMMC, articulated the arguments for not treating even detailed mental health records differently from any other medical records.

First, he said, “‘non-psychiatric’ notes can also contain very sensitive material, which extra protections for psychiatric notes wouldn’t address.”

He said that psychiatric notes may contain information “that is valuable for the overall medical team (such as a psychiatric consultation that could help the primary care physician formulate an appropriate treatment plan).”

Finally, he reiterated a concern raised by others, that “while some would argue that extra protections for psychiatric notes is a proper response to the societal stigma related to mental illness,

one could also argue that such extra protections perpetuates that stigma by implying that mental illness is somehow different.”

Pierattini is familiar with those perspectives.

The “rapid response team” for medical emergencies in the hospital is concerned that because the providers have to go through extra steps to access psychiatric notes they “can’t get in a timely way” for information they might need, and “they don’t know what is or isn’t in there.”

In fact, those notes are unlikely to contain anything helpful, and the response team members can still get to them by coming physically to the inpatient psychiatric unit, Pierattini said.

He also hears that sensitive information is shared with other providers — such as family physicians — and receives no added protection, and that it promotes stigma by protecting mental health records in a special way.

“I don’t buy that argument” in the context of the UVMMC debate on sensitive notes, he said, because “the diagnosis is not hidden.” He also said that the notes in question are not analogous to things “discussed in the [typical] doctor’s office.”

“It’s all a balancing of values and needs,” he concluded.

Burda thinks there are already ways to balance what a physician needs to know with maintaining confidentiality. Most primary care doctors “are just interested in [knowing] if their patient is getting [their] need met, and want to make sure that that part of the treatment is going well.”

He doesn’t think the doctor, if “satisfied that therapy is going well,” feels there’s a reason to inquire into the issues being discussed.

“Because their focus is on the more medical needs, and that’s plenty for them to deal with. Unless the therapist notices a red flag that the [doctor] needs to be aware of.”

Hansen said she recognizes the concern that expecting different standards of confidentiality for mental health records may promote stigma.

“The hard thing is that if we act as if there is something to be ashamed of, we perpetuate the stigma,” she said.

She places the balance of values, however, on the side of confidentiality.

Counterpoint Telephone Poll

Issue: Confidentiality

Question: Do mental health records need more privacy than other medical records?

Vote by calling **888-507-0721** (Toll Free call)

**To vote “Yes”
Dial Extension 12**

**To Vote “No”
Dial Extension 13**

Results of the poll will be published in the next issue of *Counterpoint*.





INPATIENT TERRACE — Construction finished on a small terrace for the inpatient psychiatry unit at Central Vermont Medical Center this past fall, creating fresh air access. Major donors for the project included Community National Bank, CVMC Auxiliary, CVMC Credit Union, E.F Wall & Associates, Montpelier Rotary Club, the Tartaglia family, the Pelletier family, Donald Provasi, Carmen Beck, Northfield Saving Bank, Norwich University, People's United, and Union Mutual Insurance.

(Photo courtesy of Central Vermont Medical Center)

Corrections Report Defers On Recommendations

MONTPELIER — The special commission charged with making recommendations to address the mental health needs of Vermont inmates reported in November it has only just begun to prioritize and draft answers to the questions it was asked by a legislative committee.

In a preliminary report due on November 15, Hal Cohen, Secretary of the Agency of Human Services, shared a list of 49 suggestions identified by individual Commission members but said the list did not reflect any consensus. “Indeed, there were and remain disagreements as to both the importance of various issues addressed in our sessions and the means of addressing them.” Suggestions ranged from closing down segregation units altogether to creating new therapeutic settings to enhancing community services.

The Commission on Offenders with Mental Illness was created in September by the legislature’s Justice Oversight Committee. The Committee wrote a detailed list of questions for the Commission about the needs of persons with mental illness, severe developmental disabilities, and traumatic brain injuries. Questions included how to divert such individuals out of corrections, how to develop best practices for identifying and meeting needs of those persons once incarcerated, and how to finance such housing and treatment.

The Committee stressed urgency brought on in part from the threat of a lawsuit by the state’s Human Rights Commission. A Human Right Commission decision earlier this year found that the state had violated the rights of a person with a disability by failing to provide adequate care, including the inappropriate use of segregation. The state has six months to resolve the violation to avoid the lawsuit.

“Formulation of the answers to those questions is still under consideration,” Cohen wrote, promising to address them in a supplemental report in December. Instead, the preliminary report focused on “underscor[ing] the complexity — and the number — of issues thought to be worthy by individual members of the Commission of being addressed by the legislature” by listing the suggestions that had been raised in the five meetings the Commission held between September 23 and November 4.

Among those appointed to the Commission are the Chief Superior Court Judge; the Executive Director of the Human Rights Commission; Disability Rights Vermont; the Defender General’s Office; the Prisoner’s Rights Office; the Commissioners of Corrections, Mental Health and Disabilities, Aging and Independent Living; and Vermont Care Partners (the designated agency organization).

The preliminary report included Department of Corrections (DOC) data, though it noted that “dissatisfaction was expressed as to the quality of the data collected and/or the ability of advocates to effectively use that data given perceived limitations in the definitions and categories employed by DOC in reporting the data.” It stated that as of September 7, 69 inmates of the total in-state population of 1,542 (or four percent) were designated seriously functionally impaired (SFI), which is a legal definition primarily used for restrictions on the use of segregation. “DOC does not record and track inmate population having severe developmental disabilities or traumatic brain injury. Nor, because there is no working definition for such, does DOC track the numbers of inmates having a ‘serious and persistent mental illness,’” the report said. There was a total “mental health caseload” for DOC for the period totaling 636 inmates, or 39 percent. Of them, in July and August, 56 (eight percent) were placed in some form of restrictive housing. AD

Two Residents In Treatment Die by Suicide

WATERBURY — Two residents at treatment programs in the state died by suicide earlier this year. Both programs were cited for deficiencies in patient care by state regulators.

The first death occurred in April at Spring Lake Ranch in Cuttingsville some five weeks after the resident was admitted to the program with a history of several suicide attempts.

The second was in July and occurred after the resident left the premises of the Assist crisis program in Burlington less than 24 hours after admission.

In both cases, the state’s Division of Licensing and Protection accepted the facility’s plans to correct deficiencies.

Spring Lake Ranch notified the Division that it would no longer admit anyone who had a known history of a suicide attempt within the past 12 months. It is licensed as a therapeutic community residence and describes itself as “a healing community for people with mental illness or dual diagnosis.”

It was faulted for failure to meet the resident’s “psychological and medical needs by failing to provide necessary care and services related to the resident’s recent history of suicide attempts.” One of those attempts had occurred within four weeks before admission and was coded as “one of high lethality.”

The Division’s report said that staff had observed “worrisome, potentially risky symptoms” but not all direct care staff were informed of critical information regarding the risk of self-harm.

When the resident did not come to the main house for lunch on April 24, a search was initiated. The resident was found dead in “an area of the ranch where there was a lack of supervision and few, if any, other residents or staff.”

The Spring Lake Ranch response to the report stated that it “disputes the accuracy of the findings in the deficiency statement,” but proposed, in response, to change its admission process.

In addition to refusing admissions to persons with an attempt history within 12 months, Spring Lake Ranch said that if a history of suicidal ideation was “revealed at any point in the admission process,” the applicant would be screened out and referred elsewhere.

Assist, which is also licensed as a therapeutic community residence, is the Howard Center’s crisis bed program. It was found deficient under the same regulations for failing to meet a resident’s needs, in this case, by failing to provide the appropriate “services or supervision.”

The Division’s report indicated that despite a policy that did not permit a resident to leave the premises during the first 24 hours, and required one-hour safety checks, the individual was permitted to leave on two occasions and was not checked for safety as scheduled.

The resident was referred at 2:30 a.m. on July 13 after a hospital observation. The resident was given permission to leave during that next day after objecting to the 24-hour rule, since Assist is described as a voluntary program.

Although the client returned with a friend, she went back out that evening to smoke and did not return. Staff checked and could not find her, and then called police, but she was not located until several days later in a wooded area behind the residence.

The plan of correction from Assist identified the intent to document one-hour safety checks during the night; to clarify in the 24-hour protocol that staff must reassess clients if they request to leave the facility prior to 24 hours; and for staff to “continue to be re-trained on the policy and procedures for suicidal behaviors, assess for risk, and intervention strategies.” AD

Commentary

Kuligoski Reporting Leaves Out Our Voice

by CALVIN MOEN

The following is a letter I sent to editors of Vermont news publications, including VT Digger and The Commons. Readers of Counterpoint concerned with the repercussions of this case are encouraged to contact their legislators and express their concerns about this violation of our rights.

Dear Editor,

Your coverage of the Vermont Supreme Court case *Kuligoski vs. Brattleboro Retreat* is lacking an important voice: that of psychiatric survivors/mental health consumers.

In news articles you've published about the court's decision and its influence, you've represented two sides: that of the family bringing the lawsuit and that of mental health providers.

The only voices you included who spoke about the impact on survivors/consumers themselves were the dissenting justices.

A court decision that effectively increases the supervision and monitoring of psych patients by mental health agencies and families sends several messages: that we are more violent and dangerous than other groups, that we will not or cannot be held accountable for our actions, that we are less deserving of privacy and autonomy — none of which is remotely true.

The decision was made under a false assumption that the attack on Michael Kuligoski could have been prevented had Evan Rapoza's parents or service providers somehow forced him to continue taking his medications.

There is no link between a psychiatric diagnosis and violence; those of us diagnosed with so-

called mental illnesses are more likely to be victims or survivors of violence.

