Strip Searches: Going Too Far?

by ANNE DONAHUE
Counterpoint News Analysis

RUTLAND — The new policy was only in effect for a few weeks.

Mandatory full body searches for every person being admitted to the psychiatric unit at Rutland Regional Medical Center were discontinued. Under the new safety search policy, a patient removes all clothing behind a curtain so that the clothing can be searched. Only a specific risk of harm in an individual circumstance might lead to a full body search.

However, the fact that the hospital believed, even briefly, that it was required to use strip searches to meet a "zero tolerance" for risk by federal regulators has brought new attention to the impact federal regulations are having on inpatient psychiatric care in Vermont.

Policies on searches at admission have varied widely, apparently based upon whether a deficiency finding for a risk of contraband on the unit has occurred under federal regulations.

A full body search at admission had also been being required at the Brattleboro Retreat, while pat searches without disrobing is the practice at Vermont's other four psychiatric facilities.

The Department of Mental Health is also blaming the way federal regulations are being applied as at least part of the reason that the Vermont State Hospital was rejected in its latest attempt at certification. The issue there included policies on searches after contraband was found in a patient's room. *(See article,below and page 11.)*

Commissioner Michael Hartman said that community hospitals are reluctant to accept seriously ill patients out of fear of demands by regulators, therefore putting more pressure on the census at VSH.

DMH is lobbying with officials at the national level to evaluate how regulations are applied to be consistent with evidence-based quality of care standards. However it would be "putting them [local hospitals] in an impossible situation" if DMH required patient privacy protections that were not acceptable to the Centers for Medicare and Medicaid Services, Hartman said.

The department is in a better position to "have it out" with CMS to challenge the way the regulations are being interpreted, he said.

Regional leaders of the federal Centers for Medicare and Medicaid Services (CMS) and the director of the state arm of CMS have completely denied any changes in how rules are interpreted or applied.

Vermont's hospitals believe that the interpretation of regulations is highly subjective depending upon the reviewers.

Full article, interviews, on pages 4-5.

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

Counterpoint

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Feds Deny Inappropriate Standards

by ANNE DONAHUE
Counterpoint

BOSTON – The branch manager for the Center for Medicare and Medicaid Services says it is the evidence of failure of the Vermont State Hospital to overcome a past history of inadequate patient supervision – not isolated new deficiencies alone – that continues to block certification.

It is the first time CMS has said publicly that its denials are related directly to the problems that led to two suicides in 2004, rather than based solely on the current status of the hospital. None of the reports issued by CMS has identified that connection.

Department of Mental Health Commissioner Michael Hartman said the closest reference did not come from Shaw or local officials, but when Randy Ferris, MD, the national consortium director "intimated the history" was part of the denial in a recent conversation.

Richard Shaw, director of Certification and Enforcement for the regional office, also said he did not understand how Rutland Regional Medical Center "came to (the) perception" that highly invasive searches at admission were necessary in order to provide an adequate plan of correction for a deficiency. The hospital's CEO has said that the hospital was acting on what seemed to be a "fairly clear" message by the surveyors at the time.

Shaw agreed that too broad an interpretation of the requirement for a "safe environment" could violate the CMS regulation on the right to patient privacy, as well as the guideline that a safe environment includes emotional health and safety. "I think I'd probably agree with that concern...that that can happen," he said. In such an instance, a plan of correction could be rejected, he said.

He said he could not speak to details regarding the original Rutland policy without having the plan of correction in front of him.

However, CMS only expects that a hospital respond to a deficiency by demonstrating that "yes, you developed a plan, and yes, you implemented it." That plan should be developed within the context of the "current standards of practice" referenced in the regulations.

"Surveyors don't make the judgment" about those standards; they cite incidents that indicate that the hospital "does not have a system to address protection of individuals" for the circumstance in question, he said.

Hartman said that the CMS "enforcement of absolute standards" was making psychiatric facilities in the state fear admitting the highest risk patients, contributing to the high census being experienced at VSH. He made a parallel to the issues that were being cited to deny certification to VSH.

Shaw responded that "his perceptions are his perceptions" and refused further comment. He did add, however, that in the most recent site visit to VSH, a surveyor from the federal office "who didn't have the history" with VSH was added to the team to provide "another layer of objectivity." That reviewer had general and psychiatric hospital experience and concurred in the assessment, he said.

The latest report "in itself doesn't read" as though the circumstances were extreme, but must be taken within the full context of the history since 2004, he said. Shaw discussed the state hospital circumstances in detail, and said that VSH was in a unique status be-

(Continued on page 3)

SPROUTING MUSHROOMS — The field at Lake Elfin in Wallingford sprouted a colony of tents that could have been mistaken for mushrooms after the lack of a main lodge added a more rustic element to the annual consumer campout this August. For more photos, see page 10. (Counterpoint Photo: Jean New)

Dartmouth Joins Hospital Proposals

BURLINGTON — Four groups have joined Rutland Regional Medical Center in expressing interest in developing replacements for the inpatient care currently provided at the Vermont State Hospital.

The Brattleboro Retreat had already submitted a written proposal for a 16-bed unit this past spring. The Department of Psychiatry at Dartmouth Medical School of Hanover, New Hampshire, Fletcher Allen Health Care, and Springfield Hospital also turned in responses to the state.

The interest by Dartmouth Medical School expressed in a written proposal was a new development. It proposes running a psychiatric service of 15 to 20 beds, potentially located at the Verteran's Administration hospital in White River Junction.

It's about

YOU

You are needed. These groups need consumer involvement!

Peer Support Leaders

The Depression and Bipolar Support Alliance made the following announcement looking for peer leaders to start new support groups in Vermont:

"Have you ever thought about the power of using your life experience to help others living with depression or bipolar disorder? The Depression and Bipolar Support Alliance makes peer-led support groups available through local chapters to provide people living with mood disorders, and their families, a place to find comfort and connections in a confidential, supportive, positive community. With almost 1,000 DBSA support groups across the country, there are still areas and people that are not being served.

"The first step in starting your support group is to request a free copy of the DBSA start-up materials at www.DBSAlliance.org/sugrequest. If you have questions about leading a peer support group in your community, contact Mary Mischka Dean, Chapter Recruitment Coordinator, at (800) 826-3632 x154 or startup@DBSAlliance.org.

"No special training is required to lead a DBSA group. All you need is a desire to give back, a commitment to helping your peers work toward wellness, and the knowledge that recovery is possible."

Boards and Committees

Statewide Program Standing Committee for Adult Mental Health: The advisory committee of consumers, family members, and providers for the adult mental health system. Second Monday of each month, 1-4:30 p.m.; Stanley Hall, State Office Complex, Waterbury. Stipend and mileage available. Applicants from the Northeast Kingdom, Addison, Orange, Lamoille and Chittenden County are encouraged to apply. Contact the Department of Mental Health for more information.

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

Vermont State Hospital Advisory Council: The advisory group to the state hospital; third Wednesday of each month, 1:30-3:30 p.m. ; VSH, Waterbury.

Transformation Council: Advisory committee to the Mental Health Commissioner on transforming the mental health system. Fourth Monday of each month;.Stanley Hall, State Office Complex, Waterbury, unless otherwise posted

Consumer organization boards:

Vermont Psychiatric Survivors
Contact Linda Corey (1-800-564-2106)
*Counterpoint Editorial Boar*d
Contact counterp@tds.net

NAMI-VT Board of Directors: Providing "support, education and advocacy for Vermonters affected by mental illness," seeks "motivated individuals dedicated to improving the lives of mental health consumers, their family and friends." Contact Marie Luhr, mariel@gmavt.net, (802) 425-2614 or Connie Stabler, stabler@myfairpoint.net, (802) 852-9283.

Hospital Advisory Groups

Rutland Regional Medical Center
Community Advisory Committee, Monthly meeting, fourth Mondays, noon; September 28; October 26; November 23; December 28.

Fletcher Allen Health Care
Program Quality Committee, Monthly meeting, McClain Rm 601A; third Tuesdays, 9-11 a.m., September 15; October 20; November 17; December 15.

Two Inmates Die; Had Mental Health Issues

BURLINGTON — A 50-year-old man with a history of substance abuse died in the Chittenden Regional Correctional Facility and a 23-year-old woman suffering from anorexia died in the Northwest Regional Correctional Facility in August.

The deaths, which occured 10 days apart, are under investigation by the Department of Corrections and by Vermont Protection and Advocacy. At a meeting of the joint legislative Mental Health Oversight Committee, DOC Commissioner Andrew Pallito said it was too early to make any assumptions about why the deaths occurred. Foul play is not suspected.

Michael T. "Bing" Crosby, 49, of Burlington had voluntarily turned himself in for possible probation violations and had only been in jail for about 11 hours, according to media reports. He was found unresponsive while he was on 15-minute checks under a department protocol for handling recently arrived prisoners who have a history of substance abuse.

Ashley Ellis, 23, of Castleton, died August 16, three days after she reported to the women's prison in St. Albans to begin serving a 30-day sentence for negligent operation of an automobile. Media reports said she had been recently under treatment for an eating disorder and had been in and out of the hospital four or five times in the prior six months. She was reported to have been on several medications, but had not yet been evaluated and was not provided her medications.

Pallito warned against drawing conclusions from media reports. AD

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Shared Safety Culture Is VSH Aim

WATERBURY – Efforts to change the environment at the Vermont State Hospital are now ranging from very concrete — creating "comfort rooms"— to more philosophical — discussion groups with staff and patients "to promote a shared culture of safety and respect."

In addition, a new staff training program has been selected to focus on empowering staff to prevent violence, and the hospital's executive team is becoming directly connected by phone every time an incident of restraint or seclusion has occurred.

Finding Comfort

Participants in planning meetings say it is not clear yet how comfort rooms can best be used, or even where space can be found for them. "Comfort rooms are a great idea. Where they go, I don't more grounded in your body," guest speaker Tina Champagne explained to the Seclusion and Restraint Reduction Intervention Advisory Council.

The Council is the steering group for a grant from the federal government to reduce the use of restraint and seclusion.

The Council grappled with what should come first: finding space within the hospital to design comfort rooms for each unit, or having a clearer understanding for how they might best be used.

"What are the different attributes or considerations" for selecting space that would be most useful? asked Ed Riddell, the grant coordinator.

"I don't know what's possible [as space options] because I don't know what's possible [for meeting needs]," said Anne Jerman, Nursing Director.

Champagne said it was important to know "what is doable" – whether space exists – before worrying too much about the way it might be used.

Fully understanding the science of what is called "sensory modulation" should not "paralyze the process" of moving forward, she said. Spaces that might not be optimal – even a small, converted office – can still be made into a friendly, comforting space.

The process of planning the use and equipping the space helps create the "shift in the mind set" to be more aware of sensory effects, she said.

Riddell wondered what the difference was, then, between a comfort room or a patient room that was comfortable. "Why aren't there 54 comfort rooms?" he asked.

"Exactly," Champagne said. "Why don't we make the whole unit more sensory-friendly?" Over time, she said, that was exactly the way a unit should evolve.

"Every time you do any kind of a renovation," the question should be, "which moves can we make now?" to create a better environment, she said. "Maybe the next time you order furniture."

The understanding of sensory modulation "must seep into the treatment planning process." The comfort room is "just one component" of a full environment.

"It's a focused project to help you go there...to help you shift your culture," she said. "Sensory modulation has huge implications across mental health."

On Call by Phone

The executive team at VSH is now responding in "real time" to follow up with incidents of restraint or seclusion, Terry Rowe, Executive Director at VSH, explained, meaning that review did not wait for a records review days or weeks later.

Leadership team members, taking "on call" turns covering 24 hours a day, hold a "structured interview" by phone about what happened, so that "staff and patient know of the concern for them."

The administration is thus "becoming fully acquainted with what is going on on the unit," she said. "These phone calls can amplify and emphasize" the efforts being made within the hospital, Rowe said at another meeting.

Violence Prevention

Jerman reported on progress with the anti-violence initiative at a meeting of the VSH Steering Committee.

"Violence prevention community meetings" are now a "well established routine" on all three units, she said, although "how the meetings flow is very different on all units."

She said she was "more pleased that ever" with how the meetings were going and with the visible behavior changes as an outcome.

The focus of the meetings is "what contributes to violence" and "what are the consequences on the unit?" for others – such as broken equipment, which everyone loses the use of.

A newsletter reported that goals of the program include "to promote a shared culture of safety and respect among patients and nursing staff" and "freedom for patients and staff from being targets, perpetrators or witnesses of verbal or physical violence."

In addition, open communication with patients and staff in meetings provides "alternative strategies for expressing anger and frustration and for giving directions and setting limits," and "patients and staff are encouraged to avoid or interrupt angry escalations" on the unit. AD

Feds Deny Inappropriate Standards In Psychiatric Regulatory Reviews

(Continued from page 1)

cause it had been terminated from CMS certification, and is now seeking to have approval for federal reimbursement restored.

