



Equal Rights, Protection and Participation

The following is a list of recommendations and policy positions aimed at creating a more supportive environment within all systems of care and support for:

- 1). individuals who work directly in peer support roles or
- 2). identify as a consumer/survivor/peer or person with lived experience of being labeled with a psychiatric diagnosis.

We worked with our members and allies, while looking at data from around the country and came up with a series of positions and recommendations guided by advocacy goals. A brief description of some of those points follows. Vermont Psychiatric Survivors advocates:

1. Supporting the development of the peer center and respite proposal as submitted by the team of Alyssum, Another Way, VPS, and Pathways for six centers located in the largest population areas of the state. These centers would serve to provide access to peer and other services, provide safe spaces for social interaction, mutual support and respite helping to stem the tide of individuals returning to EDs due to lack of adequate community supports.
2. Supporting, encouraging and funding greater collaboration of psychiatric survivor communities with substance use communities in recognition of the large overlap of those with co-occurring diagnoses. This includes cross-training, resource development, and more coordinated services to those with co-occurring conditions.
3. Increasing the funding necessary to actually enable agencies to fulfill the mandate of Act 79 by focussing on the end goals of specific initiatives to create opportunities for more access to funding outside of DMH. For example, instead of asking for more money for training peers from DMH, we believe those funds should be considered as part of the state's ask for federal funding around education and workforce development. Budgets have been stagnant for years causing hard choices to be made about killing programs or losing people. Placing these requests in the departments that govern activity for non-peers illustrates the systemic disparity happening as a result of being treated as broken. Ex: training like IPS, WRAP, Hearing Voices, and Recovery Coach Training should be part of vocational rehabilitation programs for

peers/consumers/survivors who wish to return to work in the same way programs have been made available to those with physical challenges.

4. Investment in regular hearing sessions among consumers/peers/survivors and their support systems in the community to do some self-assessment on how DMH plans are having an impact on those using the system and their supporters. Nothing about us without us. Plans and evaluations of plans for peers are often done without querying those using services in any meaningful way. The information most often comes from advocates and service providers who each have their own agendas. Hearing sessions should be for end-users to express their experiences. To that end, we also advocate the creation of a more transparent system for peer organizations, designated agencies, and peers to engage in the mediation of conflict face to face which includes the input of those being served by both parties in disagreement, as well.
5. Legislation and regulation that aims to remove structural and systemic barriers to housing for people who live with mental health challenges including discrimination in placement for seniors in nursing homes, sheltering for the homeless and victims of domestic violence, and loss of housing as a result of psychiatric involvement of tenants.
6. Judicial recognition and support of Advance Directives when deciding on the forced treatment of individuals in crisis in the same manner directives are honored in other health-related situations.
7. The provision of a peer to act as a sort of guardian ad litem for all Out-Patient Hospitalization hearings who has had at least 48 hours of access to assist in organizing information and testimony.
8. Mandatory training of all first responders in how to manage mental health crisis situations, as well as any law that reduces the chances of fatal encounters with law enforcement.
9. Self-identified peer representation in the leadership of DMH at 20% within six years.

The ultimatum by the Brattleboro Retreat should give us all pause when considering the level of dependence that we have placed on psychiatric stays in all facilities versus community-based services. While there are individuals who do rise to the level of needing inpatient care, many could be better served in the community. With that idea in mind, Vermont Psychiatric Survivors would like to advocate for the following actions to be considered universally as conditions for continued funding to all hospitals who provide that care:

- That Olmstead rules regarding discharge be upheld. Whether a person has a place to go with a support system or they need supervision in a community setting that is less restrictive, they cannot be held like criminals in a correctional facility.

- That patients be included in treatment team decision-making processes as the law demands.
- That Grievances be treated in a formal manner with written replies, and that said grievances are made available to relevant parties via an online database. (Relevant parties which should have access would include Legislative Committees overseeing inpatient care facilities, DMH, DRVT, VPS, L&P, and APS.)
- That literature about civil rights and peer support resources available in the community be included in intake and discharge packets for all patients, and that said materials not be seized from patients or patient rooms.
- That a dedicated slot for community members unaffiliated with the facility be established in the employee orientation in order to introduce employees to the peer movement and the supporter role that advocates hold with that community.
- That an audit of staff training by DRVT or another disability rights organization be conducted on a yearly basis to ensure the staff trainings are non-prejudicial and endeavor to create trauma-informed employees.
- That all direct care staff receives regular training in the Six Core Strategies to Reduce Seclusion and Restraint.

The end goal of all of these recommendations is the support of peers services so it includes:

- empowering people to engage in meaningful work while being able to support themselves and their families;
- a greater voice of the marginalized in response to actions taken by the state and the agencies that are supposed to serve them;
- greater support for peer agencies against organizations who don't see their input as necessary or relevant to the bottom line
- access to training and certification as a means of vocational rehabilitation
- creating peer centers with respite beds to stem the flow of individuals to inpatient care

- expanding the net of peer services by engaging with other AHS areas serving communities with co-occurring issues
- realization of patient rights in an atmosphere that is supportive of (at minimum) shared decision making without threat or coercion in the least restrictive environments possible.

Thank you for the opportunity to share our thoughts.

In service to the Community,

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