Recent studies show no evidence that psychosis precedes acts of violence, or that adherence to medication prevents them (*Clinical Psychological Science*, April 24, 2015). In fact, studies have shown that the use of SSRIs (antidepressants) can lead to violence and suicide (Bielefeldt, A. O., Danborg, P. B., & Gotzsche, P. C., 2016).

And yet, media coverage of instances of violence again and again paints a picture of some psychotic patient off their meds going on a rampage. This leads to a political climate in which legislation like the Murphy Bill (HR 2646) threatens to codify a nonexistent link between psychiatric diagnoses and gun violence, while taking away funding for community-based peer supports.

In my experience working as a peer advocate at the Brattleboro Retreat and other treatment facilities in southern Vermont, when folks stop taking their medications, there is a reason. Instead of exploring these reasons with patients, most doctors try to convince them to take the drugs with unscientific analogies involving cookies or broken legs, and if that fails, to get a court order to force medication on them.

According to the Supreme Court, the Retreat did not work with Rapoza on plans for his discharge, but rather developed an after-care plan with his parents, whom the court refers to as his "caretakers."

The underlying current in all of this is that survivors/consumers are not listened to, not included in decisions about our lives, not considered fully

adult or even fully human.

Your publication can work to reverse this current by seeking out our voices when it comes to events that affect us. The disability justice movement began to declare in the 1990s, "Nothing about us without us."

In that spirit, I invite you to reach out to organizations like Vermont Psychiatric Survivors for commentary on consumer/survivor issues. VPS is an independent, statewide mutual support and civil rights advocacy organization run by and for psychiatric survivors (full disclosure: VPS is also my employer).

Media in this country have the power to influence popular perception of marginalized groups and ultimately policy decisions. With that power comes a responsibility to be fair and diligent in your reporting.

Calvin Moen
Guilford



Calvin Moen

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

Advance Directive Rejected, But Value Still Seen

BERLIN — A patient who had his advance directive rejected by a judge still believes there was value in having drafted it and that it was still a useful tool during an involuntary medication hearing.

Harry, who asked that his last name not be used, was a patient at the Vermont Psychiatric Care Hospital when he executed an advance directive to state that he did not want to be on medications. An advance directive controls decisions that are made when individuals are no longer able to make decisions for themselves.

The Family Court judge hearing his case ruled that he had not been competent at the time he signed it, and so it was not legally binding. That cleared the way for the judge to order drugs.

"If I had to be on anything," though, it was "the one I'm on now," and the "judge took that into account" in his order, Harry said.

Harry said that the lesson he learned was that because a person has to be competent to sign the document, people need to have the doctors verify that they have a basic understanding of the diagnosis. "The doctor has to put it in the notes," he said.

Harry said he heard about advance directives in a group at the hospital led by staff from Disability Rights Vermont.

There need to be two witnesses when a person signs an advance directive and if the person is in the hospital at the time, there needs to be a spe-

cific additional person who explains the document. In Harry's case, those roles were filled by staff from Vermont Psychiatric Survivors, including Michael Sabourin, who is a patient representative legally authorized to be the additional required witness. Sabourin said they discussed the meaning of the document with Harry. Sabourin was out of town and not available to testify at the hearing that challenged the validity of the document.

After the validity of the advance directive was contested in court, a representative from the Department of Mental Health contacted VPS to question whether its staff played an improper role in assisting an "obviously psychotic patient" with an advance directive.

DMH Commissioner Frank Reed said that the question to VPS was based on what was reported in court, but after review, DMH determined that there were no technical problems with what was done.

Harry's lawyer, Gail Sophrin, declined to comment on the details of the Family Court ruling. According to Vermont law, the court is required to follow the instructions in an advance directive at an involuntary medication hearing if it was validly executed.

AJ Ruben from Disability Rights Vermont says that the agency warns persons who are psychiatric inpatients that there is "probably a presumption" that they do not have the capacity to

sign an advance directive. They advise getting a note from the treating doctor placed in the record that says the patient does have capacity in that situation. "That's the only way to protect yourself," he said.

But he still encourages patients to use advance directives as a way to plan for the future. "It's a recovery tool" even if it isn't legally binding yet, he said.

A Vermont law passed in 2014 requires hospitals to give information about advance directives to any patient who is in the custody of the Commissioner due to being involuntarily hospitalized. That includes material created by Disability Rights Vermont and the Vermont Ethics Network. Both agencies said they are currently working on preparing materials to give the hospitals.

Harry, who was working on a new advance directive at the time of his interview with *Counterpoint* — this time, he said, with the support of his psychiatrist — said that while "I had to go through the whole court process learning about it," he recognizes now how to create one that will hold up.

Even if a court rejects it, "it's a preference list" and "it's very helpful in trying."

"Is it a ladder to get you out of this place [the hospital]?" he asked. No — but "it's an umbrella to protect you from some of the hailstones they throw at you."

"Any buffer to get through this" is worthwhile, Harry said.

Corruption of Ethics in Psychiatry Led to Nazi Killings; Risk Still Exists

Speakers at a University of Vermont Conference
Cite the Appeal of Science as Threat for New Oppression

by ANNE DONAHUE
Counterpoint

BURLINGTON – Prestige. Money. Power.

It was those things, not the fear of Adolf Hitler or the actions of “a few fanatic doctors,” that led psychiatrists to become deeply involved in the killing of an estimated 250,000 to 300,000 psychiatric patients and, later, six million Jews.

The desire of psychiatrists to be accepted as true medical doctors through scientific research linking genetics to psychiatric illness was a leading factor.

Some of the same social factors are at work today as a result of the influence of the “mental health medical industrial complex,” and present a new threat of oppression of psychiatric patients.

Those were the dramatic messages of three of the speakers at a conference titled “Psychiatry and the Third Reich: Historical, Scientific and Philosophical Perspectives, Legacies and Lessons” at the University of Vermont this past fall.

The “understanding of past errors” and the history of a “darkest episode of the past” has relevance today in a world where “optimistic expectations” about biological psychiatry also raise doubts, said C. Scott Waterman, MD. He is a retired UVM psychiatrist who later got a Masters’ degree in history and who was a co-convenor of the conference.

Despite the “self-serving pronouncements” about the value of biology and drug treatment, drugs have proven to be “less effective” and “less benign” than predicted, he said. The biological model of “broken brains” requiring experts for treatment “has served to increase alienation and reduce hope.”

According to Sheila Faith Weiss, a history professor at Clarkson University in Potsdam, New York, the forces that led to the Holocaust began through seeing science as “a tool to advance society” with an “effort to biologize social and economic problems.” She was the first of the day’s speakers.

Volker Roelcke, at the University of Giessen in Germany and also a history professor, focused specifically on the role of psychiatrists. He said they organized the medical infrastructure for the killing and, as part of their jobs, made up the review panels of those who selected the victims.

They used what were considered advances in medicine and genetics research that would “improve the genetic health of the population,” and took the initiative “as a medical expertise” to “determine who was worthy of living.”

Roelcke said the historical evidence was that the majority of psychiatrists were willing to cooperate with the Nazi regime in its goals of racial cleansing because they were ready to yield to the temptations of power and resources.

They were not just “a few, fanatic doctors forced from the outside” to participate, he said.

Those who refused were not penalized, but those who participated saw the opportunity for an improved stature for doctors and for career opportunities in the emerging field of genetics.

They also wanted to be seen as “real scientists” and to participate in the increase in prestige

that the medical profession was experiencing, separating themselves from the psychoanalytic tradition that was not seen as worthy of true medical status, Roelcke said.

The emphasis on science through neuro-psychiatry and neuro-pathology – with illnesses caused by brain structure – created the shift to genetics, with hopes for treatment methods that could prevent illness. Instead, it led to sterilization and then euthanasia being used as a means to prevent future generations of persons with such illnesses.

“It was considered sound scientific research” to tie genetics to inherited mental illness that could be eradicated by killing those who carried the gene, he said. The “welfare of the community” as a whole took priority over the individual.

The closing speaker of the day gave a warning about the factors he sees in play today that create a risk of abuses in a society that is “captivated by science,” with a “culturally accepted belief about the power of science.”

John Sadler, MD, a professor of medical ethics at the University of Texas Southwestern Medical Center, said that social policy can be corrupted by a scientific-technological elite in which money exerts huge power and control over the direction of research.

That influence is evident in the excessive funding for “psychiatric genetics” and new drugs with only distant promise, he said.

In contrast, there is underfunding in areas of research that could provide immediate help: psychosocial interventions, public health and health system improvements.

Sadler pointed to 10 elements that he sees as creating the threat of oppression by a mental health medical-industrial complex:

- ▶ The fact of millions of persons with mental illness as an “eager audience for magic bullets” and as a captive audience, “sometimes literally captive” when held involuntarily;
- ▶ Big pharma as a for-profit industry, expanding the categories of illness to increase profits;
- ▶ The American Psychiatric Association, with the DSM (Diagnostic and Statistics Manual) as its “major source of income”;

- ▶ Academic medical centers with huge conflicts of interest in research because of financial incentives;

- ▶ Public buy-in of a “passive, pill-taking path to mental health”;

- ▶ The taxpayer subsidy of Pharma by the National Institute of Mental Health;

- ▶ Advertising and mass media marketing to consumers that “create ‘needs’ even for pseudo-disorders”;

- ▶ Politics that is heavily influenced by lobbying money, with no effective voice for non-pharmacy treatments which have no products to profit from, and with even some mental health advocacy groups accepting Pharma money;

- ▶ A healthcare system with a for-profit insurance model that excludes the highest-need, most expensive patients;

- ▶ For-profit providers, who see drugs as cheaper than psychosocial treatments.

Underlying all of it is the money that buys power in Congress, he said. “Big money supports lobbyists and lobbyists support special interests,” he said, so “one can see the potential for skewing of public policy.”