"This type of facility doesn't have the appeal rights of a new facility" that is seeking certification he said. Instead, it has the burden of showing it has "removed the causes of the termination" – in this case, the failure to supervise patients properly to prevent harm.

"We have had the conversation" to explain this context to the hospital's administration, he said.

The newest survey report released on August 17 critiqued the record of the internal follow-up after an incident in which a patient was able to horde medications and other supplies in his room. The items were found in a room search for a wall sign that could have been used to cause harm; staff had noticed that it was missing.

Hartman said it was a type of incident that no hospital could prevent absolutely, and that if this were the standard CMS intended to use, it would never be possible to meet. Hartman has described the CMS position as appearing to expect that hospitals should be "guaranteeing that patients don't have anything dangerous" – which would require almost constant searches – while VSH policies were based upon believing the protection of rights requires "some kind of just cause" for searches.

He said when he once told CMS officials he had heard that a predecessor in his position was told that "we would never get recertified," they were offended at the suggestion. However, "it looks like lots of evidence" support that VSH is being singled out to a higher expectation than the quality at the "point in time" of a review as is usually applied.

"This is consistent with how they have become much more unreasonable in how they approach" psychiatric hospitals in general, he said.

Hartman said that the presence of an "observer of the [local] surveyors" from a federal CMS office to verify that they were doing their job appropriately did not give him any confidence that it would be more objective.

He also said that hospitals in other states that had problems "at least as serious" or more so than VSH have been able to continue to be certified. This denial was "based on VSH records of a single episode of care."

If CMS asserts that this is the regulatory standard for a hospital to regain certification, then "I don't think this is the way... to get collaboration to improve care," he said. He noted all that VSH has done, including doubling its operating budget, and the fact that other outside agencies have found that VSH is now operating at a "mid-range or higher" in quality.

"It seems self-defeating" if CMS when CMS denies even the opportunity for a plan of correction, he said.

Shaw acknowledged that the particular individual in the situation was not a high-risk patient, nor was there harm to anyone as a result, but that was "not because of the hospital's planning," which was what was deficient, he said.

The patient had been exempted from the usual level of scrutiny for room inspections, which showed a failure to have a uniform system in place for protection against harm, Shaw added.

"This is the reason they were terminated" originally, and thus directly addressed whether the systems for patient supervision were still inadequate.

Shaw emphasized the history of VSH since a patient suicide in 2004.

The hospital knew the patient was at high risk "and failed to supervise and the patient died."

While the plan of correction was still underway, another suicide occurred when a staff person stepped away from monitoring a high risk individual, and that patient died, again as a result of "a failure to properly supervise a patient of extreme risk."

VSH was able to regain certification. Then a person who had just left the hospital committed suicide. In that case VSH was not found to be at fault, although there could have been greater care in assessment, he said.

Subsequently, a patient at known risk who was under the supervision of two staff members being escorted to an off-site medical appointment was able to abscond.

"Now we were back to the exact same situation."

After new safety deficiencies identified last fall, CMS, "though [it was] not required" under the federal process, eventually permitted VSH to submit a plan of correction.

The return visit to review implementation of the plan this summer led to the finding of a continuing lack of an adequate system to protect patients from harm, Shaw said.

See pages 4 and 5 for more news on the debate with CMS, and page 11 on the VSH review.

Strip Searches:

CMS Doesn't See a Problem In How It Applies Right to Safe Setting

WATERBURY — "The standard for a hospital in terms of surveys is that a patient is going to receive safe care." That is the essense of the federal regulation that has been the focus of growing controversy in Vermont over the past several years, according to Frances Keeler, Director of the state's Division of Licensing and Protection.

Psychiatric inpatient units, in particular, have appeared to many observers to be the target of more rigid standards for physical safety, such as the prevention of contraband, regardless of the impact on privacy of patients. The strip-search policy for all new admissions that was temporarily in place in Rutland brought wider attention to the issue.

"There's been no change," Keeler said bluntly at a hearing of the Mental Health Oversight Committee that focused on the regulations from the Centers for Medicare and Medicaid Services. CMS is a federal agency, and remaining in compliance with regulations in all areas is essential for a hospital to receive its federal funds. However, hospital evaluations and investigation of complaints are carried out through state agencies that act on CMS' behalf.

Keeler testified that all surveyors undergo the same training, and "I have not detected a difference" in interpretations used in different regions of the country. She said in an interview that medical standards themselves — for instance, about what is considered "safe" — may change or differ based upon the medical specialty involved, but the core standard is that the "environment should be inherently safe." It "should not rely on humans" with the chance of human error, such as in relying on supervision, instead of safe equipment, to prevent injury, she said.

When it comes to certification of psychiatric care, two standards are involved: first, the general hospital quality standards; second, those involving psychiatric-specific issues. The state surveyors do review only for hospital-wide standards; they are "not qualified" for the regulations related to psychiatric care, she said. However, the psychiatric care regulations address records and staffing — they do not address any issues about what a safe psychiatric care environment is, Keeler agreed.

"If we were conducting a survey, we do have access to CMS for consultation in terms of some of the specialty areas" such as psychiatry, she said, but "not in an organized way."

A CMS spokesman for the Northeast region agreed with Keeler's overview.

Safety is primary and applies to all inpatient care, Keeler went on to say, but for any policy "there has to be some reason to expect that there's a concern." For example, a setting must exist in which, "unless we ensure (against) contraband, that there's a risk." If a person coming in for an X-ray were strip-searched, "that would be totally inappropriate."

"Unless the hospital has some reason to believe" a danger exists, such as if there is "reason to believe [a patient is] suicidal or homicidal" it could not set such a policy. Would that mean it would be reasonable for all psychiatric admissions to be strip-searched? "I'm not saying that would be," Keeler said, declining to answer hypothetical questions.

The strip-search policy at Rutland Regional Medical Center "was not put in the plan of correction that my office approved," Keeler said, apparently having not observed the search descriptions in that document. The plan of correction listed as one policy change to address a violation that "Staff will complete a visual inspection of the patient's skin to ensure that they have nothing taped or hidden on their body. The patient will be asked to raise their arms and turn around. Staff will check under skin folds."

The plan accepted by Licensing and Protection did not include another section of the policy , also later removed, that said patients who refused to comply might have their body involuntarily searched or might be discharged.

Reviewing the federal guidance on the regulation, Keeler pointed out that there was a regulation requiring protection of a patient's right of privacy, as well as right to safety.

"It appears to be saying that there has to be imminent and serious risk of harm...to limit a right of privacy," she observed while reviewing it. She also noted that the regulatory guidance said that a safe environment includes the right to "respect and comfort."

Keeler told legislators that the division was always available to offer technical assistance on "what a regulation requires" if a hospital requests it, even during the course of correcting violations.

> *"Staff will complete a visual inspection of the patient's skin to ensure that they have nothing taped or hidden on their body. The patient will be asked to raise their arms and turn around. Staff will check under skin folds."*
>
> *Original Rutland hospital policy for all psychistric admissions in its plan of correction to CMS.*

Rutland Hospital Felt No Other Choice Was Left

RUTLAND — Rutland Regional Medical Center's Psychiatric Care Unit felt it had few options about a search policy that required all new admissions to remove clothing for a full body search for contraband, officials there said. It was later revised.

"The level of review and scrutiny have increased in a fairly dramatic way" and the way CMS deals with psychiatric services "is the most problematic" and is based upon a "deep misunderstanding of psychiatry," Chief Executive Officer Tom Huenber told state legislators.

CMS is taking the same medical issue of "perfect safety," but the "black and white" criterion "is not the real world," he said. The policy as first drafted was in response to violations in patient safety that CMS cited when a patient was able to access a cigarette lighter and other contraband from her purse, which had been left unattended at the nursing station.

The Rutland facility's experience regarding the review that led to the strip search policy was different from what occurred earlier in 2009 at Central Vermont Medical Center.

CVMC debated surveyors and pressed for where the evidence-based research for risk was, apart from just a "sense that it could happen." CMS "backed off" a demand for replacement of all patient beds after being shown a national facility guidance handbook, said Jim Tautfest, the unit's nurse manager.

In contrast, according to Chief Executive Officer Thomas Huebner, the reviewers in Rutland "were fairly clear about what they expected of us" and there did not appear to be any room for discussion on the search issue.

After input from its community advisory committee, the policy was changed to remove the visual body inspection. It was replaced by a requirement that patients remove all clothing behind a curtain while the items they are wearing are searched. Some patients do not have clothing returned, but are required to wear "hospital garb" instead.

When told that this policy remains more invasive than any other Vermont hospital, Huebner said RRMC was working with the Department of Mental Health's initiative to identify a statewide policy. "We don't want to be an outlier...that's not our goal," Huebner said.

Across the State: Current Search Policies

Vermont State Hospital: "Staff shall conduct a pat search of all patients at the time of admission...staff will require the patient to turn in his or her personal belongings and inventory those belongings." A strip search requires authorization by the Executive Director and Medical Director, and "must be based on reasonable suspicion that the patient is in possession of contraband that poses a risk of harm to the patient or others."

Fletcher Allen Health Care: At admission, nursing "will inspect the patient's belongings thoroughly" and will check "pockets, beltline, shoes." Search of patient's body "may be conducted when there is reasonable suspicion that a patient is in possession of contraband which could present a danger to the health or safety of that patient or other patients or persons in the hospital."

Brattleboro Retreat: "On admission, a person's body, belongings and clothing will be checked for contraband items... Each patient's body will be visually inspected for contraband." *[See article, page 5, on revisions to policy.]*

Central Vermont Medical Center: "All patients and their belongings will be searched upon admission," search includes "all the patient's bags, purses, pockets, cuffs of pants and person," which does not include a body search. Body search or use of metal detector (as less invasive process) could occur, but only if specific individual risk is identified.

Windham Center (Springfield Hospital): "On admission, a patient's belongings and person are checked for contraband items... A 'person check' for contraband items will entail patient turning pockets inside out and removal of shoes and socks." Nursing assessment, if "clinically appropriate," including specific safety concerns, may include a "body map" (defined as full medical skin assessment.)

Rutland Regional Medical Center: On admission, all belongings are either searched or secured in a place without patient access. Patients must remove clothing behind curtain so that all clothing can be searched; clothing then returned unless individualized risk assessment indicates need for patient to wear hospital garb. Full body search limited to individualized assessment.

Going Too Far for Safety Needs?

State To Seek Privacy Balance And Push Back on Federal Regulators

MONTPELIER — It is the state that will have to continue to press for a more reasonable balance between "a person's integrity" and a federal standard requiring an absolute level of safety, the Department of Mental Health's Commissioner, Michael Hartman, told legislators in late August.

Hartman also said the department will also lead an initiative to identify an appropriate clinical standard for searches in Vermont.

The department is in the best position to "have it out" with federal regulators because individual hospitals have too much at risk — their entire federal funding share — if they challenge what CMS requires.

"We can't reasonably tell a hospital 'don't listen to CMS,'" he told legislators at an earlier meeting.

It "has come up as a huge conflict," he said. There is a "never event atmosphere" regarding risks that demands the "least amount of risk when they (patients) come into the hospital." A "never event" is something that health care standards identify as a negative outcome that "shouldn't be able to happen" in a hospital.

"Clinical judgment [in psychiatry] is actually being put aside in favor of broad and absolute rules," Hartman said. "Engagement of the patient has been replaced" by criteria for the physical environment that are "sterile" and "anti-patient centered."

Hartman said the negative consequences of the clear change in the CMS approach regarding risks in psychiatric units has contributed to blocking certification of the Vermont State Hospital. *(See details, page 9.)*

The costs and the liability are also "definitely putting a chilling effect on willingness" by hospitals in the community to accept higher risk patients; this means more referrals to VSH and stress on its capacity, he said.

Since a high in 2005, the percentage of persons being involuntarily hospitalized who were admitted to a community hospital under state authority has dropped every year. It was 70 percent in 2005 and 55 percent in 2009.

The state is beginning work on a statewide policy regarding searches, something that may help in demonstrating an appropriate standard to CMS. "It would be better if we could be doing the same thing" among Vermont hospitals, he said.

That work will attempt to look for a unified baseline" of "how far short of a complete body search" would meet CMS standards. Hartman said his hope would be that a dialogue with CMS regulators in Vermont would result in agreement on what is appropriate.

Hartman said Vermont's Congressional delegation has also been approached about the problem. Hartman said he told them that "this is not promoting quality;" it is not taking accont of patient needs. "That's not a good environment for quality health care."

