Darby Penney

Memories

I was the Central New York (CNY) representative on Darby Penney's Recipient Affairs team from 1998 to 2004. One venture we shared began in New York City (NYC) with Howie the Harp and the Restraint and Seclusion Team for Office of Mental Health (OMH). When we entered my first meeting we were tasked with reducing the use of restraint and seclusion (R and S) in OMH facilities. By the end of this meeting the committee's agenda was changed to ELIMINATING the use of R and S in all NYS OMH facilities. Meetings continued in Albany with a wide range of OMH officials, Psych Center Directors and we three representing peers.

Grace McNassar, a registered Nurse at Mohawk Valley Psych Center was moving into a restraint and seclusion free facility and was moving toward that goal with detailed reviews of each incident with the person involved, staff, advocates and anyone the individual chose. She invited me into the meetings to share a recipient point of view.

As the OMH committee was moving towards a report of their recommendations the meeting was challenged by a psychiatrist who led a Forensic Facility downstate. He declared that it was impossible to eliminate R and S because his facility housed the very worst violent patients in our state. He confirmed that statement by remarking that anytime a 'prominent' psychiatrist or forensic specialist visited NYC, he would engage them in reviewing the approaches they had established for people committed to his facility.

I asked if he had ever invited a peer to review and comment on their practices and he restated that they always sought the most prominent professionals in psychiatry. He admitted that no peers were among the reviewers. I asked if he would be willing to try this and Darby looked at me with her big question mark face and when I nodded yes, Darby smiled her incredible smile and asked how we would set up such a 'consultation'. She

made a public offer that he couldn't refuse, though his face indicated a frustrated smirk.

A month or so later as we followed up with the offer, the Psychiatrist said he would forward the records of the 'worst' patients in his 'care' to me in advance of a visit. With Darby's support, we got to refuse the records at least until we could have a meeting at his facility. By the time I arrived at the Psych Center, I was met by this psychiatrist and informed that I would only need to review one person who, by all staff and consultants, was considered the 'worst' and most violent patient in the state of NY.

I went through the personal search process and then into the courtyard of the facility. Several patients came up to this psychiatrist, Dr. S, and some literally begged for his consideration of their discharge. It was quite evident that he was in control of all. We then went through another locked door, a locked elevator and then a long hallway and into a large meeting room with people sitting around a large table and a second row behind them. Dr. S had told me that he was not able to remain but these staff had all known the patient we were to speak about. I was not allowed to meet with the patient until I had been briefed by all relevant staff. We moved to a presentation of his Social History, Medication History, Psychiatric History, Physical History and various other information the group deemed necessary for me to understand what a challenge he was.

For confidentiality, I will refer to him as Michael. He was a young man in his late 20s from the local area of the hospital. His family was known to many of the staff and his Mother had maintained contact with him as had his siblings and nieces and nephews. He had been relating to the relatives that he had known prior to his incarceration but refused to acknowledge any nieces or nephews who were born afterward. His siblings were visiting very little as this was so frustrating to them that he would not speak with any of the newer family members.

When he was a teenager, he had been missing from home for a while and was discovered in a local 'garage' owned by a man unknown to the family. He had

also been in a car accident and sustained 'minor' injuries including to his head. He later was enrolled in a local Junior College. They shared his gigantic list of drugs, none of which had proven to be helpful according to the staff. Also shock, known by some as 'ECT' had not been successful in modifying his behavior.

In the facility he had had the highest number of staff injuries of anyone (they said statewide) else. Many of the injuries were to men who had some hint of being gay (an earring, way of speaking or characteristic.) He had also had the distinction of putting the largest number of staff out on disability, many permanently. He was scheduled to go swimming and playing basketball though he generally landed in video monitored seclusion and missed his physical exercises. Michael would do pushups and personal workouts in the seclusion cell. He also read the paper daily, especially the sports section. He was being given Psychological testing via a computer. He rarely disrupted things, only staff.

After about an hour of briefing for me on all of his problems and their responses, he was allowed to enter the room with two very large staff on either side of him. He was clearly well drugged and sat facing me on the side of the table. He was spitting as he spoke apparently due to heavy psychiatric drugs. He said to me that I was fat and obviously cut myself judging from the scars on my arms. I acknowledged these facts and then his attention turned to the psychologist who was giving him the psychological testing and asked if he could be discharged if he 'passed' the tests. The psychologist said they would speak about that at a different time. At that point I realized that Dr. S was sitting in the back row fairly crouched down though Michael spotted him. Michael also asked Dr. S if he could get out if he 'passed' the testing. Dr. S nodded to wait for that discussion. Michael then closed his eyes, put his head on the table and went to sleep.

Michael was taken out of the room and I was left with the table of staff. I asked questions and the psychiatrist who was designated as the person in charge of converting services to 'trauma informed care'. She said that she

now could see that Michael was a trauma survivor. She was surprised that as his primary psychiatrist at that time, she had not considered the possibility of his being a trauma survivor. I asked questions as to what they knew about his being found in a man's garage. Was it possible that he was abused by that man? Did anyone know what happened to him when he was missing? His psychiatric issues emerged not too long after he was discovered in that garage. Also with what little I knew about brain injuries, staff filled in some blanks about his non recognition of relatives born after his accident and body and head injury. I had known several brain injury survivors who were not able to fully incorporate new information after sustaining their brain injuries. Also we spoke about the fact that he was fairly consistent in losing access to the facility's 'recreation' opportunities but rather kept strong and threatening to staff by working out in seclusion. Since he rarely damaged things, only people, was there a way they could have him work on computer activities rather than his dreadful life offering no positive outlets for his life energies. His lack of a positive response to the psychiatric meds they had tried endlessly as well as shock treatments may be an indication that they were imposed on a person with a brain injury offering less than the desired effect staff sought. The conversation was painful and lengthy and in the end the staff remaining (Dr. S had left the room) asked if I would meet with the Mother and family and share my thoughts. It was clear to me their responsibility to see his potential without the blinders of his being the worst!!! Michael's attorney contacted me much later to discuss ways of being helpful to Michael.

Dr. S and his comrades took me to dinner and affirmed that each area we had discussed staff had felt had merit and they would be following up with a new perspective on their work with Michael. He also shared with Darby later that he still would need to maintain a facility practicing restraint and seclusion because they needed it for protection!!!

Darby continued to support the efforts at Mohawk Valley and was able to use this meeting as a reason to have peers involved in all aspects of OMH. The Commissioner agreed and Dr. S found himself too busy to attend the

rest of the deliberations! Others around the state followed up and peers were included in many incident reviews in order to keep a human perspective in the clinical reviews.

Darby led the pathways for psychiatric survivors to have all in roads possible in affecting what happened in state psychiatric facilities. She was under no pretense that the change was permanent but continued to open doors for peers to influence positive change while she was Director of Recipient Affairs in OMH.

It was such an honor to be challenged by her tenacity to move into worlds that influenced all of us who had the designation of a consumer/survivor/ex-patient in New York State.