On the other hand, “the voices of the mentally ill as a stigmatized, oppressed minority have little to no impact on needs for access to care, evaluations for safety...”

Between the presentations of Roelcke and Sadler, several University of Vermont researchers offered background and their hopes for the bene-

(Continued on page 13)



Adolf Hitler



AFTERMATH — A US Army soldier views the cemetery at the Hadamar Institute, where people with physical and mental disabilities who were victims of the Nazi euthanasia program were buried in mass graves. This photograph was taken by an American military photographer in 1945, soon after the liberation of Germany.

(Photo courtesy of Rosanne Bass Fulton; US Holocaust Memorial Museum)

The Power of Connection for Safety and Healing

by Mary Phelan

The first thing you notice upon entering the emergency department at Rutland Regional Medical Center is the gaggle of uniformed security guards clustered midway down the hallway to the left of the nurse's station.

Why, one might ask?

Has a serial killer been brought in by the police, perhaps a dangerous criminal from Marble Valley Correctional is here for treatment or, maybe, a peace officer has been wounded in the line of duty and security is providing privacy and protection?

The answer is no to all of the above. The uniformed security presence is there to impose and maintain control of patients seeking emergency psychiatric healthcare.

The underlying assumption in this practice is that psychiatric patients are violent and need to be controlled externally through the use of physical force. While it is true that some patients come into the ED exhibiting violence, I submit that the vast majority do not.

Some patients, me included, have been elevated to volatility when threatened with psychological or bodily harm by the uniformed security force. The mere presence of uniformed security at the point of contact in ED Psych sends a symbolic signal to the patient: submit or be controlled through the use of physical force.

As a psychiatric survivor, I can tell you this is a terrifying feeling, and as a member of the animal kingdom I go into fight or flight mode.

How does this play into health care treatment?

When you set the table to demonstrate that control tactics are the vehicle by which you are delivering medical care, you strip the patient's sense of self-autonomy, human dignity, and psychological integrity.

Are these not the very attributes that at this time of psychiatric crisis need to be rescued, resuscitated, and repaired?

The physical control model is a failure. We are now beginning to see one that emphasizes connection slowly being nurtured in its place. Just as police tactics like "stop and frisk" are being challenged for their efficacy and for crippling psychological harm in communities of color, the heavy use of a uniformed security force in Psych EDs and units is coming into question.

A model built on connection makes so much more sense, not only for patients, but also for staff.

Ostensibly, the physical control model of security is to preserve safety. No one denies the absolute importance of maintaining safety.

However, given the confrontational nature that the physical control model sets up, it is far more likely this antagonism will destabilize the safety of the environment.

With respect to psych safety, strategies that employ empathic communication, de-escalation, patience, non-threatening persuasion, humor, kindness, and compassion are far more effective for everyone.

I will relate a personal episode which demonstrates my point about how connection is the most powerful tool for de-escalation and safety.

In September 2015, I presented at the RRMC emergency department for psychiatric care. A nurse gave me a Johnny gown and told me to take off my clothes and get into it.

I told her that I would turn over shoes, laces, ties, personal effects, anything she deemed dangerous, but that I refuse to strip bare and put on a gown as it makes me feel ashamed and humiliated. (I am a childhood sexual assault and rape survivor.)

She steadfastly insisted, things became verbally heated, I started sobbing, and a Rutland Mental Health Crisis Counselor entered with three uniformed security guards behind him — the "show of force."

He said, "Mary, put on the gown, it's hospital

policy." The security guards gestured to signal they were prepared to assault and subdue me. My fight or flight response kicked in, and being from South Philly, I was going to give as good as I got.

At that moment, another security guard, whom I have known from my many trips to the ED, Tim, handed me the gown and with a look on his face that acknowledged my pain said, "Mary, do it for me."

And I did.

Connection is a holistic means to achieving behavioral control and ensuring safety and healing. It is a culture, an orientation, a perception, a way of thinking and relating to people.

Connection takes time, it is labor intensive, it takes investment in training not just those involved in direct patient care, but entire staffs. It is an institutional undertaking where results are not always measured in customer satisfaction surveys.

It takes far more imagination, effort, and commitment than creating catchy public relations slogans. And it demands a covenant between the institution and its employees that demonstrates in words and deeds that they, too, are valued in a deep and meaningful way.

However, as significant as the investment in and dedication to the development of a culture of connection is, so too are the rewards to be reaped. Where patients and staff feel safe in a mutually supportive and respectful space, the miracle of healing is possible.

Mary Phelan is a survivor from Rutland.



Mary Phelan

Corruption of Ethics in Psychiatry Led To Nazi Killings

(Continued from page 12)

ficial knowledge of science in modern psychiatry.

Robert Althoff, Ph.D., MD, said that research a few decades ago searching for specific genes for specific psychiatric disorders was "barking up the wrong tree." Althoff is with the Pediatrics Department of Psychology at UVM.

He said that despite early work in the wrong direction, the role of genetics cannot be considered eliminated.

One recent past theory was the genes-environment interaction: the idea that having a certain genotype and then experiencing abuse, for example, could increase the probability of a major depressive episode.

Current theory is that genes are expressed, or "turned on or off," based upon factors in the environment. It raises the potential of a future in which genes can be edited, or specifically have their effect turned on or off, he said, as medicine increases the ability to target genes for change.

The "ethical implications are being discussed, but likely, not rapidly enough" in contrast to how quickly technology is moving, Althoff said.

Jim Hudziak, MD, the second UVM researcher, said that the current diagnostic system

was "deeply flawed," and was followed by medications that had "deeply flawed scientific evidence" for usefulness. Hudziak is a professor in the Departments of Psychiatry and Pediatrics.

He said he believes that all health comes from emotional-behavioral health emanating from the brain.

He pointed to the "Adverse Childhood Experiences" study that indicates that the "same factors that put you at risk of psychological illness are the factors that put you at risk of [all] illness."

"Adversity's bad for the brain and every other part of the body," but "if we build healthy brains, healthy bodies will follow."

He said that because genetic research now shows that it is the activity of the gene, not its function, that changes, there are external influences that can create positive change.

Hudziak uses music and exercise in his work and research with young patients, and reduces or eliminates their use of medication, he said.

The future of rational health care, he said, will be a new psychiatry that recognizes that psychiatry is for the benefit of all, "not only for the persons judged to have psychopathology."

The conference concluded with a brief ques-

tion period and panel discussion, with an observation that "we have to own" what went wrong, and a question: could something like the atrocities led by science in Germany happen again?

Roelcke said that in Nazi Germany, science became a "cultural authority," and was used by the political system to make its actions seem plausible.

"Why does science have this authority... for society in general?" he asked during the later panel discussion. There is an intrinsic problem in science, because a central belief is that "now, we know it" — but it can be wrong, he said. "How do we know what we use today is right?"

Critical self-reflection is essential, he said.

"Science is socially constructed," Weiss said during the panel discussion, "How do we balance the social context with what is fact?"

She said that what can make a difference is having a "diversity of voices" as a key to protecting against excesses.

Althoff offered an open-ended comment. He observed "how much the field shifts when the money shifts," and wondered aloud what might happen to a commitment to ethics "if the prevailing focus" were to shift.



Point →

A Psychiatrist Objects to the Court Process...

Doctor argues that the adversarial legal system obscures truth, denies the compassion and empathy of a medical decision-making process, and is not about what is best for the patient.

Have You Played Charades Today?

by STUART GRAVES, MD

Have you ever walked into a courtroom, sat down behind a big desk, and then, as a clerk announces “all rise,” stood until a judge, often in a black, floor-length robe, gets him or herself seated behind a desk equally large or larger and higher than yours?

And then have you watched as a bored clerk tending a tape recorder and possibly packing heat, asks a doctor, or a case manager, or an emergency clinician to raise their right hand and swear to tell the truth?

And do you then listen, as a prosecutor asks the clinician questions about their recollection of you and the health care you have been receiving, and thought, “Is that me they’re talking about?”

And finally, do you ever wonder, as your defense attorney objects to some fact about your health being admitted as evidence, “What crime have I committed?”

Or perhaps you have stepped into that self-same courtroom, but sat in the back on a bench until the prosecuting attorney calls you as a “witness.” And then, after swearing to “tell the truth, the whole truth and nothing but the truth, so help you God,” have you found yourself answering questions on the nature of diseases, and wondering what “whole” and “nothing but” can possibly mean for disease, given the size of medical texts, and the volumes of scientific articles collecting day by day in libraries.

Or, more amazingly yet, find yourself answering questions from memory about a patient despite the fact you spend much of your life painstakingly recording patients’ medical histories for the express purpose of overcoming the limitations of one’s own memory.

And, finally, have you begun recounting some fact recorded in a patient’s chart only to end passively sitting in dumbfounded awe of the solemn absurdity unfolding about you: the “admissibility” of the information is challenged as “hearsay” on the presumption that clinicians carefully recording their day to day work in medical records were in fact accidental witnesses: unexpectedly, suddenly, and fleetingly exposed to the shocking scene of a crime, instead of being people simply going about the daily duties of a job, specifically trained for, and performed over and over across the years?

And yet, there are three more people playing our game of charades!

Perhaps one is playing the “prosecuting attorney,” armed with statute, and charged with representing the “state’s interests,” who must struggle to get a clinician who is feeling awkward dressed up for court, confused by the rules, and desperate to escape, to stop rambling about with clinical words and ambiguities irrelevant to the law, but instead to be concise and speak in the words of the statute.