Newer standards are based on the medical field, with ignorance of psychiatry in terms of how it may differ, he told legislators. Applying the same type of standard is "taking away the treatment environment that is based on engagement" with patients. If you do some of the steps required, you create "an environment that pushes people away" from care.

In a dialogue with the advisory Transformation Council, Hartman said the issue had become, "How do you 100 percent guarantee" that no one will ever be in possession of something hazardous? He asked for input on how prevention of contraband could be improved upon in the most respectful way for patients.

> *"Our work requires us to understand that the absolute prevention of suicide would necessitate removing privacy and personal freedoms, and this must be balanced against the goals of fostering independence and recovery."*
>
> *Brattleboro Retreat CEO Rob Simpsonin a 2007 statement after the suicide of a patient.*

That discussion was focused on VSH as a result of the CMS refusal to certify the hospital after learning that a patient had been able to horde medication and other items in his room. The only way to have prevented it would be to require constant searches without cause, he said.

"Zero risk does not exist," Nick Emlen of the Vermont Council of Developmental and Mental Health Services responded. He pointed out that there are diminishing returns for safety efforts that aim for such an impossible standard, while the "curve of greater personal intrusion" that go with such measures is steep. A policy "that attempts to approach zero risk wreaks havoc on clinical goals."

Articles by Anne Donahue, Counterpoint.

Retreat To Reshape Its Current Practice

BRATTLEBORO — The Brattleboro Retreat intends to revise its current contraband policy after a review spurred by the controversy over searches, a spokesman has confirmed.

Last year the Retreat was cited by CMS after several high-risk incidents involving contraband. The existing policy requires that "each patient's body will be visually inspected for contraband" in a search taking place at the same time as an admission medical exam.

The Retreat said that it had intended to minimize the invasion of privacy by having the medical exam conducted at the point of admission rather than later the first day. By including the safety search during that exam, patients would only need to expose their body once.

The routine physical itself, however, would expose any hazardous items, Retreat officials recognized during a discussion of the policy in late August. As a result, there is no need to have any body search conducted to scrutinize patients for contraband. Disrobing for the purpose of a physical is very different than being searched, they agreed.

The new policy will remove the patient body search requirement entirely. Search requirements for belongings, and handling of contraband found under any circumstances, will remain the same. Medical care such as the physical is always subject to consent, the Retreat noted. The policy is that a patient refusing an exam is monitored and his or her physician is involved in encouraging collaboration.

Advocates and Providers Are Stunned by Policy

RUTLAND — While reactions to a requirement for an unclothed visual body search for all patients being admitted to the Rutland Regional Medical Center's psychiatric unit have differed in focus, all reflected a continuing concern even after the policy was revised. For many, the issue is the perceived pressure from federal regulators, and how much it may continue to deter quality care.

"That horrifies me" to think that federal safety regulations could push a hospital to such an extreme, said Kathleen McCann, RN, PhD, Director of Clinical and Regulatory Affairs at the National Association of Psychiatric Health Systems in Washington, D.C. "That's quite a way to start a therapeutic relationship." Her group specializes in standards for safe facilities.

"I would just hate to see the tide turn" against progress on patient-centered care, McCann said. "The safe environment *is* the therapeutic relationship between patient and doctor...that's where the only safety is."

Current requirements by CMS are "draconian" when they result in such policies, Springfield Hospital's CEO, Glen Cordner, told a legislative committee. "This is outrageous."

Linda Corey, Executive Director of Vermont Psychiatric Survivors, pointed out that "we talk about the idea of people being willing to accept mental health treatment," but violating trust is not likely to encourage individuals to seek help. Such policies are "very degrading and traumatic," she said, and it perpetuates the stigma that "they must be a criminal if they have a psych issue."

Jack McCullough of Vermont Legal Aid's Mental Health Law Project was more directly critical of the hospital itself. He said that "even though they have apparently backed down on the most abusive characteristics of this policy, it calls into question not only whether Vermont should look to Rutland as a site for a new inpatient unit, but whether they are qualified by attitude and values to provide any inpatient psychiatric treatment."

CMS Regulations: What They Actually Say

The patient has the right to personal privacy. *Interpretive Guidelines:* A patient's right to privacy *may be limited* in situations where a person must be continuously observed, such as when restrained or in seclusion *when immediate and serious risk to harm self* (such as when the patient is under suicide precautions or special observation status) *or others exists.*

The patient has the right to receive care in a safe setting. *Interpretive Guidelines:*The intention of this requirement is to specify that each patient receives care in an environment that a reasonable person would consider to be safe. For example, hospital staff should follow current standards of practice for patient environmental safety, infection control, and security. *The hospital must protect vulnerable patients*, including newborns and children. Additionally this standard is intended to provide *protection for the patient's emotional health and safety as well as his/her physical safety.* Respect, dignity and comfort would be components of an emotionally safe environment. *[Emphasis is added under both regulations.]*

More Private Information Sharing Is Discussed as a Consumer Benefit

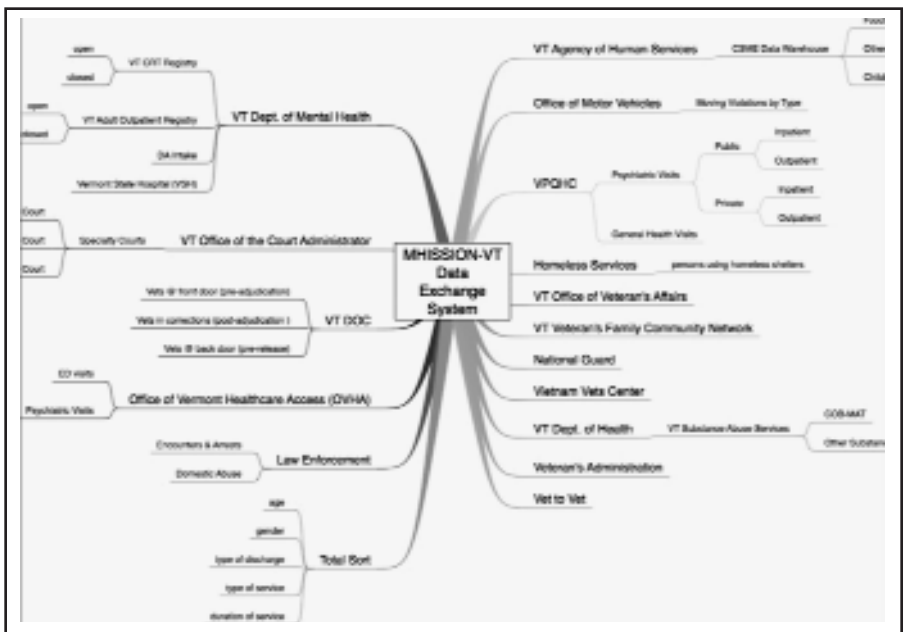
By ANNE DONAHUE
Counterpoint

MONTPELIER – Exchanging data about individuals from different records in the system is the essential communication link to help divert persons with mental illnesses from the criminal justice system into treatment, according to members of a task force organized by the state's Chief Justice.

Its importance was also pointed out in work being done in several projects that are already underway and were presented to the task force at its summer meeting.

"Information sharing is the linchpin" of a reform to the system that "applies the evidence of behavioral health science to the practice of justice decision-making," Chief Justice Paul Reiber and Rob Hofmann, Secretary of the Agency of Human Services, wrote in a letter seeking support from Senator Patrick Leahy for a series of federal grant applications.

"The information exchange must be seamless and the information must be available not only to the participating partners in the traditional justice system, but to the providing agencies of health, mental health, and substance abuse, to victims, to community justice, community diversion, and non-profit agencies," the letter said.



Data Exchange Network as illustrated for MHISSION-VT.

MHISSION-VT

Tom Simpatico, MD, presented an update to the task force on work under a federal grant that was originally targeted to identify and help veterans with trauma-related disorders.

It is now enabling the state to create "an infrastructure upon which anything can be built" for matching computer information from different data files, he said.

Simpatico, Director of Public Psychiatry at the University of Vermont School of Medicine, told the task force that as a result of federal stimulus money, the project's aim had been broadened to become an "information exchange for Vermont" for persons with mental health and similar needs who may encounter the criminal justice system.

Branches of state government have applied for a total of 12 other federal grants that they hope will support the "Public Health and Justice" model envisioned by the task force, which was convened in 2007 by Reiber.

Simpatico told members that the project he was leading would have its information technology in place by this September to have a list of veterans who have separated from the military and identified Vermont as their home.

It will then be able to cross-match and identify those in the custody of the Department of Corrections, and those arrested and listed in the Attorney's General's data base.

At this summer's meeting, Reiber used a reference from the 911 tragedy to illustrate how vital the ability to share information is. He reminded the task force that rescuers who rushed to the scene "couldn't talk to each other" because their radio frequencies did not match.

"This is sort of a metaphor for the problem we are trying to address here," as the criminal justice system attempts to respond to persons with mental health and substance abuse problems, he said.

Karen Genette, the task force coordinator, said that getting the information technology up to speed included "taking into account individual rights and due process."

"We know there is some controversy on it," and "respect that and understand it," she said.

Earlier in the meeting, Ed Paquin, the Executive Director of Vermont Protection and Advocacy reminded the group that it was important to keep its "core values" as part of its responsibilities, including respect for the "rights to self-determination, autonomy and due process."

The task force, named "The Chief Justice Task Force on Mental Health and Criminal Justice Collaboration," was started as an effort to divert individuals "whose conditions result in impaired decision-making or functioning" into treatment and community supports.

It includes members from the court system, law enforcement, the legislature and the Agency of Human Services, including from the fields of mental health, substance abuse, developmental disabilities and traumatic brain injury.

Reiber said he hoped the group could continue its work as a tri-branch task force – judicial, legislative, and executive (administration) – rather than led only by the judiciary.

The project Simpatico is heading, "MHISSION-VT," will be able to collect and cross match data from records such as federal benefits eligibility and the state public inebriate program, he told the task force. The acronym stands for "Mental Health Intergovernmental Service System Interactive Online Network."

If public defenders receive information they can match with a client, they will have the ability to inform the person about eligibility for mental health court or other treatment options that might apply, he explained.

In another example of its use, he said that if offenders in prison "apply or are mandated" to participate, the information would be able to help coordinate treatment for re-entry into the community.

Although initially planned primarily for veterans, he said veterans' groups wanted to see it accessible to everyone.

The grant was awarded for screening "veterans and other adults who present through the criminal justice system for trauma-related disorders."

Project goals range from creating the coordinated infrastructure through data-sharing agreements that maximize identification of such persons, to expanding the availability of treatment for those in the criminal justice system who are "unwilling or unable" to access services from the Department of Veterans' Affairs.

The implications for the gathering and use of data still "remains to be seen" as it grows in the potential to include "different information streams" that contribute to the criminal justice system involvement of individuals with impairments, Simpatico said. There are also ways to be "more creative" with the information the system already has access to, he said.

The "Data Exchange System" in the MHISSION-VT presentation displays a network of information connected to and sorted from 16 different locations and many subsets from those locations.

These include the Department of Mental Health (showing community mental health agency intake, CRT and outpatient, and the state hospital), the Office of the Court Administrator (its speciality courts), the Department of Corrections (veterans pre- and post-adjudication and pre-release), Law Enforcement (encounters and arrests; domestic abuse), the Agency of Human Services data warehouse, the Office of Motor Vehicles (moving violations), the Vermont Program for Quality in Health Care (public and private psychiatric and general health visits), users of homeless services, the Department of Health (Substance Abuse Services), and sources for veteran information: the National Guard, Vietnam Vets Center, Vet-to-Vet, the Veterans' Administration, the Vermont Office of Veteran Affairs and the Vermont Veterans' Family Community Network.

The Sparrow Project

A second presentation updated members on the "Sparrow" project in Windsor County, which offers treatment and support as an option for persons charged with nonviolent felonies who would otherwise "be headed for prison."

A key to its success was the "hard groundwork on due process and information sharing" that was done with public defenders, according to George Karakabakis, the Chief Operating Officer at HCRS (Health Care and Rehabilitation Services), which is running the program.

"Everyone at the table was concerned about these issues" of confidentiality, he said, and defense attorneys worried about whether the program could actually get the services and make the connections for people that it was promising.

In fact, clients are now receiving help with everything from housing to employment, "sometimes in really creative ways" that the staff identify.

"All this is voluntary," Karakabakis said. It is

(Continued on page 7)

Consumer Feedback Is Positive On Agency Services Received

BURLINGTON – More than ten years after the start of client surveys, consumers in the Community Rehabilitation and Treatment (CRT) program continue by a margin of 80 to 20 percent to give positive ratings to overall performance by the agencies that serve them.

In one specific area – respect – scores have made a steady increase from the first survey in 1997 to the most recent one, conducted in 2008.

In 2008, 84 percent of those replying gave positive answers to questions about being treated with respect. In 1997, the favorable responses were under 75 percent.

The survey was done every three years the first three times, and has been done every year since 2006. It is conducted by the Department of Mental Health through a confidential random sample of approximately 75 percent of those receiving services that year. Forty percent of the consumers sampled answered the survey in 2008. The data were reported by the department's research and statistics unit, and the full report, including a breakdown by agency, can be found online at www.healthvermont.gov/mh/docs.

The 45 questions are grouped into five categories. In 2008, respect ranked highest; followed by service (83 percent favorable), access to services (80 percent) and autonomy (79 percent.) Autonomy questions asked how much consumers were able to direct their own planning.

The lowest ranking has remained "outcomes" of treatment, with an average of 71 percent giving favorable responses to statements about feeling better in social situations, at school or work, or in a sense of belonging in the community.

The single highest survey response, at 92 percent favorable, was in reply to the statement, "Staff treated me with respect."

Emergency Room Average Ranges Up to Nine Hours

BURLINGTON — Initial data gathered by the Department of Mental Health show that emergency room waits for involuntary admission to an inpatient psychiatric unit may range as high as an average of nine hours (Northwest Counseling and Support Services) to just over three hours (Washington County Mental Health), with an overall average of five-and-a-half hours. The information was based upon screener reviews of the five most recent admissions.

For voluntary admissions, emergency room waits ranged from almost six hours to two-and-a-half hours, with a state average of three hours and 40 minutes. AD

NEWS BRIEFS

Drug Company Ties May Bias Diagnostic Manual

Financial ties between pharmaceutical companies and many of the experts who are working on developing the fifth edition of the "Diagnostic and Statistical Manual of Mental Disorders" (DSM-V) have led some academics to question the new edition's objectivity, according to an article in USA Today.

Of the 160 people working on updating the manual, 68 percent have economic ties to drug companies, the article said. In addition, the industry pays for two-thirds of the research, and many researchers themselves are advisors to drug companies, hold stocks in the companies that make medications, or are on their corporate boards.

USA Today said that some believe that people with these conflicts of interest can't be objective, but there is little consensus on how to shield the new edition of the DSM from drug companies' financial interests.

Information Sharing as a Benefit to Consumers

(Continued from page 6)

"really a carrot" rather than a stick because of what it offers to its clients.

Rep. Alice Emmons, a task force member, said the pilot project was providing justification for expansion because of "what you're starting to bring to light" about the needs of people which can lead to criminal involvement.

Interagency Teams

The third update provided to the task force was progress on creating interagency teams to identify a lead case manager and develop planning for persons with serious functional impairments "who are either in the correctional system and due for discharge, or in the community at serious risk of incarceration."

The state team is now established and is reviewing situations where there are "specific complex system barriers" for getting appropriate services, according to Scott Johnson, Deputy Commissioner of Field Services for the Agency of Human Services.

Local teams will be in place by this fall to "triage supports and services" for the highest needs.

The task force also held a discussion about new members who might help as it broadens its mission. Representation from the Department of Public Safety, the Chiefs of Police organization of local law enforcement, and hospital emergency rooms were among those suggested.

Michael Hartman, the Commissioner of the Department of Mental Health, suggested that its legal counsel might be helpful.

One person in its legal department is the link with all the district attorneys regarding court-ordered evaluations for capacity and for orders of non-hospitalization when a criminal case is resolved through a treatment order, he said.

It is another "avenue that can have an exit out of the criminal justice system," he suggested. It also sometimes addresses defendants where the situation "seems to stray into other kinds of conditions" than mental health.

The individual might not fully meet the criteria to be ordered into the custody of the Commissioner of the Department of Aging and Independent Living (DAIL), which addresses lack of competence due to a serious developmental disability, so he or she is placed under the Commissioner of Mental Health, he said.

"It kind of lies between two worlds," Hartman said.

The task force agreed that it was a topic that would be better addressed through one of its work groups, to then be brought back to the full task force.

Beyond Mental Illness

Since its work in reviewing the issues of mental health and criminal justice, the task force has expanded its scope to include other groups of persons who may have impaired decision-making, including those with co-occurring disorders, traumatic brain injury, and developmental disabilities.

Recognition of a broader group of diagnoses that might create functional problems for persons is expanding in the state.

This past spring, the legislature passed a bill to expand protections for individuals in corrections with a serious functional impairment.

The Department of Mental Health has also been reviewing the issue of persons who are sent to the Vermont State Hospital when the diagnosis is not a mental health disorder, working with DAIL to identify more appropriate placements.

Studies Give Evidence: More Help Pays Off

Two different studies have provided information about links between mental health supports and avoiding prison, as well as the numbers of those with mental illnesses in prisons.

Vermont's Performance Indicator Project, which assess existing data, recently provided information that showed a significant correlation between use of community mental health services and low rates of imprisonment.

A comparison of 48 states in 2007 showed that in general, "state with higher community mental health utilization rates had lower rates of imprisonment," the report said. The information used was for "prisoners under the jurisdiction of state or federal corrections authorities sentenced to more than one year."

Vermont statistics indicated that it was ninth from the lowest among states for rates of imprisonment, and 17th from the highest in terms of utilization rates of adult community mental health services.

According to the National Mental Health Consumers' Self-Help Clearinghouse, a new study done jointly by the Council of State Governments Justice Center and Policy Research Associates has concluded that 14.5 percent of men and 31 percent of women entering prison have serious mental illnesses.

The Clearinghouse said that Vermont's Senator Leahy is leading efforts to try and end the warehousing of persons with mental illnesses in the nation's jails and prisons, by advocating for full funding of the Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA). The act expands treatment programs and mental health courts.

Vermont State Hospital Futures Plan Update

DEBATING THE FUTURE — Among the regular participants in the Transformation Council are (left photo) David Gallagher and Jean New, and (right) Ed Paquin, who is the Executive Director of Vermont Protection and Advocacy. The Council gives input to the Commissioner of Mental Health on the future of the state's mental health system, including the replacement of the services currently provided at the Waterbury state hospital campus. (Counterpoint File Photos: Anne Donahue)

System's Status Includes Hospital Bed Crunch

MONTPELIER — Mental Health Commissioner Michael Hartman provided an overview of the steps thus far "to build up the capacity of the community" to prevent unnecessary use of the state hospital at a summer meeting of the legislature's Mental Health Oversight Committee.

Committee members expressed concerns about a rising census at the Vermont State Hospital in the interim, despite the new programs.

"This sounds to me like a crisis," committee co-chair Rep. Mike Fisher said at a later meeting.

Testimony differed as to whether budget cuts to outpatient services, or new reluctance by community hospitals to accept acute patients, was the primary cause of VSH now reaching near capacity on a frequent basis. Twice in August, patients in Vermont were left in emergency rooms without access to any inpatient bed.

In reviewing the community portions of the Futures plan, Hartman said that the housing contingency fund was doubled as part of community support, and "that so far has seemed successful" in helping with crisis housing needs.

New beds in the community – either completed or in planning – will be at 47. This includes 14 already open at Second Spring in Williamstown (increased from its initial 11), six under development at Meadowview in Brattleboro, and 15 planned for the secure recovery residence in Waterbury, all to replace unnecessary inpatient care by creating a higher level of treatment in residential beds. Meadowview continues to be on track to open this fall, he said later.

To divert people from needing inpatient care, nine new crisis beds have opened in four different communities, bringing the number statewide to 26. Three more beds are to be developed as peer-run respite beds.

Sen. Matthew Choate, a new member of the legislative committee, said that it appeared that the new programs have expanded capacity without creating any savings.

Hartman said it was "a murky proposition to define" the specific savings that the alternatives create. The "hugest cost savings" won't occur until all programs (inpatient and residential) have federal participation in funding.

However, there has been a "leveling off and a slight decline" in inpatient hospital use by persons in the Community Rehabilitation and Training (CRT) program for those with long-term illnesses. The "upward pressure" has come from persons who are new to the system, he said.

"We're adding capacity and just filling it," said Sen. Doug Racine, co-chair of the committee, noting the increase in the census at VSH despite the opening of Second Spring two years ago. "If you just keep building it, are you just going to fill it up?"

Racine compared it to the use of health care services that often occurs whenever greater capacity is available.

"If we squeeze down the capacity, what then?" he asked. Would the result be inappropriate placement of people, or have there been inappropriate intakes?

Fisher asked about the destabilizing effect of the "tough economic times" combined with budget cuts.

Hartman said that he was "not able to say" services in the community had actually been reduced as a result of budget cuts, but there were fewer persons being served.

A new group had been identified that will not be served by any of the program currently planned, but does not need inpatient care. These are VSH patients who need nursing care that will not be available at the secure residence, but who need a more secure setting than a nursing home.

Deputy Commissioner Beth Tanzman said the solution being developed is to "enhance some programming and staff in existing [nursing home] units" and "develop a business model" to reimburse for the "sub-specialty care" needed.

Margaret Joyal, chair of the outpatient directors' committee of the mental health agencies, testified that access to care for non-CRT clients has worsened since the budget cuts.

"Part of what causes inpatient to spike is a lack of access to outpatient," she said. The waiting list is up by 30 percent in some agencies, and at Washington County Mental Health, Joyal's agency, there are 40 persons on the waiting list, she said.

Jeff Rothenburg testified on behalf of CRT directors, but focused on the challenges in accessing inpatient care. Emergency screening and crisis services are "the backbone of our system," he said. At a "most stressful" time for clients, it is "taking an average of five hours" to locate a hospital placement, he said, as a result of "the ongoing ambivalence of the general hospitals" regarding more acute patients.

The expansion of the alternative crisis bed system could play a key role, he said, but the programs are receiving "negligible referrals from hospitals" for diversion.

Emergency services workers are the ones in every instance "trying to find a place [the patient] can go...going down the list, hospital after hospital after hospital."

"Medical clearance is a big issue" as well, he said, in causing delays for patients, and "insurance authorizations are often difficult." In some cases, screeners have been told they must call the insurance company and get agreement for payment before the hospital will agree to an admission.

Fisher asked if hospitals that had "do not admit" lists for some patients listed them by name, and if some were on lists with more than one hospital, and Rothenburg answered, "yes."

Was it based upon being difficult to treat, or disruptive, he asked. Rothenburg said that some were patients who, because of past admissions, the hospitals felt "they were not able to help ," or that admission was "enabling" an ongoing psychiatric issue.

For some patients, seeking admission is perceived to be "looking for what they know" and are comfortable with, rather than learning to cope with crisis.

Even if a patient is on a "do not admit" list, screeners must call each hospital, he said, and if the patient is involuntary, the length of time to find a hospital increases. AD

CONFLICT OF INTEREST NOTICE:
The writer of the articles on pages 7 and 8 about the Mental Health Oversight Committeehearings, Anne Donahue, is also a member of that committee.

Secure Site Chosen On Waterbury Campus

WATERBURY — State officials have indentified the proposed site for a 15-bed secure recovery residence being planned for the state office complex. It replaces an earlier, draft site that was criticized for being placed among office buildings and and with little outdoor space.

The new site would be opposite the "Osgood" building in an area currently in use primarily for parking. It would face open fields that would be able, planners hope, to be used for outdoor recreation space. A work group of interested parties has been meeting to give input on architectural design and program planning. AD

Vermont State Hospital Futures Plan Update

Inpatient Capacity Proposals Are Outlined

MONTPELIER — The Mental Health Oversight Committee this past summer received an overview from most of the hospitals that later submitted proposals for state hospital replacement services.

CEO Tom Huebner of Rutland Regional Medical Center presented its proposed collaboration to the committee, saying that it wants to participate in replacing services from VSH "because we believe it needs to be done."

The key piece that "has not yet been tied down" is the money, he said. The proposal includes construction of a 28-bed new wing to replace the current 13 to 14 beds that currently operate under the hospital's 19 bed license.

Rutland needs "reasonable assurance" that it can repay the debt on construction to the nonprofit entity that would build and own the building. There needs to be a "sufficient revenue stream" from those paying for care there, "particularly from the state of Vermont," to pay the lease, he said.

Sen. Jeannette White asked if the debt would put the state on the hook just for the 12 new beds or for more of the construction.

"You're on the hook for more," he said. "All the incremental capital costs" must be assured, because RRMC "can't afford to build [a new unit] for its existing beds."

She asked about the vacant space that the current unit would leave, and Huebner said he didn't know how it would be used yet. He said RRMC currently rents office space around the city.

As far as increases in need, Huebner said that was most evident in the public inebriate program.

RRMC is "detoxing far more patients and admitting them" through the emergency department. Substance abuse and psychiatry in the ED represent a "minority, but they absorb an enormous amount of resources."