Next, one could be the “defense attorney,” who must prove their “client” is less sick or in-

jured (the analogue to innocence or guilt) than a certain picture drawn in the statutes. And that person must take this position, regardless of what he or she actually knows, thinks and feels, regardless of the competency of the patient to give direction, or regardless of the absence of an agent. That person’s only goal is to stop the syllogisms of law from turning the gears of medicine. Under these constraints, questions and actions may take on a surreal character: “And doctor, the patient sat and talked to you, is that correct?” or “Your honor, the patient’s temperature in the ER is hearsay.”

And finally, poor soul, one may be playing the

“In this day and age in which we piously express concern about the stigma attached to mental illness and the effects of trauma, it is amazing we choose to force the people so afflicted into our legal system... It is patently barbarous.”

“judge,” who knows not how fate has him or her measuring illness and prescribing treatment, rather than finding guilt or innocence.

Where is the person to be found guilty or not — is that the empty chair? What are the points of law to be argued — other than bending the rules of evidence enough to finally find out what’s going on? Who are these witnesses, at once deferential and diffident in need of something, and yet disdainful of the questions they must answer? And what is one to rule on: “Yes, give that medicine,” or “No, don’t give that one”; or the truest inference here is; or the most reliable knowledge here is; or the “defendant’s” values are; or suffering this much, this long, in that place is legal?

You may think from reading the above that I have no patience for any of it, but, in fact, I do. I have willingly participated in many such “hearings” as a “witness” to the best of my ability, and the attorneys and judges and patients I have worked with have also faithfully carried out their roles to the best of their abilities. We have all done so because we all know that amidst all the feudal, Monty-Pythesque bath water, there is a very important baby.

When an illness or an injury has deprived a person of the ability to adequately appreciate their circumstances, and therefore of the ability to direct their care, then it becomes fearsomely important how we decide such things for another person. There are two important decisions: 1) deciding a person cannot adequately appreciate their circumstances and take care of themselves, and then 2) what to do, or not do.

Bringing these kinds of situations before a court at least conveys the seriousness of the situation, and the courts may be a ready-made mechanism for our culture to turn to, but that does not make them the correct mechanism any more than a hammer lying at hand makes it right for opening a window. Turning to the courts is to make them a procrustean bed for each and every need of a culture. In the case of medicine, it’s such a bad fit one could argue there isn’t even a bed there!

A medical decision is not best made in an adversarial way. Compassion and empathy are a necessary part. These are lost when it is hoped two proxies (one for the patient and one for the clinicians) competing for the recognition of a third person (with no prior connection to the care, fleeting current connection, and absolutely no on-going connection) will somehow enable that third person to uncover “the truth” of what to do.

In medicine the truth is explored and made as clear as possible to all, and then compassion and empathy are used to sort out what to do by all involved.

A medical decision is not best made when some aspects of a situation are excluded. In medicine, all aspects of a situation are allowed to be discussed, and known, and weighed in the balance for veracity and importance. “Rules of evidence” distort this. Medicine does use rules of logic, and rules for weighing the likely truth of this or that description of the world, but these are a far broader universe of knowledge than the rules of evidence a court uses.

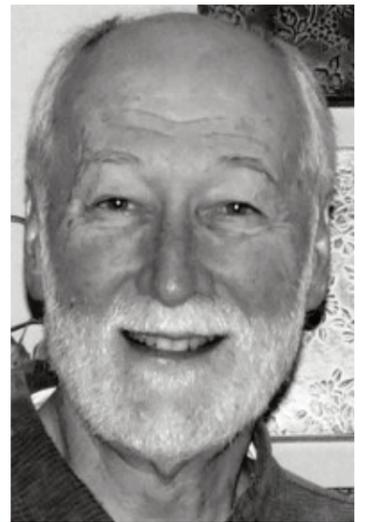
A medical decision is not best made when some feel less equal, less respected, and certainly is not best made if the process is not one about what is best for a person as opposed to best for the abstract entity, the state. A sense of equality, and of empathy, and compassion for the well-being of a person is necessary.

Finally, turning to the courts is actively damaging. In this day and age in which we piously express concern about the stigma attached to mental illness and the effects of trauma, it is amazing we choose to force the people so afflicted into our legal system. Could we do anything more stigmatizing? How must it feel sitting in the “defendant’s” chair, listening to lawyers questioning one’s clinicians, and awaiting what: a sentence? It is patently barbarous.

I know all the parties involved do their best to cope with being in court. I know that they do their best to overcome the obstacles it presents, but for the reasons presented above, they can’t really overcome them. I’m also quite sure all the people involved can imagine a better and more humane way to do things.

So why don’t we get on with it? Why don’t we, instead of expending all our energies simply coping, make something better for ourselves?

Stuart Graves is a retired psychiatrist from Montpelier.



Stuart Graves, MD

Counterpoint



...and Two Survivors Reject His Assessment

A former involuntary patient says that diagnoses are based purely on opinion and medications are harmful, so the avowed good will of psychiatrists cannot be trusted.

by PAMELA SPIRO WAGNER

It is not confusion that has assailed me upon stepping into a courtroom for a forced treatment hearing, as Dr. Graves suggests, but rather, a sense of WTF?

The defense lawyer and psychiatrist representing me spent all of two minutes getting to know my case, and he literally told me that “you only need a sip to know something is orange juice...” which included the patients he was representing. I had had bad feelings about the whole business, and now here we were, and already from the sounds of it, no one was going to listen to a word I had to say.

Not when the prosecuting attorney (or at least the one that was speaking on behalf of the hospital psychiatrist) was saying such things as that I was “chronically psychotic, unable to make rational decisions about taking medication, severely impaired and would decompensate without immediate intervention...”

Huddled together at the head of the table, even my lawyer was talking with them as if in collusion. It did not appear that he was fighting very hard on my behalf. Every so often someone stopped talking and looked over at me, but they did not appear to register my presence otherwise.

I am not sure what Dr. Graves means by medicine, because in psychiatry they can measure almost nothing with scientific certainty. Certainly the art of diagnosis is purely a matter of opinion and feelings, the feelings being those of the diagnosing psychiatrist.

How many doctors are told, for instance, that they can easily diagnose Borderline Personality Disorder on the basis of how a patient “makes them feel”?

Indeed, time and again, I have heard providers say this, casually, and as if joking, but it is clearly

Another says process wasn't confusing:

'It was clearly an attempt to deprive me of my rights'

by ELEANOR NEWTON

My perception of the court procedure for deciding whether or not to force treatment on patients is quite different from Dr. Graves'. My major objection is that the patient is not allowed to speak.

For me, as a patient, the experience was not at all confusing. It was clearly an attempt on the part of the psychiatric system to deprive me of my legal right to refuse medication, among other things. That was at a time when I had rational fear that the medications might kill me, and I know that, in any case, they would undermine my ability to live independently and take care of myself.

I knew I was powerless, and my lawyer in fact was not well acquainted with me or my situation. In addition, he had been lied to — in my presence — by a clinician at the hospital. Although I told him that, he said that he did not think I had any rights I could defend. And the hospital personnel had tried to prevent me from attending the hearing. But I got there, accompanied by a lawyer and a representative of VAN (the Vermont Advocacy

something they take seriously: If a patient makes them feel like murdering, then the patient is to blame and likely has borderline personality disorder.

Unlike the psychiatrists who choose to fault their patients, I have learned over my long life that no one can make me feel things, that my feelings and how I control them are up to me and to me alone. But apparently this does not apply to the great profession of psychiatry, not when psychiatrists are under the demonic control of borderline personality patients whose emotional control is not only total but absolute as a fusion bomb. Obviously we need to excuse the poor shrinks at such times for behaving under their influence.

But I will add that psychiatry remains a matter of a doctor's opinion as to diagnosis, and nothing more or less.

Why else could I have seen a dozen different doctors and gotten half a dozen different diagnoses? I am not different. It is only that opinions differ widely.

And opinions, not scientific facts, make all the difference in the changing and vague world of psychiatry.

But the author of the article wants to have it both ways. He wants to both be vague and artful and to claim his role is both medical and precise.

Which is it?

Well, I doubt that any of his knowledge of “schizophrenia” or “bipolar illness” would stand up to the rigorous testing of such real diseases as smallpox or malaria. But they don't have to, because he is claiming the status of Disease for them and no one challenges him behind those closed doors of the courtroom.

There is a real procrustean bed, of course, because any bed that one is strapped down to and

Network, which later morphed into Vermont Psychiatric Survivors.) The VAN member was there for personal support.

I had prayed about the situation and so felt sure that God was on my side, and said so.

The judge heard my lawyer and that of the Department of Mental Health, and was leaning in my favor. Then the lawyer representing my family arrived, late. That testimony was clearly influencing the judge, who was about to rule without hearing from me.

That was intolerable.

“Your honor,” I spoke up. “You have just heard some half-truths, skewed truths and outright lies, and I have not had an opportunity to respond to any of this!”

Without missing a beat, the judge declared, “The temporary guardianship is hereby dissolved.”

God was indeed on my side, and I believe He still is.

Eleanor Newton is from Burlington and is on the Counterpoint Editorial Advisory Board.



by Pamela Spiro Wagner, June 2015

restrained on, which has happened to me involuntarily in Connecticut and Vermont numerous times, for no good reason, is or should be illegal as torture.

But Dr. Graves would likely call it a necessary good, not torture, never having been wracked on one. So he would not see his medicines as torture, either. And he would likely call the effects of such drugs — obesity, agonizing restlessness, weight gain, diabetes, dry mouth, dental cavities, torticollis, leaking breasts, dizziness, anxiety, akathisia, etcetera — “only side effects” and not important. Though try telling someone who has gained a hundred pounds and become dependent on insulin injections that this is “unimportant.”

But has Dr. Graves read the research saying that most drugs in psychiatry do more harm than good, and most do no good at all? Who is he to force any drug on an unwilling patient, whoever he or she is, capable or not, when that drug may do harm?