"Acuity is definitely going up" as well, he said, making RRMC have to "push back" on the admissions it can take. Because there is only one main common area in the Rutland unit, it is "very difficult to take very acute patients," and there is an increasing length of stay, particularly with the difficulty in finding placement for geriatric patients. He said he was "heartened by comments [by Hartman] regarding skilled nursing."

White asked how the number 25 was identified for the new unit, and whether 25 was "still an appropriate number" if some patients would be better served in skilled nursing facilities.

A unit of 25 is a good size for care needs, Heubner said. RRMC wants to "do our part" but is a general hospital and the 12 VSH replacement beds are "what we're willing to take on." Twelve beds for statewide needs already "goes beyond" the hospital's role as a provider for Rutland County, he said.

Agreement on a mechanism for setting the reimbursement rate is essential to protect RRMC after committing to a new building, he said.

"I want to be able to walk away. I need to have the ability to walk away." The "barriers that we have to overcome are fairly formidable," he said.

Springfield's CEO, Glen Cordner, opened by saying the same that Huebner had: that Springfield was "interested largely because it needs to be done."

"We've been an active part of this work [state involuntary care] for a long time," he said. Four beds in the current 10-bed unit could be "redeveloped as intensive care" beds almost immediately. It could also create an added 10 beds – the Windham Center had 20 beds previously – if Springfield Hospital received a CMS waiver for size. The Bellows Falls campus is "nearby" the main Springfield campus, he said.

> *"The care of the most severely ill is part of [Fletcher Allen Health Care's] mission" for psychiatry just as with other medical categories.*
>
> *- Chair of Psychiatry Bob Pierattini, quoting CEO Mindy Estes*

Racine asked what the difference was with "intensive care" and why Springfield Hospital was unable to provide it now.

Unit director Jim Walsh said that the ability for patients "to engage" was part of how severity was determined, and more acute patients "need external controls for safety." The "potential for disruption" for other patients is too great without a "discrete unit" to meet that need.

White asked about the distance to medical care. Walsh said medical access was sometimes even better in Bellows Falls, because the unit is in the same building with a walk-in medical clinic with X-ray, lab work, and similar services right there. If more is needed, patients are taken to the emergency department in Springfield.

"We get patients from all over the state" already, Cordner said in response to the issue of geographic access. "We want to be part of the solution."

The Brattleboro Retreat CEO, Rob Simpson, said it was proposing a plan because "this is what we do."

"It's all we do. We're a specialty center. We don't walk away from it." He said the Retreat's proposal represented how it believed it could help respond. "If there's enough interest [by the state]...then we're interested in the next step."

The Retreat's goal is to "continue to be seen as a center of excellence."

"There are challenges of geography" and "there are challenges of the IMD" status for the Retreat to be a resource, he acknowledged. IMD status refers to the federal rules not allowing payments to hospitals that are not part of a general hospital.

The Retreat's proposal is to rehabilitate one of its current units for $4 million as a 16-bed VSH replacement. It would be based upon partnering with the Brattleboro Memorial Hospital and "using a portion of their licensed beds" in order to comply with the federal rules, he said.

Robert Pierattini, MD, testified on behalf of Fletcher Allen Health Care, noting that it had agreed to collaborate on replacing VSH services in 2005-6 through independent, new construction. That plan had to change when the state decided upon a "distributed model" around the state instead.

The state has asked for a 20-bed expansion in the current FAHC, but "we cannot – there is no space," he said. Expansion requires construction of a new facility, which cannot occur until a full master plan is developed for all the hospital's inpatient beds, he said. That is not likely to occur "before the mid-point of the 2010 decade."

Thus while FAHC is "receptive to the idea" of creating an integrated program with all levels of care, the time frame is a dilemma.

He said he wanted the committee to be clear about the consistent position of CEO Melinda Estes: "Her view is that the care of the most severely ill is part of its mission," just as the care of the most severely ill in other medical categories, he said.

"I don't want [you] to misinterpret a lack of interest" on the part of FAHC because of the inability to move forward immediately, he told the committee. The psychiatric providers there are eager to provide the care, and "the hospital stands behind them," he said. AD

INPATIENT PROPOSALS AS SUBMITTED AT A GLANCE

Brattleboro Retreat

BRATTLEBORO — The Brattleboro Retreat, a specialty hospital licensed for 149 psychiatric beds, proposes to renovate a floor to become a16-bed acute care unit. The unit would operate under the license of the Brattleboro Memorial Hospital to avoid federal restrictions on funding of free-standing psychiatric hospitals. The Retreat estimates that the renovations would cost $4.2 million.

Dartmouth Medical School

HANOVER, NH — The Department of Psychiatry of Dartmouth Medical School (a separate corporate entity from Dartmouth-Hitchcock Medical Center in Lebanon), proposes to develop a 15-to-20 bed unit for patients with severe psychiatric illness to be constructed as an addition to the Veterans' Hospital in White River Junction. The Department currently provides psychiatric services to New Hampshire's 240-bed state hospital a 92-bed state facility in Maine.

Fletcher Allen Health Care

BURLINGTON — Fletcher Allen said it would propose to integrate a unit of at least 20 beds for complex, acute care into its current 28-bed psychiatric service when its new campus master plan was completed. Development would begin in 1016 or 1017. An option that could be developed sooner, but would be less preferred clinically, would be operation of a facility off-site from the main campus.

Rutland Regional Med Center

RUTLAND — The Medical Center presented the only proposal that was described as being ready to move forward to apply for regulatory approval within the next year. It proposes a 28-bed new building attached to the hospital to double its current capacity. Six of the new beds would be an "intensive care" unit. The construction estimate in 2008 was $25 million; RRMC said even with the payments on construction costs, it would save money for the state because the current VSH beds receive no federal matching funds.

Springfield Hospital

SPRINGFIELD — Springfield Hospital proposes to convert its existing 10-bed unit at the Windham Center in Bellows Falls into acute psychiatric care, including an intensive care unit component. It would develop a 10-bed medically monitored crisis stabilization program on the same campus, as well as an intensive community crisis intervention team to complete the continuum of care.

Peer-Directed Respite Program To Hire Coordinator as Next Step

WATERBURY — A peer-directed respite project is expected to move forward with hiring a development coordinator this fall, despite uncertainty about whether there will be enough funding to design the type of program some would like to see.

The purchase of a house for a 5-bed program may give way to renting space for three beds, Linda Corey, Executive Director of Vermont Psychiatric Survivors told members of the Transformation Council last month.

"To be quite honest...nobody was really able to come up with what would be the most feasible" — and that would be the role of a full-time project developer, she said.

VPS would hire the individual, but an advisory council would evolve into a full board of directors as the new program becomes its own nonprofit agency, she explained.

The Transformation Council is an advisory group to Department of Mental Health Commissioner Michael Hartman.

Hartman said that under the difficult economy and with the budget being cut back, "adding money to anything right now" beyond the original budget figure would be a challenge.

The peer project work group had reported that the budget money put aside for the project by the Department would not be adequate for the staffing needs.

The type of housing — rental or purchased — would also be dependent upon "what our financial situation is," Corey said.

"Since we're talking about starting a program, that can take a lot of time," Hartman said, suggesting that by the time it was developed and ready to start, the economy might have improved.

"My view is that it would be important to buy a place, and then you would have it," said Xenia Williams. She said she already had an eye on one property that would be ideal.

Hartman pointed out that a Northeast Kingdom program has started out by renting hotel rooms, keeping a low cost overhead, rather than "buying the ideal space" to begin with.

Those who had worked on planning, as well as others on the Transformation Committee, described the importance of having a program run by peers as alternative to existing programs.

"People would actually have choices," said Williams. The program would be based upon "a holistic model rather than a specifically medical model," and "avoid the confrontation that results when people are dedicated to one model and one model only."

"I like this project and I think we should go ahead with it," Council member David Gallagher said.

"I would like to see a peer place happen because peers are very important to recovery," added Jean New.

The Council also discussed why the newly expanded crisis bed system around the state is not being used as much as it could be.

Nick Emlen, of the Council of Developmental and Mental Health Services, said the agencies are reviewing use with emergency and CRT directors.

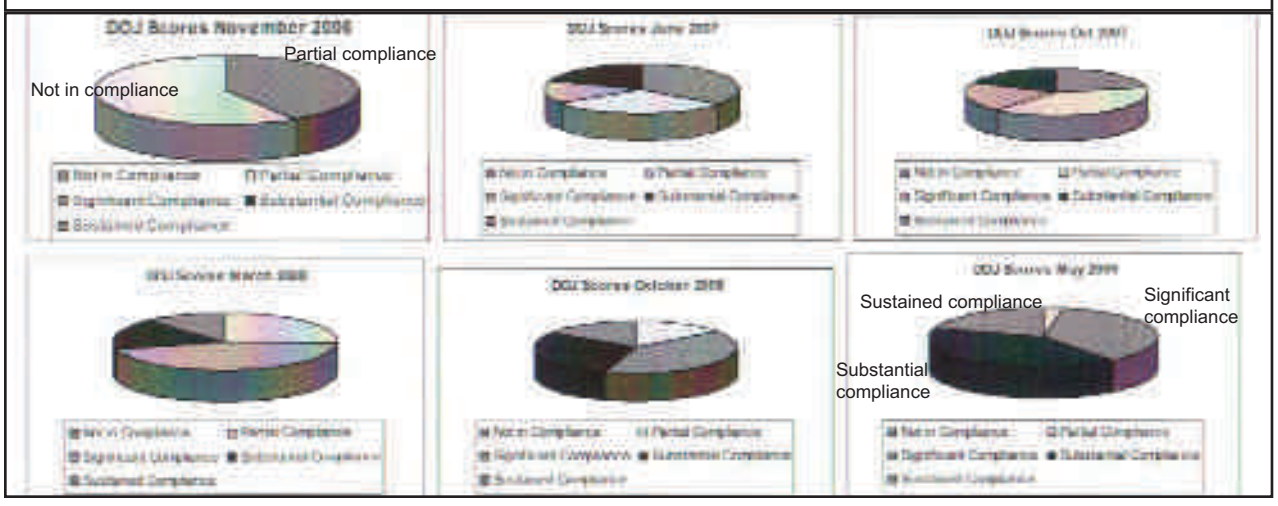
One member pointed out that crisis beds will not reduce emergency room use when consumers must go to the emergency room before they can be referred to a crisis program. AD

Counterpoint
Photos:
Jean New

CAMP 2009 at Lake Elfin in Wallingford was another success despite the lack of a main lodge, showers and kitchen that made it "much more rustic," according to Vermont Psychiatric Survivors Executive Director Linda Corey. The weather was cooperative and guests included state mental health Commissioner Michael Hartman and deputy Beth Tanzman — who joined campers for a swim. The annual consumer event was coordinated by Kitty Gallagher, with funding from federal block grant money for peer initiatives administered by VPS. In the photos above, those attending listen to a talk by Tanzman (top) and enjoy meals and other presentations. A bunny rabbit made an appearance as well.

Vermont State Hospital: Department of Justice Scores Over Time

Summary: The DOJ released its sixth compliance report in July, reporting on the May, 2009 survey. It indicated that VSH has improved scores in 41 of 149 elements since the last survey. Scores decreased in two elements. As a whole, VSH has now achieved "significant compliance" or higher in 97 percent of the elements scored. The graphs below, supplied by the Department of Mental Health, show the progress in the past two and a half years since the DOJ began its reviews under its settlement with DMH of a court action alleging violation of patient constitutional rights.



VSH Continues Gains, Despite Federal Dispute Over Safety

WATERBURY — The Vermont State Hospital "again made major gains" this past spring since the previous compliance visit by reviewers from the United States Department of Justice. The reviewers also disagreed with safety concerns raised by the federal Centers for Medicare and Medicaid Services (CMS).

"We acknowledge that the hard work by VSH staff has resulted in the third compliance report [in a row] with no findings of non-compliance," the 82-page report said.

The report was released in late July, shortly before CMS once again denied certification for federal funding *(see article this page.)* It was the sixth since the DOJ began its reviews of progress in meeting terms of the settlement of its lawsuit alleging that patients' constitutional rights were being violated by the lack of adequate care.

The report identified a large number of quality areas in which it has found VSH to be in "sustained compliance," that is, that it has maintained compliance for at least a year.

The two psychiatrists who filed the report also directly disagreed with findings last fall and winter by CMS — a separate federal agency — that an unsafe environment existed because of exposed pipes in a newly renovated treatment mall, and because of pipes and chain link fencing on the unit porches.

Both areas were closed and are being repaired.

The Department of Licensing and Protection in Vermont acts as the local arm for CMS, and its director, Frances Keeler, said in an interview that a hospital environment "should be inherently safe" and "should not rely on human [factors]" which can allow for errors. This is clear from patient safety literature and the "lesson taken from industry," she said, which does not allow for human oversight as a safety assurance.

The Department of Justice disagreed. Its report said that "VSH correctly conceptualizes three levels of risk," including a highest level with access to more dangerous items, but patients are "staffed 100 percent of the time in 100 percent of the area."

"There are low-risk, but no risk-free environments," the report said.

"Thus, the porches with exposed pipes and chain link fence, and the Treatment Mall with exposed pipes do not pose a patient safety risk problem as long as patients are supervised 100 percent of the time, which is VSH's policy and practice."

The two psychiatrists who wrote the report implied that VSH should not be overly concerned about CMS findings. They said that VSH should "stay the course" of working with the DOJ process and "not get unnecessarily side tracked by findings that contrast with those in this report."

The reviewers said the closing of the new mall area and its return to the Brooks basement "has been a major step backward" with a "significantly negative impact on programming and on patients' willingness to attend (as articulated by patients themselves)."

They also cited other factors outside the control of the hospital that impair the ability of VSH physicians to "meet accepted standards of practice" and for VSH to come into compliance. The report referenced availability of community residential placements, willingness of general hospitals to admit all eligible inpatients, and Vermont laws.

Some practices, however, although rated as being in "significant compliance," continued to receive criticism, including "no rationale for medication, no consent for medication" being documented by physicians. Several detailed examples were given.

Integrated treatment plans, an area that had lagged in progress, is improving, but with "wide variation amongst teams — some have already arrived, others struggling, all trying." AD

New Record High Set For Youth in Hospitals

BURLINGTON – Hospitalization for Vermont children has climbed rapidly and reached an all-time high in 2007, the most recent year for which numbers are available.

The report compiled by the Performance Indicator Project of the Department of Mental Health shows that the number of hospital days for patients under age 18 increased from 3,225 in 2003 to 5,605 in 2007. According to the report, there have been many variations in the amount of inpatient hospital use for children since 1990. In 1993, the number of inpatient days was almost as high as it reached in 2007.Between 2000 and 2003 there was a steady annual decline, which was then reversed by the annual increases through 2007.

A majority of the children and adolescent hospital days were at the Brattleboro Retreat.The percentage of days provided by the Retreat ranged in the past from 48 to 81 until 2000. Since 2000 the Retreat has provided an average of 90 percent or higher of all such care. AD

CMS Again Denies OK To Hospital

WATERBURY — Hopes of federal certification after a plan of correction had been accepted were dashed this summer when the Vermont State Hospital was told it had to start over in the application process.

The state Department of Mental Health said it is appealing the decision.

Lack of certification by the federal Centers for Medicare and Medicaid Services does not mean the hospital cannot operate. However, it blocks any federal funding support, at a current cost of an estimated $15 million per year to the state.

In a history that began with decertification in 2003 after two patient suicides, CMS has faulted the hospital for failure to provide active treatment and for numerous dangers in the physical plant.

The state has spent several hundred thousand dollars in renovations and safety repairs and increased the budget to significantly enhance staffing and management, but CMS has found new deficiencies on each return visit.

Its report this summer criticized how VSH responded to a staff discovery of contraband. According to hospital records, staff conducted a search of rooms on Brooks 1 for a missing wall sign that could have been used for injury.

In that search, they found that one patient had gathered and hidden a supply of 52 Tylenol, other medication, small cereal boxes and other supplies, the CMS report said.

Although VSH addressed that patient, it failed to adequately look at whether the way the items were obtained and hidden showed a larger safety problem, such as a need for more frequent or thorough searches, the report said.

Commissioner Michael Hartman told advocates and legislators in August that he saw a pattern in CMS reviews both at VSH and other hospitals that placed a priority on absolute physical safety above the privacy rights of patients.

The pressure by CMS on community hospitals is resulting in fewer admissions there, placing more pressure on VSH.

At a meeting of the Mental Health Oversight Committee, Senator Jeanette White expressed frustration over the efforts that have been made when it appears CMS may not intend to ever certify VSH in its current facility.

"I'm so tired of CMS," she said. "Let's just forget CMS. We're trying to appease someone that is not going to be appeased." AD

Majority in Vermont Report Caring Attitude

BURLINGTON – A majority of Vermonters – 62 percent – believe that "people are generally caring and sympathetic to people with mental illness," according to data gathered by the Performance Indicator Project of the Department of Mental Health.

That made Vermont tied for the highest ranking with three other states in a 24-state review. The others were Oklahoma, Rhode Island, and Iowa. The lowest ranking came from Washington, D.C., with 42 percent of people agreeing that people were generally caring. AD

being bipolar:

two people speak out on living and coping

by Sue Hohman

I don't know what it is about us bipolar people. We are always whining and complaining about something concerning our treatment.

The meds make us gain weight. They make us drowsy, they make our affect flat. They kill our libido. There are too many of them, they are too hard to remember to take. The list goes on, and that's just about the meds.

Then there are the doctors and the therapists. I know, I love my therapist dearly, but he is always raining on my parade.

Like when I am just beginning to feel really good, he tells me I need to take some Seroquel and stay home the rest of the day instead of going shopping like I want. Or when I've told him about the 60 pairs of socks I bought on sale, he tells me "everything in moderation". He just won't let me enjoy my mania. If I get so high that I want to jump off the roof of the hockey rink because I think I will bounce—he calls the police and has me put in the hospital!

We want to be able to have our highs when we want them. And we want the meds to keep us right at that point of mania where we feel great, but not over the edge of danger. Is that too much to ask?To have our doctors work hard to keep us not too high, but just high enough?

It's really impossible. The meds just don't work that way. As my psychiatrist told me, Bipolar Disorder is not a designer illness. We have to accept our side effects, and our limitations, and the fact that we can't be superman or superwoman any more.

That's really hard to take. To have had mania, and then be told you can never have it again is worse than telling a chocoholic that she can't eat chocolate ever, ever again. It doesn't even compare.

This is why there are so many bipolar people who do not comply with their treatment plans, or who drop out of treatment all together. And it is dangerous.

Bipolar depression can be deadly when left untreated. Often, it follows a period of mania. The plunge downward can be fast and hard, and suicide is always a risk.

But we tend to forget about the downs while we are going up. We need to make good use of the up time to evaluate our lives and write out our treatment plan. We need to spell out what we will do if we get too high that are judgment is impaired. We need to spell out what we will do when we get so depressed that suicide seems the only alternative.

Who will we call? Where will we go? We need to put in writing so it is there in black and white where we can see it when we can no longer think rationally

Support groups can be invaluable. Gathering with other bipolar people and sharing experiences can help us not feel so alone.

In my own support group, we speak the same language that people who have not "been there" just don't understand. We keep tabs on each other, and help each other not to go too high or too low without seeking medical help. It's nice to know someone who understands is there.

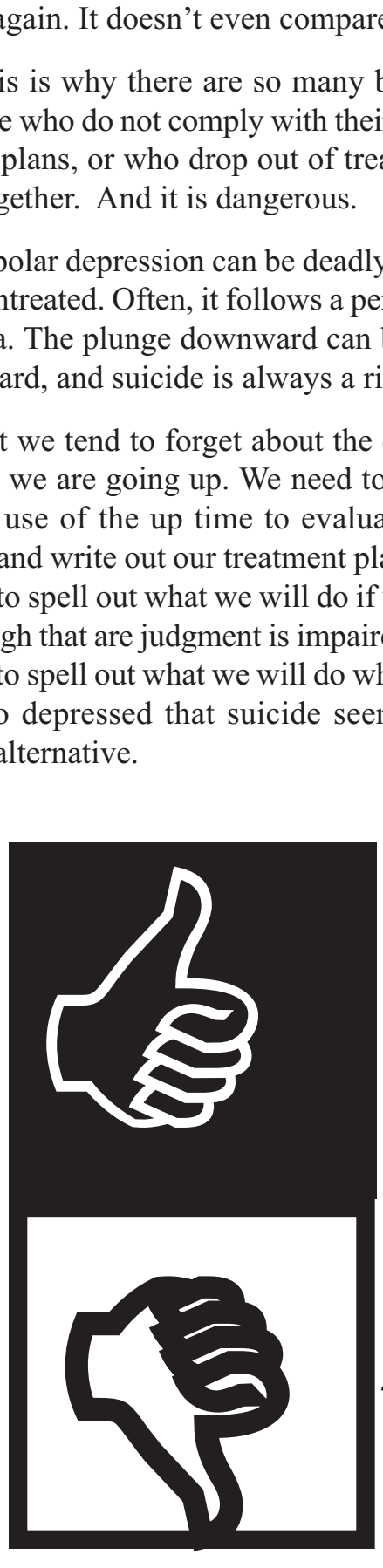
So, in a way, Bipolar is an illness that has design: a system of treatment, medication, support and written plans for times when our thinking is distorted.

But it is not a designer illness. We can not control the amount of mania we have, like we control the amount of gas we release as we press our foot on the accelerator. We can not always avoid the side effects of the medications we need the most.

Sometimes we have to compromise and give a little, for our health's sake and for the sake of those who love us.

Does it stink? Yes. But no one ever said life was fair.

Sue Hohman writes from Bennington.



Point

***Point → Counterpoint* is a regular feature which presents different vantage points on matters of interest in the mental health community. Views expressed do not necessarily represent those of *Counterpoint*. Responses are encouraged. Write to *Counterpoint* at 1 Scale Ave., Suite 52, Rutland, VT 05701 or at counterp@tds.net**

with manic-depression

by Arleen Alexandra Fortune

My name is Arleen Alexandra Fortune and I am one of the staggering number of 5.7 million American adults who suffer from the mental illness called bipolar disorder.(formerly called manic depressive illness)

It is incredibly common today, in fact almost a "fad." I often wonder, "is there something in our drinking water?" Perhaps it is over-diagnosed? Recently I did an internet search on famous people with bipolar disorder and came up with an enormous list which includes half of Hollywood and virtually every eccentric artist, especially the "extreme" but unforgettable ones like the painter Vincent Van Gogh, who cut off his own ear.

No one knows the real causes of bipolar disorder except that it can be genetic. I know that for me, my illness was brought on by medication, specifically, antidepressants I took some 20 years ago. Prozac, very popular at the time and touted as a wonder drug, drove me into a full blown psychotic mania.

NAMI recently published an article about this medication-induced illness and calls it "bipolar 3." Had I never taken these drugs perhaps I would never have had a manic episode. But I would have then had to live my life with a debilitating depression (which didn't seem to exist before I was in college). There is no easy answer to this pharmaceutical tightrope that many of us with imbalances in brain chemistry have to walk.

For people who don't understand the illness, I explain simply that depression and mania run along a continuum from incredibly sad to insanely happy. Antidepressants, if the right match is found, can almost magically alleviate the symptoms of depression, yet they often, at least in people with bipolar illness, can trigger a mania. So you go from feeling really sad to feeling better, then BETTERBETTERBETTER until you crack up.

A lot of us who take psychiatric meds feel like guinea pigs. Most of the drug companies which produce the drugs and virtually all of the psychiatrists who prescribe them are not mentally ill. Thus, they have no clue what it feels like to go nuts!

Although I am very grateful for the help that antidepressants have given me and also for the aid of several compassionate, competent psychiatrists (and there also have been some autocratic idiots), I am somewhat resentful of the fact that these drugs have also caused me to become so mentally ill, at times delusional and psychotic, that I have been hospitalized countless times. My psychiatric files are so many they would probably fill up a Volkswagen!

Along with the humiliation of being forcibly carted off , often by the police — I was once taken in handcuffs from my home in Arizona in front of all of my neighbors — are the untold losses that follow a manic/psychotic episode. Severe manic episodes have caused me to lose jobs, apartments, relationships (even a marriage), and most importantly, self-esteem.

The devastation that I have experienced from this illness is so overwhelming that I can hardly believe it happened. It has been a true nightmare. And then there's the formidable task of overcoming the shame for all the crazy, insensitive things that I have done while sick, then attempting to make amends to the people I've hurt, and the slow road of rebuilding my life.

I have done this more times than I care to remember or discuss, but somehow I have bounced back and am still functioning, still standing, and learning to hold up my head again. For this I give thanks foremost to God (and mine is Jesus), and to close friends (especially those who are also mentally ill), family who loved me unconditionally and gradually came to understand my illness, ministers who prayed for me faithfully, and last but not least to all of the mental health professionals, from psychiatrists to therapists to social workers and case managers who helped me to survive.

The hardest person to thank is myself, because, as I said, my self-esteem has taken a huge blow since my diagnosis seven years ago. I was a mental health professional for over 30 years, working with all kinds of people and helping them with a wide variety of problems. I taught assertiveness training, did workshops on self-esteem, and I learned the concept of "resilience" as applied to abused children. Now I need to apply it to myself as well. I think a lot of us who have mental illnesses have trouble giving ourselves credit for all we do to survive and hopefully, thrive in this world.