Who is he to say that the condition that person is in is indeed too harmful to live with? Too many doctors who forced commitment or medications on me did not *like* me, and tortured me with 30mg of Haldol IM a day for that reason alone.

So why should I trust any psychiatrist on the basis of his own avowed good will? Good will would leave me to make my own decisions, even if they are bad decisions.

That is what this country is all about: The freedom to make our own choices, even when the choices are bad for us.

Pamela Spiro Wagner experienced her court hearings in Connecticut. In Vermont, she says she was advised to accept the outcome and not attend. “I felt at the time that I just did not want to hear them talk about me... and since I accepted the commitments I felt I did not want to hear the degrading and dehumanizing words they would use to justify it.”

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

Editorial

Teeth and Brains

The Department of Mental Health has suggested in a commentary that dental health and mental health have a lot in common, saying that “much like mental health and medical care are often managed discretely [separate from each other], medical and dental care remain steadfastly separated in many cases.”

It went on to say that, “This is due to a variety of factors including separate schools, payment mechanisms, and practice locations; all similar issues for mental health.” The commentary was titled, “Including the Head in Healthcare Reform: What Mental and Dental Health Have in Common.”

The comments suggested a striking lack of sensitivity to the things that are radically different about teeth and minds, and about how they have been treated by society. They also assume that “integration” means the same thing for both: that teeth and minds both just need to become part of the mainstream medical model.

There are certainly some parallels. Mental health was left out of insurance coverage until the battle for insurance parity; dental health is still left out of most health insurance. They also have strong connections to overall wellness. And psych meds can result in damage to teeth, and bad teeth can hurt self-esteem.

But the differences are dramatic and painful:

There is no dentistry that is forced upon those who do not want it. There are no courts issuing orders to the dental chair. Dentistry has never been a tool of oppression in society. There have never been institutions incarcerating thousands of people based on claims of bad teeth.

Tooth decay is not a socially defined illness that is based purely on symptoms but no scientific proof of a physical malady. If your teeth are crooked or falling out, the evidence is pretty concrete. If you are hearing voices, there is no broken brain part that shows up on an X-ray. Bacteria eat at our bodies and our teeth, but not our minds. Teeth are organs made up of body tissue. Our minds are far more than just the brain tissue in our heads.

People seek dental care because the symptoms bother them. Psychiatric care is often based on symptoms that do not bother the individual, but bother other people.

Dentistry has not been separated out because of stigma or because of blame on the person with symptoms. No one suggests that your tooth problem will get better if you just “pull yourself together.” Even though failure to brush may result in tooth decay, oral health is not demeaned with the title, “behavioral health.”

Dentistry is a recognized component of medicine within today’s medical model of care. When it comes to mental wellness, it is the system itself that needs to change to become holistic and address body, mind and spirit.

Parity for dentistry is about money.

Parity for mental health is about fundamental human rights.

Obviously, there are many good reasons to support our need for access to good oral health.

Calling that a parallel to the way those with psychiatric labels have been treated in society, however, makes it oblivious to the suffering of so many of us, for so very long.

PUBLISHER’S COMMENTARY

Why I Decline to Co-Sponsor Mental Health Advocacy Day

by WILDA L. WHITE

Earlier this month, I received an email from the Vermont affiliate of the National Alliance on Mental Illness (NAMI-VT). The email was addressed to “Dear Mental Health Advocates” and included an invitation to become a co-sponsor of Mental Health Advocacy Day.

The email went on to state that it wanted to “involve [me] and those [I] represent to advocate for an improved mental health system of care, meet legislators, and share our stories at the State House.” Co-sponsorship required only that I show up at the State House on the appointed day.

As I have written before, NAMI does not speak for speak me, and I have no interest in working alongside an organization that advocates for forced drugging and decreased privacy rights for those labeled by psychiatry. But the reasons behind my declining to co-sponsor Mental Health Advocacy Day go beyond the involvement of the sponsoring organizations.

I became a psychiatric survivor after a psychiatrist misdiagnosed me with Attention Deficit Hyperactivity Disorder and prescribed a stimulant for this presumed condition that triggered a protracted, psychotic manic episode that went undiagnosed despite telephone calls and emails to the psychiatrist from friends and me telling him that I was manic.

The episode left me homeless, jobless, penniless, deeply indebted, and with a battered reputation. I lost friends and family. My sense of self was badly shaken.

The episode caused me to leave San Francisco and my long-time partner, and move to Vermont to secure employment that eluded me in San Francisco because of discrimination against those who have been labeled by psychiatry. My income is less than half of what it was before the episode and the opportunities that I once enjoyed as an attorney and businesswoman have evaporated, again because of discrimination.

My brother fared no better. He was psychiatrically labeled with schizophrenia in his early 20s, and forced drugged ever since.

Now in his 60s, he still hears voices. He also suffers from tardive dyskinesia, diabetes, kidney failure, and his thyroid and all of his teeth have been removed, all side-effects of the drugs forced on him. He can no longer draw, play the trumpet, read, or play sports, all things at which he used to excel.

My and my brother’s experiences are not unique.

As Executive Director of Vermont Psychiatric Survivors I have heard from hundreds who have been harmed by the mental health system. However, these outcomes are not part of the national conversation. No one cares and no one has been held to account because our society devalues those of us who have been psychiatrically labeled.

This devaluation is embedded in the mission of the federal agency responsible for advancing

the country’s mental health. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), its mission is “to reduce the impact of substance abuse and mental illness on America’s communities.”



Wilda White

This is not a mission that is focused on valuing people.

Under such a mission, the rights, needs, and preferences of individuals suffering or perceived to be suffering from mental illness or substance use can be sacrificed whenever it would reduce the impact of such suffering on America’s communities.

Individuals are not the subject of SAMHSA’s mission, they are merely the object. That is why our society sweeps under the rug the amount of harm our current mental health system inflicts on individuals.

Mental Health Advocacy Day does not challenge what is fundamentally problematic about a system that does not put people at its center.

With its focus on improving the mental health system, Mental Health Advocacy Day accepts the ideology underlying the system that would have all those psychiatrically labeled acknowledge their illness and seek help; accept the psychiatric explanation for their personal experience; and accept the psychiatric solutions without question.

Mental Health Advocacy Day ignores the harm done by the system to individuals, like my brother and me. It ignores the unequal distribution of societal resources based on perceptions of sanity.

It leaves unchecked the system’s hierarchy of power and knowledge, which places psychiatrists at the top and patients at the bottom even when it comes to their own experiences.

To participate in an event called “Mental Health Advocacy Day” is to say that one is fundamentally okay with a system that does not put people first, that harms people and holds no one to account, and offers psychiatry and drugs as the primary response to mental and emotional distress.

I choose to advocate with and on behalf of people, for their civil and human rights, and not on behalf of a mental health system that causes so much harm, offers so few choices, and devalues people, if not by design, at least in effect.

Mental Health Advocacy Day tinkers with the system, where the need is to dismantle it.

Please Respect Decision To Take Meds

To the Editor:

These past few years I have been hearing a lot of anti-medication news. While I understand that the pharmaceutical companies gouge people — or, are “crooks” in U.S. Senator Bernie Sanders’ humble opinion — I must add that the meds I take allow me to live a pretty “normal” life.

But what is “normal”?

Well, they allow me to sleep and keep my sanity, for one thing. I work part-time and am able to keep commitments in my life, such as going to council meetings and standing committee meetings.

I tried being off meds several times in my life and the result was always the same: mania followed by what the medical field calls psychosis and of course the inevitable hospitalizations. (Many hospitalizations which were far more traumatizing than what I was initially experiencing anyway.) I’ve often said if one could bottle the euphoria that manifests in a manic episode it would be worth millions of dollars. That being said, society locks me up when I don’t take meds. Period.

So that leaves me with two choices: stay on meds and lead my life in a happy way or stop taking them and get locked away in an institution. For me the choice is clear: unless I want to stop taking them and be up for four days straight, unable to work, unable to function — perhaps even embarrass myself to no end in front of family, friends, co-workers, and the state of Vermont — I **choose** to take meds.

I would rather sleep well, be in a loving romantic relationship, keep my job, and be able to function than be peer-pressured to stop taking the meds which allow me to live my life the way that is best for me.

Of course I understand there are some who do not take them, some who do. To each his/her/their own. I have written articles before against forced drugging/seclusion/restraint. Enough said by me on those subjects. But please do not judge me for doing what I need to do in order to live my life successfully.

When big Pharma decides to stop gouging people on the outrageous cost of meds that will be a great day. Good health should not come at such an extreme expense. Good health is a basic human right. (As is housing a basic human right, but that is a subject for another time.)

Thus, medications, therapy, support, work that I love, good people in my life, sleep, animal therapy, music, reading, walking — all of these things help me live a life worth living.

It is only because of my vast experiences, both good and bad, that I am able to be empathetic with people about all kinds of subjects.

Balance is key. Live and let live, I say. I was also told by someone famous when I was 20 years old to “live and learn.” I share my experiences, hope, and strength here with readers so that it doesn’t take someone 15 years, like it did for me, to really learn what works for them. It took at least 15 years for me to get on the right meds, to find just the right people — so, better late than never. While I respect the value of the human experience, and many opinions on the subject of meds, please humbly respect my decision to take them.

And a note to big Pharma: please stop all of the horrible side effects! You are multi-billionaires for goodness sake! It has to be possible to make safe medications and also to import meds

from places like Canada. Stop price-gouging people and insurance companies! Everyone has the right to a happy and healthy life.

MARLA SIMPSON, MA
Randolph

Money Drives Concern About Patient Discharges

To the Editor:

For the past 10 years or so one of the first things psych hospitals have you do upon admission is fill out discharge planning goals.

WTF? You’re sitting there a hot mess, totally broken down psychologically, barely being able to muster the courage to overcome the gauntlet of humiliation you’ve just been subjected to, and they want you to summon the clarity of thought necessary to formulate treatment goals? Must be an insurance mandate, as we used to say at Ford Motor Company: gotta keep the iron rolling.

Now, fast forward and psych hospitals are facing [a court decision] that may hold them financially liable for the actions of patients upon discharge. All of a sudden the pipeline is backed up with people doctors are worried may pose a societal threat.

Never mind all the patients they may have given the bum’s rush to in the past who went homeless or committed suicide. Now, it’s an exercise in institutional risk management. A bean counter thing. Call me cynical, but my motto is: follow the money.

MARY PHELAN
Rutland

Homeless Policy Leaders Need Political Support

by WHITNEY NICHOLS

I had the prestigious opportunity this fall to attend a conference on “Collaborative Solutions To End Homelessness” presented by the federal Substance Abuse and Mental Health Services Administration (SAMHSA). About 30 consumers nationwide received full scholarships to discuss “Aligning Principles, Programs and People” in that effort.

There is clarity, respect, and commitment from national public policy leaders in their willingness to increase interagency cooperation and consumer input.

However, in my opinion, bipartisan political will is essential if any constructive national social reform can ever be expected. There are strong social and moral disincentives, and a noticeable need to improve systemic state and local discrimination and stigmatic social challenges.

Two plenary sessions, “Aligning Policy and Services to Maximize Outcomes: Federal and State Perspectives” and “Redefining Experiences - Alternatives to Criminalization of Homeless-

ness” were on cutting edge subjects.

The first session detailed the importance of interagency planning and cooperation using a non-traditional combination of Medicaid and HUD funding.

The second presentation provided much-needed input for fundamental changes to an anachronistic and barbaric social system.

An afternoon workshop on “Bringing Together Health and Housing in Supportive Housing” further explored ways to support Medicaid beneficiaries in supportive housing.

I had an opportunity to share a Vermont legislative success story for the Medicaid for Working People With Disabilities (MWPDP) program, and the issue of age discrimination, with co-presenter Rene Buchanan from Santa Monica, CA.

It was titled “Improving Positive Peer Influence in the Everyday Workforce.” The National Independent Living Council recommends that all states adopt a similar policy change, based on the Vermont experience, for the inclusion of every person who qualifies for the MWPDP program re-

gardless of their retirement age status.

On the recent occasion of my 70th birthday, I met several younger persons who appreciate the “Baby Boomer” generation’s experience and wisdom. I was overjoyed to become reacquainted with a Social

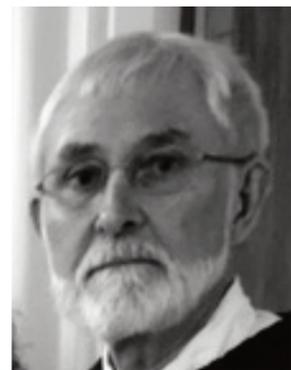
Worker, Catherine from Detroit, who introduced herself during an interim break.

Last December, she and her family attended St. Michael’s Episcopal Church’s “Longest Night Service” in Brattleboro, intended for persons who experience difficulties with darkness and the Christmas holiday season, which I helped officiate!

Brian Smith, who administers the Program to Assist in the Transition from Homelessness (PATH) at the Vermont Department of Mental Health, and I are in regular contact.

I look forward to participating in the newly formulated SAMHSA Consumer Workgroup, and continuing my association with other national leaders.

Whitney Nichols is a consumer advocate and peer specialist, and a member of the Vermont Psychiatric Survivors Board of Directors from Brattleboro.



Whitney Nichols

Have an Issue To Discuss with Other Survivors?

Share your thoughts here!

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

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

SECOND PRIZE, PROSE

The Cherry of THAT Family

by Fred Trombly

Her name is Alexa. She comes from a dysfunctional family. There are a lot of those these days. She's only 15. People look down on the members of families like hers. Their sentiments are damning. It's guilt by association. They'll say things like: "The apple doesn't fall far from the tree." "She's no better than the rest of her family. She can't be. Leave her alone."

Her Dad's an alcoholic. He's out of work more often than not. Sometimes in his drunken rages he beats his wife, who certainly deserves better. That's just plain wrong. The wife is marking the days when she can find a way to leave him and hopes that somehow it will work out well for her children. When she finally does leave him then her loser husband will act like it came out of nowhere and wallow further in his pathetic self-pity as he continues to spiral downwards in his self-destructive path.

Alexa's 16-year old brother despises his father for what he is. Yet, unknown to him – in a strange and seemingly impossible way – he will grow up to be just like him. Even now he's doing pot. He can't hold a job either, just like his Dad. He got involved in some foolish vandalism with his likewise foolish and weak-minded buddies and now he's well known by the local police and not in a good way.

The poor mother is no angel herself. She's so used to just trying to survive that she's become a very selfish person, thinking only of herself, sometimes her three children and what she can do to make it through another miserable day.

It's too bad for her that she has such a toxic personality. She gossips about whichever "friend" that isn't in her presence. She blows up easily and erupts over small matters. She's mostly alone now. Few of her former friends call and her relatives already know to keep their distance. If you do anything good she will find fault with that or tell you what you could have done that would have been even better and yes, you're stupid for not thinking of that yourself and where would you be without her?

Her loneliness has led to her depression and becoming a member of the "Prozac Nation." She sees no way out of her despair and unhappiness, except maybe in suicide. She wonders if the next day will be any better. There IS another way out, but it would involve her making some major personality changes and she's used to taking the easy way out and blaming others for the results of her poor choices and behaviors so that's not going to happen any time soon.

Alexa's younger sister is now 13. Like Alexa, she has some pretty features. Now that she's emerging from puberty the boys are noticing her longer legs and growing breasts.

Lacking any normal male, fatherly attention from her often drunk and angry father she seeks the approval of the boys that are after her for their own selfish desires and eagerly seek to take advantage of her. It's easy to receive their approval when you give it away to all who caught her eye. Her road to happiness is to become sexually promiscuous. Sadly, this doesn't bring her the warm, caring relationship and the happiness she had been so desperately seeking. It's actually created other problems and strife for her. It's a miracle she's not pregnant yet.

Alexa is a sophomore in high school and has volunteered to work in the school library during some of her study halls and sometimes after school. She has a friend, Nena, that also does the same thing. They are both thinking of maybe being a librarian for a career.

Nena is also a nice young woman but not quite as gifted in this area as her good friend, Alexa.

One day, Alexa finds her library co-worker, Nena, sobbing in a stall in the Girl's Room. She lightly taps on the stall door and in a very concerned voice asks, "Nena – what's wrong?" No one else is present.

From behind the closed door, Nena wails, "I can't understand what Mrs. Carpenter is telling me.

It takes me forever to put the books back on the shelves and the numbering system is very confusing. You take half the time to put a stack of books away as I do. I'm so stupid. I should quit this."

Alexa, standing just outside the closed stall door, feels so badly for her friend. It takes her but a moment to know what to say or at least give it a try. "Nena – you're NOT stupid. Nobody is smart in every area. You can learn this and I will help you because you're my friend, my best friend!"

Nena has stopped weeping and for a few moments there's a silence. Alexa wants to give Nena a turn to speak and hear what she has to say. Nena asks, "Really? Wouldn't I just slow you down?"

Alexa, finding her dear friend so devastated by something so easily solvable found this humorous but dared not laugh, fearing that would be misconstrued as mocking her. Still on the other side of the door, at least Alexa could smile. Her reply to Nena was, "Who cares? We're volunteers working for free and besides, when you get up to speed then together we'll be better than ever!"

At that kind and considerate answer, Nena opened the door to the bathroom stall where she was held hostage by her feelings. She was only sitting down on the john. She just needed to get away to a private place and this was the closest and best place she could think of at the moment her emotions overwhelmed her.

Without a word, the second she emerged from her solitary confinement they both hugged. Nena's face was streaked with tears. Alexa's face, until this point, a profile in perfection, started little streams of empathetic tears flowing as she warmly hugged her flustered friend.

After a minor makeup touchup session the girls headed back to the library, smiles on their faces!

Another day, when Alexa came home from school, she once again found her mother, all alone in their home, with no lights on. True, it was daylight out but it wasn't that bright a day that you didn't need indoor lighting.

"Hi, Mom. It's dark in here. What are you doing?" "Nothing." Sensing her mother was in one of her depressive funks again, Alexa cheerily said, "You'll never guess what happened today!" "What?"

The cafeteria made hundreds of cupcakes and they were delivered to our classrooms just before school got out. It was such a nice surprise! They're calling it the "First Annual Cupcake Day".

Her mother, not much for conversation up to this point asked her older daughter, "Did they taste good?" "I don't know. I gave it to our school bus driver. He really liked it. He was so surprised and thankful!"

For some unknown reason, this angered her mother who went off on Alexa. She angrily screamed, "How the hell could you do THAT? He's not our relative or even a friend of ours! That was stupid! Why didn't YOU eat it?"

Alexa explained her unselfish action. "I like him. He's probably the nicest school bus driver we've ever had. He doesn't angrily scream at us like some of the other bus drivers did before him. He always says "Hi" to everyone and tries to remember all our names. He's nice. Besides, I'm watching my weight."

Her mother could not understand her lovely daughter's gift to, in her eyes, a total stranger. She kept on berating her and saying she should have done this or that with the cupcake instead. Alexa knew the drill. She was ready for times like this. She already had an escape plan in mind. It was one of her ways of coping with her "lovely" mother.

Alexa told her mother, "I have to go over to Maria's house. We're working on a homework project. What time do you want me home for supper?"