I am very involved at the Clara Martin Center in Randolph. I see a therapist, a psychiatrist, a case manager, a vocational specialist, attend a womens' group and the vegetable garden club. I don't like being dependent on these programs, but they have been a lifesaver for me.

We have also recently started a NAMI chapter (National Alliance on Mental Illness) for consumers, called "NAMI Connections." We were trained at a weekend in Burlington to become facilitators. Our group has met a few times and is gradually growing. It feels good to be reaching out to the community, as there are definitely people who are mentally ill who are not clients of Clara Martin and we don't want to exclude them. I also attend the "Living Room Project" at Clara Martin, which is largely a social and recreational group, which I enjoy.

I attend a church in town that I really like and have started volunteering for "Habitat for Humanity" to help raise funds to build homes for poor people. I am trying to expand my social group into the population who are not mentally ill, though most people these days suffer from at least anxiety or depression anyway. I like to keep busy, yet I have found it difficult to work, with all the stress, anxiety and so forth, so I have been doing a bit of freelance journalism and squeaking by on my disability.

I've been on SSDI disability for about 5 years. As with many people, my disability claim was denied the first time. I reapplied and continued to struggle. It got so bad that I was homeless in Florida, living on the beach and panhandling for food. Then finally, by some miracle, my brother spoke to an understanding "angel" at the social security office and they finally approved my claim. This awful scenario is hard to believe after I spent 30 years as a social worker, earned two master's degree's, etc., but I just don't feel like the same person I was back then.

Surviving a mental illness means rebuilding my life and I know other people can relate to this. I am working on a documentary about my life and another on mental illness in general. These two projects have been years in the making but are plodding along. I feel a deep need to share my story. It is cathartic for me and hopefully will help others, too. I never had children and now I have gone through menopause so it's too late, but with a genetic mental illness maybe it's better I didn't? That's a sad can of worms but I bet other people can relate to this, too.

I refuse to take meds that make me gain excessive weight, screw up my sex life or turn me into a drooling zombie, so I stand up to my psychiatrist and advocate for myself. I feel sad for the people who can't do this and suffer severe side effects from their meds.

I thank God every day for the strength to hold my head up and move forward. I am inspired and comforted by the friends I have made who share this journey of mental illness into wellness. I enjoy sharing stories with others and if anyone wants to be part of my documentary on mental illness you can reach me through my email at cwbeachgirl23@yahoo.com.

I am grateful for this opportunity to tell my story in *Counterpoint* and I encourage others to do the same. We are amazing people, very gifted, creative, intelligent, and caring and together we can help to conquer the stigma of mental illness and to live full, happy lives. Thanks for "listening". God bless you.

Arleen Alexandra Fortune is from Randolph.

Editorial Page

Editorial

Weighing Honesty

Being open to criticism is not the easiest thing in the world. Getting negative feedback is never a great feeling, even if it is helpful.

A decision to be open about policies and to invite comments carries risks:

— the risk of being told you made a bad decision;

— the risk of being seen in a bad light because a bad decision becomes public.

It also carries some clear benefits:

— hearing views from other people that might help improve policies (even if the policies were good...but can be made better);

— the benefit of the reputation of being honest and willing to accept criticism by other people who care about the quality of your work;

— avoiding the bad impression that it makes when something negative is "discovered" by someone else, instead of problems being shared voluntarily.

When all is balanced out, if the real concern is about quality, then being open is always the best policy. When other eyes look at the same thing, there is almost always going to be new information or a new point of view that may be helpful.

So how do the mental health providers in Vermont make out on that score? The rating would have to come from local Program Advisory Committees when it comes to the community mental health agencies. Is the committee able to set its own agenda and ask questions? Does the agency involve the committee in reviewing information? Or is the committee mostly controlled by agency staff? The answers to those questions would tell a lot about openness.

Our hospitals are sometimes more in public view when problems arise, so it can be easier to tell how open they are being. Most of them seem to be taking good steps forward. The Vermont State Hospital still has real challenges when it comes to answering questions directly and bringing information forward. Its administration still ducks and evades.

The ideal is when a hospital has an active advisory committee that meets regularly. At Fletcher Allen Health Care any member of its program quality committee can ask for an item to go on the agenda. The committee discusses uncomfortable topics. Anyone in the public who is committed to regular participation can join. Problems don't always get fully resolved, but a real effort is there. Rutland Regional Medical Center has a similar advisory committee.

But surely, this past summer, Rutland Regional Medical Center deserves top honors for being open and honest. It was the hospital itself that shared its new policy on searches and asked for input from its community advisory committee. No one had to hunt the information down.

There was a lot of very bad reaction to the policy, which required full body strip searches for every patient admitted to the psychiatric unit.

The hospital held its head up to the barrage of criticism and said, in effect, "this is why we ask for input from others. We get feedback that can help improve policies."

That was a courageous and admirable response.

Personal Reflection

Would I ever go back if I needed to?

by Anne Donahue

I wonder if there isever a way to communicate to one who has not experienced it what it feels like to admit oneself to the psychiatric unit of a hospital.

You would not be there unless someone had reached out through your agony to tell you that you needed to be there. And somehow, despite the desperate urge to find a way to end the pain forever, there was still enough of a flicker of the will to live – or the fear of death – to obey.

And then the hours of crushing degradation and humiliation begin. People are kind. Sometimes the most demeaning are those being too kind. And strangers are asking you to say out loud to them what you are feeling, and whether you had a suicide plan, and what it was. After haltingly getting the words out, there is someone else again, wanting to hear it again. And again. To bleed some more; to spill those deeply private parts of yourself all over the floor to be mopped up by the next cleaning crew. It's only little pieces of yourself that you are spilling out.

Minutes, hours, go by. Time would be irrelevant but for where you are sitting waiting, sure that every person passing by your section of the emergency room knows why you are there. It is plastered on your exhausted, drawn face – and is obvious by your lack of visible blood or IV tubes. Just another psych patient, waiting for admission.

There is a sense of unreality. This cannot be me, sitting here, about to be admitted to a psychiatric unit. Numbed by pain, numbed by the self-horror, waiting.

The words and the label hang heavily upon you, as though life will never be the same – no person will ever look at you in the same way again. A psychiatric patient. And although you can't know it then, if it has happened this first time, it is likely that it might happen again; that a relapse will bring you back. But it will never become easier. There will never be less of a sense of failure or less of the awareness that the world looks upon you at that moment with mild disgust.

You are walked up to the unit, escorted carefully. After all, you might turn and run. You can't be trusted. You are a psych patient.

You walk through doors – two sets of doors – that lock behind you in sequence. The second one doesn't open until the first lock clicks shut, just like prison doors. I'm here asking for help. Why am I being locked in this way?

Just when you believe you have reached a place of sanctuary, you are processed: empty your pockets, have whatever bag or purse you have with you carefully searched. Your very identity is taken away: your wallet with its ID cards, your cell phone. You will have to share the common pay phone in the hallway.

I haven't committed a crime. I feel as though I am being treated that way, and it sinks into my fibers.

I'm a person; but now I'm a person who can't be trusted enough even to simply be asked – "do you have a penknife or anything sharp with you?" To just be told, like an ordinary person: "for everyone's protection, we need to make sure there aren't any dangerous items brought in by mistake."

Of course not. You are a psych patient, and nothing will ever be the same.

The overlay of the shame and humiliation becomes one with the numbness and the anguish, but it will never be disconnected from the experience.

I came for help; can't I simply understand and accept that this was necessary for my safety?

But I chose to come for help. If I weren't trying to save my own life, I could still be at home, able to access any of dozens of ways to hurt myself. I didn't do that. I made that desperately difficult, overwhelming, crushing decision, and I came.

I wouldn't have come if I had had any other option, but something in me still wanted a way to escape from the pain in a way that didn't mean facing death. So I accept the humiliation of being treated as an incomplete person, not fully worthy of the dignity others would be afforded. I must surrender my very self as a person at the door. It takes little from the external environment to take away your dignity, because any sense of dignity is so far gone already when you walk in those hospital doors. The smallest bit of degradation is intensified.

That is my lived experience of admitting myself to the psychiatric unit of a hospital: 1994, 1995, 1996, 1998, 2001.

That was then.

Today, if I lived in Rutland and I were admitted to Rutland Regional Medical Center, it would be different. I would be brought into a room and told to strip naked – socks, underwear, everything. To "protect" my dignity, I would be allowed to strip behind a "curtain" created by a nurse or counselor holding a hospital gown up in the air.

Stripped not only of clothing, but stripped naked emotionally and psychologically, while I stand and wait for my clothing to be thoroughly searched.

In the name of safety.

Protection of that so very fragile psyche, the bleeding part that brought me to these doors? Protection of my already deeply damaged ego?

Protection against new trauma? Protection against emotional harm in the very place I came because I was in emotional crisis?

Not the priority anymore.

If I were mentally coherent enough, I might object. But standing there alone and defenseless, I would not even think to object. The thousand more deaths I was dying would remain a silent inner humiliation. I am not in a position to be capable of the courage to object.

The mantra of a "risk-free" hospital unit is eating away at the core principles for recovery and the building of trusting relationships and hope. Stripping people does not build trust. It moves us backwards into the dark ages of psychiatry: back to when the stripping of all dignity was the norm because psychiatric patients didn't deserve any better, and didn't know or feel anything, anyway.

Rutland Medical Center was too panicked about being found in violation of federal regulations to make an effort to identify less invasive alternatives to prevent contraband from getting onto the unit – or, perhaps more damning, didn't think it was significant enough an intrusion on patients to warrant finding an alternative. And federal regulators apparently believe physical safety outranks everything else.

We have fought for years to reduce the stigma against asking for help, something long identified as one of the greatest barriers to treatment for an otherwise highly treatable illness. This is a radical backsliding. It is the equivalent of destroying critical body tissue with overuse of an anti-infection agent before surgery to save that same body part.

It is also about the impact upon me – and you, or your mother, or spouse, or sibling or friend – in facing that desperately difficult, overwhelming, crushing choice about going to a hospital for help.

Would you bring your depressed, elderly mother there, knowing she will be asked to strip off all her clothing so that even her undergarments can be inspected for contraband?

Would I ever go back if I needed to?

Even thinking of that question shakes me to my deepest core.

Anne Donahue is the editor of Counterpoint.

Op-Ed

Opinions and Letters

Supreme Court: Strip Searches Are Degrading

WASHINGTON — The Supreme Court has discussed the "obviously different meaning" and "degrading" nature of exposing the body when such an exposure is used in the way usually "reserved for suspected wrongdoers."

The court was specifically addressing a search in the context of "adolescent vulnerability [that] intensifies the patent intrusiveness of the exposure," calling it a "categorically extreme intrusiveness" to conduct "a search down to the body of an adolescent" because of the emotional harm caused.

The case involved a middle school student who was required to "pull her underwear away from her body in the presence of the two officials who were able to see her...breasts and pelvic area to some degree" in a search for contraband. The court said that "both subjective and reasonable societal expectations of personal privacy support the treatment of such a search as categorically distinct" from searches such as a search of outer clothing and belongings.

"The indignity of the search does not, of course, outlaw it, but it does implicate the rule of reasonableness," the court said. The court has ruled in the past in school-search cases that there must be a degree of suspicion of dangerous contraband that matches the degree of intrusion of a search. AD

Lawsuits Have Settled Matter in Other States

Searches or mandatory undressing of psychiatric patients without a specific justification have resulted in settlements against hospitals in both the United States and Canada.

In 2009, a Montreal hospital paid $1 million in damages for practices including "strip-searches without prescription and without circumstances [the search] would justify."

Also in 2009, Beth Israel Hospital in Massachusetts settled a case involving a "mandatory clothing removal policy" that applied to all psychiatric patients in its emergency room, regardless of any evidence of imminent risk from an individual.

Patients who refused were forcibly stripped.

The case not only resulted in a new policy at Beth Israel, but also a new licensing requirement for all hospitals in Massachusetts, to be enforced by the Department of Public Health.

A state document declares that "psychiatric patients in emergency departments have a right to retain their clothing," and that forced removal is a form of physical restraint that cannot occur unless "compelling clinical information indicating imminent risk to self or others" exists.

"We hope this settlement will make clear that hospitals must comply with federal restraint requirements and anti-discrimination law before requiring psychiatric patients to remove their clothing or be disrobed by force," an attorney involved in the case said.

In 2004, the state of New Jersey agreed to pay damages to patients who had been subjected to a universal strip search, and adopted a search policy that established standards and guidelines for conducting searches of the person, his or her room, and mail. The settlement also required a monthly report detailing any searches, including the circumstances, the extent, whether any contraband was found, whether force was used, and clinical justification for the search. AD

Recognition for the Seneca Program

To the Editor:

I want to share with you the secret I found on the hill. It was Seneca.