In a snit, her discontented mother sneered, "I'm not making any supper tonight!" Rather than argue, Alexa simply said, "Oh, okay. Bye. See you later." Then she made her exit. It was sort of like bailing out of an airplane with a parachute. She

thought to herself as she stepped down to the ground, "Geronimo!" She had made up the homework story. She just had to get out and the sooner the better.

Right after the door shut and Alexa was gone, her mother started bitterly crying.

Alexa would have preferred to have tried to console and cheer up her mother but had tried that many times before and her efforts failed miserably and then SHE felt like crying for things that were not her fault and that she had no way of fixing or changing.

It's nearly impossible to change toxic people. Alexa learned the only thing you can do is practice damage control. It sounds selfish but it's not. Sometimes it's all you can do to save yourself. Alexa was wise beyond her years.

On another occasion, Alexa was in line at her high school's cafeteria. She was behind two other girls. Among the desserts the cafeteria staff had lovingly prepared that day were some homemade pudding cups. The flavors were vanilla, chocolate and butterscotch. They tasted better than any store bought pudding that was made last month and were better for you with no preservatives and as fresh as fresh can be. Butterscotch was Alexa's favorite flavor of pudding!

A much smaller quantity of the butterscotch pudding cups were made because chocolate and vanilla were much more popular and not everyone likes butterscotch.

One of the girls ahead of her in line said to her friend and Alexa could easily overhear her words, "Butterscotch is my favorite! I wish they had it every day instead of only once a month. I've been looking forward to this ever since I saw it on the lunch menu!" Alexa thought to herself, "What a coincidence! We both love butterscotch pudding!"

By the time they got through the line to the dessert section, Alexa peeked ahead and saw there were only two butterscotch puddings left. If the girl in front of her and her friend took them then she would be out of luck. That would be so disappointing!

With a bit of nervous apprehension, Alexa looked on as the raving butterscotch lover took one of the remaining two butterscotch puddings. Then her friend took a chocolate pudding. What a relief that was!

Alexa then got her turn and she took the last remaining butterscotch pudding. Her mouth was already beginning to water. She thought, "I think I'll eat my dessert first today."

As the three girls carried their food trays to the remaining open spaces at a distant table, when the raving butterscotch pudding fanatic went to sit down, a strap from her shoulder bag slipped down her arm and she almost lost her grip on her tray as she tried to set it on the table.

This commotion was just enough to cause her cherished butterscotch pudding cup to tumble from her tray onto the floor, face down. She mournfully cried out, "Oh no! My pudding! I was looking forward to that all day!" It looked like she was about to break down and start crying. Maybe she wasn't as mentally stable as everyone thought she was or she was just an emotionally fragile person. After all, it's only a pudding cup!

Rather than wait to see if she was going to have a meltdown, Alexa, who had already placed her tray safely on her table, quickly stepped over with her favorite flavored pudding and handed it to the distraught girl who accidentally ruined her own pudding and in a matter of fact manner told her, "Here – you can have mine. I meant to get chocolate."

The bereaved young girl accepted her generous offer and thanked her very much. Alexa then went to eat with her friends. What a sweet, thoughtful and generous act! Alexa didn't even know her.

How could Alexa be so different from the rest of her family? How could she rise above her sordid circumstances and blossom in an attractive and beau-

(Continued on page 19)

RUNNERS-UP, POETRY

Energy dip

Energy dip
Body still
Fatigue

Dim inside
Shades down

Cars swooshing
Phone beeps
Stillness remains

Numb mind
Heavy body

Thoughts without power

Electricity out

Not resting. Not relaxed.
Here, still.
No movement.
No completing thoughts.

Familiarly indescribable.

Heavy exhausted unpaced breath.
Tired heavy muscles.
Slowed fragmented thoughts.

Realization of energetic difference.
Slouched ragdoll. Poof!

MELANIE JANNERY
Burlington

The Cherry of THAT Family

(Continued from page 18)

tiful way, like a flower rising from the ashes?

She enjoys being nice to other people and so they're naturally drawn by her warm personality, her smile and her kind words. She's learned that when you give to others you don't have less, you receive more and for some unexplained reason — it makes us happy about ourselves and feels good.

In recent years, psychologists, other researchers and some mental health experts have discovered that those that practice unselfish giving get good results and these aren't isolated instances. They're true and founded ways to be happier. They've also learned that generous people have a higher contentment with life and suffer from fewer or less severe mental and even physical illnesses.

Sure — a lot of people are quick to say, "The apple doesn't fall far from the tree." Maybe a lot of time that is true — meaning that a person doesn't turn out much different than those they were raised by and the environment they grew up in.

Yet, it doesn't have to be that way.

Time and again throughout history there have been well-known and obscure examples of where someone rose above their circumstances, defied all odds, and became a better person than you might expect, given their difficult and challenging background and upbringing. These people might be rare but they're also very special. When you see how unselfish and different they are from the rest of their family — you just know they're special.

What about Alexa? She's going to be okay.

Indeed, she is: "The Cherry of THAT Family"!

Fred Trombly is from Colchester.

Would You Like to Know?

If you looked me in the face right now, what would you choose to see? If you looked me in the eyes right now, how deep would you go?
How deep would you go?

I could take you on a journey, a journey well unknown.
I could take you on the ride of your life, if you'd like to go. Would you like to go?

Would you choose to see the pain that I've borne, or the tears that I've cried?
Would you choose to see the smiles I've seen, or the happiness all inside?
Would you choose to see the suffering that I've been through, or would you choose to see the hopefulness that got me through?

When I wake up each morn', you'll see a twinkle in my eyes. When I watch the kids all at play, there's a joyfulness all inside.

I could take you on a journey, a journey well unknown.
I could take you on the ride of your life, if you'd like to go, deep into my soul.

If you looked me in the face today, what would you choose to see?
If you looked me in the eyes right now, how deep would you go?
Would you like to know?

ERIK JOHNSON
Irasburg

Enter

The 2017

Louise Wahl Memorial
Writing Contest

Total Prizes up to \$250!

Named for a former Vermont activist to encourage creative writing by psychiatric survivors, mental health consumers and peers. One entry per category (prose or poetry); 3,000 word preferred maximum. Repeat entrants limited to two First Place awards. Entries are judged by an independent panel.

Contest Deadline March 15, 2017

Send submissions to: *Counterpoint*, Louise Wahl Writing Contest, The Service Building, 128 Merchants Row, Room 606, Rutland, VT 05701 or to counterpoint@vermontpsychiatricsurvivors.org. Include name and address.

2016 Contest Winners

Prose

First Place — \$100

Angel in My Closet

Vesna Dye, Essex Junction
(Published in fall edition)

Second Place — \$50

The Cherry of THAT Family

Fred Trombly, Colchester



Poetry

(All published in fall edition)

First Place — \$50

Everything Remains Still-Paralyzed

Emily Dooley, Brattleboro

Second Place — \$30

If I, Kevin Cook, Orleans

Third Place — \$20

Christmas Farewell

Kenn Ash, Bennington



by Pamela Spiro Wagner, Brattleboro

SPEAK

You try
not to make it longer

than a paragraph
the things
you used to say
unsaid

until

they can talk to you

by CARMEN WHITE
Berlin

Call to Artists

The Howard Center Arts Collective provides exhibition opportunities for artists receiving or providing mental health services. We invite people interested in showing with us to submit work in any medium.

Deadline for winter shows: Nov. 30. Showing at the Burlington Record Plant in December and at Nunyuns in January and February.

Deadline for spring show: February 26. Showing at One Main Street in Burlington in March.

Contact Adam Forguites at Aforguites@howardcenter.org

Omnivorous Portal

This world is always on.
On and on, all the time, like
a TV in the living room
of someone who will happily
say: "Hey, I don't want to miss
anything." And then
they forget who you are, why
you're in their living room.
It is on. And on and on all the time,
this world, and the pressure on us
to always have and keep one thing or another
in mind. Forget about any conclusion of
the broadcast day. There won't be any
non-sectarian chaplain
leading you in prayer, leading the late-night
audience into the test pattern
anymore. You and I must take it upon
ourselves to make the High
Definition go away. Upon ourselves to crush
the omnivorous 3D
portal.

by DENNIS RIVARD
White River Junction

Warriors

You say I'm a warrior
But why do I feel like the war zone itself
Tangled up with ashes and blood
There goes a stream of dark tears
Watch it turn into a river I swear
It will

You say I'm a warrior
But I've been killed in my own war many times
The will to live resuscitating my body
Afraid to die, afraid
To live
Like this

You say I'm a warrior
I'm trying to believe
I am courage, light, spirit

Thank you for saying that I'm a warrior
Sometimes it takes another warrior
Who has also been through trials
and immense suffering
To remind you that you're one, too

You say I'm a warrior
Please look in the mirror
Let's stand together
Our smoky eyes of war
Gleam with peace

by EMMA BENARD
Waterbury

Arts

Poetry

Memory's Gift

Too long we have gone without
 Too long we have lost our way
 Our children hunger, cry in their sleep
 For we all, lady freedom weeps
 Fear not, though, among us is a voice
 A light of hope for all to see
 We shall gather ourselves, man woman and child
 Our belongings, beliefs, our history
 We will sail the mighty ocean
 Follow the stars, challenge the wild
 The unknown, though dark and forbidding
 We are willing, we shall survive
 For many days and nights we lived upon the strength of the
 waves
 The strength of the faith
 Of the Almighty
 With the shore of a new land before us
 Trees, birds and mountains to see –
 Upon that rock Plymouth we landed, began our new history
 Eagerly with the springtime mornings, we plant the fields
 with the sun ablaze.
 The souls of this land that were here, accept us
 Though truly not with ease
 Through the endless nights of summer, we learn by the
 campfires, of their ways.
 With the sight of all the colors, it's fall again
 Short are the days
 The season's circle turns
 The cold, the snow, no mercy, no grace
 Without the help of those of this land, many more would
 have died in this place
 Yes, we have shown them religion
 They in turn have helped us survive
 Freedom's light upon both our peoples
 In this new land all are truly alive
 A great harvest has come upon us
 All of this land. Man woman and child.
 This autumn evening we share our bounty together
 With the spirit of peace and living
 You bless us Father, with the gift of Thanksgiving

by EARL EVERETT RICE



by Lisa Carrara, Weathersfield

Share Your Art!

Express Yourself in Drawing,

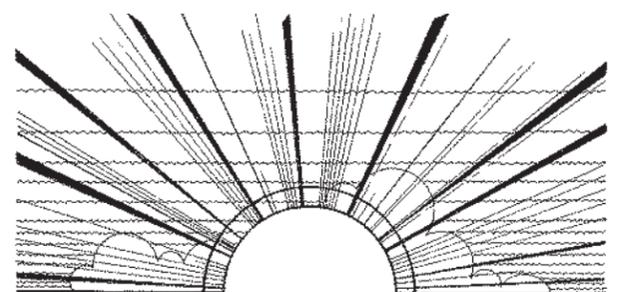
Prose and Poetry...

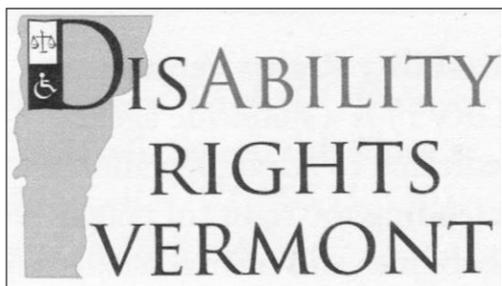
Counterpoint

Is About Peers

Sharing With Peers

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





DISABILITY RIGHTS VERMONT ANNOUNCES FY 2017 PRIORITIES

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

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

DRVT has continued our work to create a more robust community-based system that will both provide needed supports for people experiencing mental health crises and avoid involuntary treatment, incarceration or other major life disruptions that occur now because of a lack of adequate community capacity. DRVT, on behalf of people with disabilities, has brought cases before the Federal Court and the Vermont Human Rights Commissions highlighting the harm that people suffer when held in inappropriately segregated and institutional settings solely due to their disabilities. Many of these cases have resulted in important systemic changes to improve conditions for people held this way, while we continue working to fix the overall system.

DRVT staff continued to provide emergency preparedness planning and disaster services for people with disabilities through work with the Vermont Red Cross and FEMA to provide functional accessibility surveys for all major shelters in Vermont and to provide disability etiquette training to emergency services personnel throughout Vermont.

We have continued our work monitoring the treatment and education of youth detained at the Woodside Rehabilitation Facility, with a focus on the use of force and segregation of youth as well as with obtaining compliance with special education laws.

DRVT maintained its main focus on detecting, remedying and preventing the inadequate provision of mental health care and the unnecessary use of force and isolation against people with disabilities in hospitals and correctional facilities throughout Vermont. This work is accomplished by DRVT staff monitoring facilities, meeting with patients and prisoners, investigating claims of abuse or neglect and assisting in filing formal grievances, complaints and litigation when necessary to vindicate people's rights.

We continue to monitor treatment environments in Vermont, including designated psychiatric hospitals, Emergency Departments, residential and community care homes. We also reach out to homeless shelters and to refugee, immigrant and other at-risk communities in Vermont.

DRVT staff continued to support the right of people with disabilities to vote by publishing the 2016 Voters Guide, conducting extensive voter registration efforts and providing polling place accessibility surveys to town officials.

We have continued to grow our work assisting beneficiaries of Social Security who face barriers to employment throughout Vermont. DRVT has helped to resolve employment and educational discrimination claims, landlord tenant concerns, access to vocational services concerns, and inappropriate overpayment demands for dozens of Vermonters.

DRVT greatly expanded our work to assist victims of crimes who have disabilities throughout Vermont, including having provided training to almost 100 law enforcement officers in Rutland County on how best to interact with victims of sexual assault who have disabilities, providing representation for victims as they navigate the criminal justice system, and by helping victims with access to safety and to social services they might need.

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

DRVT is publishing our formal Fiscal Year 2017 (10/1/16 - 9/30/17) priorities for the Protection & Advocacy for Individuals with Mental Illness (PAIMI) program on the adjoining page. These priorities serve to focus the work of the agency and are developed by our Board and our advisory council, who get input from the community and staff.

Your input is appreciated! We strive to do as much as we can with the resources we have and we can do that best when folks in the community let us know their greatest advocacy needs!

We need volunteers, too!

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

Each applicant must identify with one of the following categories:

You are a psychiatric survivor

You are or have been a recipient of mental health services

You are a mental health professional

You are a mental health service provider

You are the parent of a minor child who has received or is receiving mental health services.

You are a family member of an individual who is or has been a recipient of mental health services

You are a lawyer

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

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

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

DISABILITY RIGHTS VERMONT FY'17 PAIMI PRIORITIES

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

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

Measure of Success:

- A. Work on a minimum of 100 cases of abuse, neglect, or serious rights violations of people with mental health issues. Among closed cases, at least 75% of those not withdrawn by client or found to be without merit by DRVT staff should be resolved favorably.
- B. In at least 2 opened cases, DRVT will advocate for adequate discharge of involuntary patients in the spirit of the community integration mandate of the Americans with Disabilities Act.
- C. DRVT will assist at least five clients to assure they receive appropriate medication, with informed consent and without coercion, and/or alternative treatment if that is their preference.
- D. Note whether the individual describes the issue as having occurred during a first contact with the mental health system because of the potential for coercion and trauma.

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

Measures of Success:

- A. Work with at least two institutions to create respectful, trauma-informed, violence free and coercion free mental health treatment environments.
- B. Conduct systemic advocacy in the legislature, and with the administration, to preserve or enhance the right of Vermonters to be free from coercion in their mental health treatment and to receive appropriate community-based services. Monitor whether the State adheres to due process required for involuntary treatment and to timelines within the Emergency Evaluation process.
- C. Work in at least one community to improve the system-wide response to mental health-related emergencies to prevent unnecessary use of force, involuntary treatment and incarceration.
- D. Monitor the implementation of standards for the use of Tasers (Act 180 of 2014) including the requirement for statistics on their use.
- E. Continue to monitor implementation of the settlement in our litigation regarding Adult Protective Services.
- F. DRVT will continue to offer Disability Etiquette trainings to emergency services providers and others requesting training, resources permitting.

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

Measures of Success:

Monitoring is conducted at a minimum of 10 community care homes (CCH), including but not limited to residential care homes, therapeutic community residences or licensed residential childcare facilities. Outreach visits, including distribution of DRVT literature & self-advocacy materials, are conducted at a minimum of 15 CCHs.

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

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

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

Outreach is conducted at least once at each Emergency Department of non-designated hospitals.

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

DRVT PAIMI Staff will receive training on cultural sensitivity to trauma and poverty.

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

Measure of Success:

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

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

Work with the administration, other advocacy groups and individuals to monitor the implementation of Act 79.

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

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

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

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

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

DRVT Staff will receive training in awareness of alternative treatment modalities available for individuals with psychiatric disabilities.

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

How can you make your voice heard?

Contact DRVT at: 141 Main Street, Suite 7, Montpelier, VT 05602

Or by phone: 1-800-834-7890 or, locally, at (802) 229-1355

By email at: info@disabilityrightsvt.org

Please visit our website at www.disabilityrightsvt.org

Resources Directory

Survivor Peer Services

Vermont Psychiatric Survivors Peer Support Groups

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

Call Sandra at 802-579-5937

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

Call UCS at 802-442-5491

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

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

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

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

www.vermontpsychiatricsurvivors.org

Peer Support

Warm Lines

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

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

Mutual Support Network

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

Crisis Respite

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

Vermont Psychiatric Survivors Outreach and Patient Representatives

802-775-6834 F: (802) 775-6823
info@vermontpsychiatricsurvivors.org

Peer Centers and Employment Support

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

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

Vermont Recovery Centers

www.vtrecoverynetwork.org

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

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

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

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

GaryD@turningpointcentervt.org or

<http://www.turningpointcentervt.org>

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

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

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

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

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

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

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

Counterpoint publishes this resource list to allow readers to seek out choices for support. Counterpoint has not reviewed or evaluated the quality or biases of these resources, and makes no representation about their value for any individual.

National Suicide Prevention Lifeline

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

Women's Holistic Outreach Learning Environment (W.H.O.L.E) peer support groups in Springfield for "women who struggle with mental, emotional, and behavioral health issues." Tuesdays from 7 to 8:30 p.m. at the Calvary Baptist Church, 156 Main St. Entrance at back on right side of building. More info at www.wholevpeb.com/

Pride Center of Vermont

LGBTQ Individuals with Disabilities
Social and Support Groups

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

Brain Injury Association

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

DBT Peer Group

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

Trans Crisis Hotline

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

Crisis Text Line

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

LGBTQ Youth Crisis Hotline:

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

NAMI Connections Support Groups

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

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

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

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

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

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

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

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

Veterans' Services:

www.vermontveteransservices.org

Homeless Program Coordinator: 802-742-3291

Brattleboro: Morningside 802-257-0066

Rutland: Open Door Mission 802-775-5661

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

Burlington: Waystation/Wilson 802-864-7402

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

Homeless?

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



www.MakeTheConnection.net

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

Vermont Veterans Outreach:

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

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

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

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

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

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

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

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

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

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

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

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

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

VA Mental Health Services

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

Mental Health Clinic: Ext 6132

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

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