This is a place where I could share with others about nearly having a mental breakdown. I was overdoing it through volunteering, or giving to others instead of myself.

I enjoyed helping people but I needed a reality check that it was slowly robbing others of who I really was. I had headaches, fits of anger, and as a person with multiple sclerosis, I needed to find balance.

I heard of Seneca, but thought it was for people with mental illness. I didn't belong in that category but had nothing to lose except my mind.

The wonderful staff at the center taught me about mindfulness. Through sharing my frustrations with others I worked on my goals that I previously set before my first group, I found my voice and learned to say no.

I learned that I can still share my passion for humanity without overdoing it. Now I am spending more time in silence and turning within for support. This program deserves to be recognized for the wonderful work that they do.

CAROL ANN WOOSTER
Burlington

Insensitivity Is a Barrier to Recovery

To the Editor:

This has been the situation I have faced all my life! Everyone in the outside world just walks all over me! They are mean to me! Uncompassionate!

As a result, how can I ever expect to recover from my persistent mental illness?

Since there are innumerable examples, I will explain the three most recent ones. Back on March 20, my hours at a local arts exchange were reduced from eight to four hours, due to the poor economy and lack of business.

Now I am forced to prioritize and do only the most critically important tasks for an area that covers a total of 6,000 square feet for both floors! But despite my diligent efforts, I still find it almost utterly impossible to do the very most important things. Tried to get one more hour, but useless.

I would resign, if I had a choice. But in this economy and area, I would never be employed again. I have to take two different medications to cope with the stress. Then, it is tough for me to cope. Since I do need the money, I am stuck in a vise. I use a vocational coordinator for support.

Last Thursday I attended the local chapter of the AARP monthly meeting. The minute I walked into the Elks, one of the other members forces me to pay 50 cents at every meeting towards the refreshments. Then when the meeting adjourns, I am not allowed to leave without handing in my membership card.

But last Thursday the card was snatched from me! I came home enraged! I no longer care to attend. Attendance is very small. I am not attending meetings anymore.

Last February, I found one of my best shrubs in my backyard pruned twice to the ground by a neighbor who is mentally ill. I was shocked in disbelief! Even though I am separated from this neighbor by a picket fence, the neighbor walked all the way around the corner of the block during dawn to inflict the damages! The culprit loves to go around town cutting grapevines in the fall. People are insensitive to my problems and my needs.

RICHARD A. WILLIAMS
Bennington

Alternatives 2009 Registration Open

The registration brochure for Alternatives 2009 is available on the Alternatives 2009 Web site, http://www.alternatives2009.org, and information will be updated as the conference draws nearer, organizers report. Registration for the pre-conference institute, "Transforming Lives Through the Arts" is also now open.

Alternatives 2009, which runs from October 28 through November 1 at the Hilton Omaha in Omaha, Nebraska, is organized by the National Mental Health Consumers' Self-Help Clearinghouse. This year's conference will include workshops and institutes in several categories: Peer-Led Programs, Leadership Development, Health, Technology, The Arts, and Diversity & Inclusion.

The Alternatives conferences are funded in part by the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. Scholarship information can be obtained on the web site or by contacting Vermont Psychiatric Survivors at 1-800-564-2106.

The theme of the conference is *Uniting Our Movement for Change*. "Although our movement can encompass a wide array of philosophies, we can unite around common goals: to guarantee that individuals diagnosed with mental illnesses have all the opportunities, rights and responsibilities available to everyone else, including the right to pursue a meaningful life."

Your Opinions Matter Here.

Share What *You* Think with Peers, in *Counterpoint*

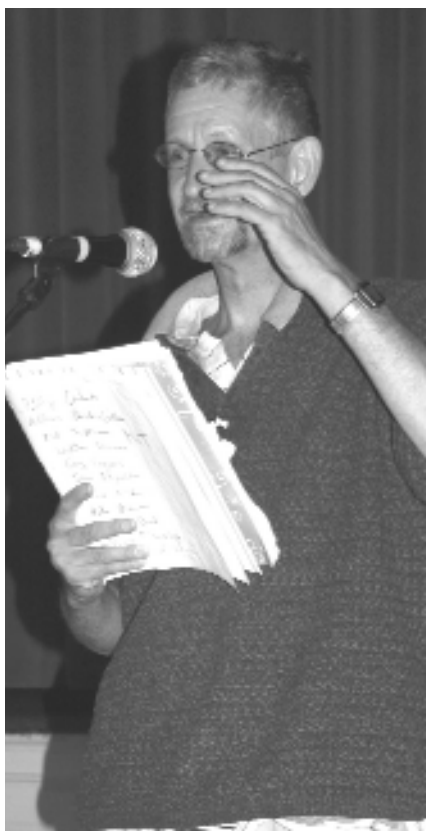
We welcome your letters and articles! Your name and phone number must be enclosed to verify authorship, but may be withheld from publication if requested. Write to: *Counterpoint*, 1 Scale Ave, Suite 52, Rutland, VT 05701 or by email to counterp@tds.net. The editor reserves the right to edit overly long, profane, or libelous submissions. Letters should not identify private third parties. **Opinions expressed by contributors reflect the opinions of the authors, and should not be taken as a position of *Counterpoint*.**

Evening of the Arts

Leta Bostan and Ivan Cruz dance the Maranga

Abby Roberts

by Chris Bousquest



Chris Hall

Bill Gallant

Stephen Tall

by Janice Kiriya

Josh Barlow

by Peter Stanton

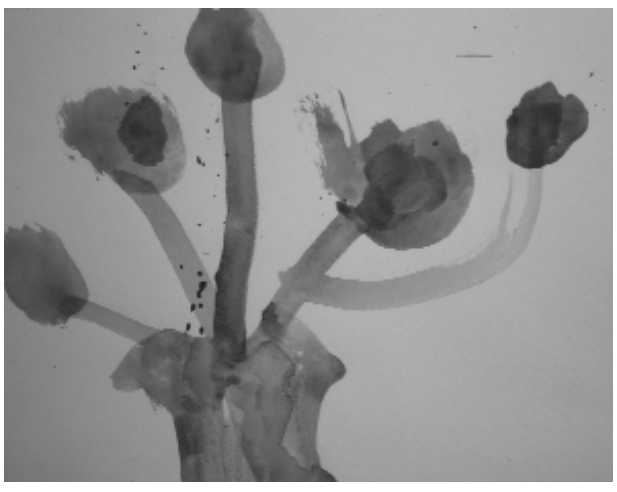
Marie Dutra

by Stephen Tall

by Josh Barlow

Neal Muse

by Sarah Smith



by Missy Bennett

by Abigail Roberts

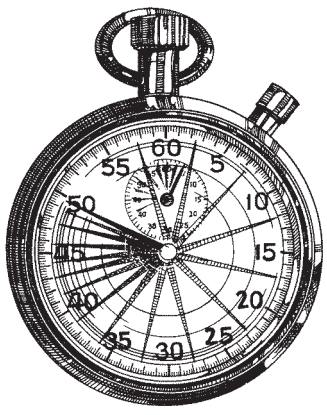
Jim Paterson

Every summer, Burlington HowardCenter's Westview House in Burlington sponsors its "Evening of the Arts to showcase local talent. This year, the 21rst annual event was a tribute to the memory of Ryan St. Amour, including a short film by Brian Cina and the Mind Over Matters Film Group, with original lyrics, music and performance by Doug McGorty.

Counterpoint Photos by Anne Donahue

Arts Poetry and Prose

Louise Wahl Memorial Creative Writing Contest Winners



First Place (Tie)

A Schizophrenic's Guide to the Art Of Being Lost in the Woods

by RON POTTS

If, God forbid, you find yourself in urgent need of this handy, indispensable survival guide, I am going to assume that you are not a seasoned woodsman such as myself, and are in really big trouble. Trouble so big that you need something to take your mind off the dread seriousness of your circumstances.

True, you are going to die because of the inexperienced situation you got yourself into, but there's no need to die all mad and depressed. Actually, you don't have to die at all if you don't feel like it. Simply use this guide.

The helpful hints described herein are time-tested, proven methods used by the survivors of such epic catastrophes as the Alamo, Little Big Horn, the Donner Party, the wreck of the Edmund Fitzgerald, and of course, your humble author, whose credentials are well-received on the schizophrenic ward at the State Hospital.

Thus said, take heart. You are already halfway out of the woods. Camp is just around the next bend...or the next one...or the next one...well...I bid you a memorable misadventure.

Now getting lost in the woods is critical business and needs to be addressed with utmost gravity.

People die from it. They die overnight. Don't ask me why, but they do.

I don't get it. Hell, I get lost every time I set foot in the woods and it hasn't killed me yet. Are you kidding? I get lost on my way to the woods. I look forward to it. It's part of the wilderness experience.

But, difficult as it is for me to imagine, you probably don't think like I do. In fact, you probably have serious issues, and aren't on the same medications as me. Therefore, I'll do my best to tailor my instruction to accommodate your confusion.

Now don't get me wrong. I know you think you're perfectly all right. But that, heh, heh, is what we all say, isn't it?

So, there you are, prancing all tippy-toed through the enchanted forest, happy, limp-wristed and gay, sniffing the pansies and batting your eyelashes at the woodland fairies, when all of a sudden you look around and find that you no longer know where you are.

OH.. .MY.. .GOD! Lost in the woods! Excuse me while I totally FREAK OUT! I'm gonna DIE! Wild animals are going to tear me up and nobody's EVER gonna FIND me!

Yep, with an attitude like that you surely are gonna die. It might behoove you to put your thinking into perspective. Just say to yourself: "Now if this just don't really suck. I'm trespassing on somebody's property, and the owner is probably a wild-eyed schizophrenic hermit with a gun and isn't afraid to use it.

So I better get the hell out of here!" Wait a minute. Isn't that why they came and took me away in the first place?

If that doesn't work, try this: Picture a great big bulldog-visaged individual in a Smokey-the-Bear hat, flinging slobber while screaming, "Why, you worthless, miserable maggot! What in the dyin' ol' jeezius hell do you mean you're lost? Do you need your mammy to change your diapers? Twenty years in this man's outfit, and you are the worst, I repeat, the WORST pile of diarrhea God ever dumped on my platoon! You make me wanna puke my guts out! If you ain't outta these woods in two minutes, I'm gonna kick your ass up so far between your shoulders you're gonna have to take your shirt off to shit! Move it! Move it! Move it!"

The idea, of course, is to put a different light on things before panic has a chance to rear its ugly head. Please don't panic. It'll ruin your misadventure and you won't reap the benefits of my expertise.

You need to swallow that impulse immediately because it's delusional. It's false. Your system is lying to you. Your system is calling for an unnecessary overreaction to an undefined danger. You're just lost. That's all.

And the state of being lost isn't going to cut your throat, rape you, beat you to death or shoot you through the head and bury you in a shallow grave — all possibilities should you find yourself lost among people in the wrong neighborhood.

Relax. Just sit down and take it easy for awhile. No need to get frantic. Nothing changed. The woods are still the same as they always were. The only thing that changed is your perception of it. Take a reality check and you'll find that it ain't that big a deal. It's more of an aggravation than any kind of threat. Try swearing. Swearing always works for me.

Have you taken your reality check yet, or are you still running in circles, pulling your hair and freaking out? Quit running and pulling and freaking.

The reality is that if you're anywhere within the borders of the United States, with the exception of Alaska, you're never more than five miles in any given direction from a superhighway, a subdivision, a mall, or somebody's backyard. You are definitely trespassing on somebody's property, and when they find out you ignored all their warning signs they are going to take you to court. That's the reality.

The circumstance of being lost presents a number of options; none of them all that appealing. Suppose, for instance, you manage a straight line for five miles long enough to reach a road. Now who, in this day and age, do you think is going to stop for you?

Get real. They're going to take one look at your bedraggled butt standing pitifully on the shoulder, and they're going to make a wide sweep and hit the gas, leaving you

(Continued on page 18)

Arts Poetry and Prose

Louise Wahl Memorial Creative Writing Contest Winners

Third Place

A Love Story for All Time

by VIDA WILSON

Here's what you gave me all those ten years; handfuls of roses and buckets of tears. Tenderness, sweetness, true love undefensive in form – a tempest, then heartbreak, a sweet ripe red rose with a hidden slippery thorn. When you held me in your arms, so sweetly, strongly, true, I know I saw through the heart of hearts to the man who is really you.

I saw through those eyes of yours, weathered but forever true. I saw the door to loving you swing open and invite me through.

So I entered in, you held me close and on and on we went, traveling from coast to coast – love's overflowing stories, travels and events…

Just like little children, hand-in-hand we went to the stories and places in our heads. You promised, my only one, to "love me to the end…" How I loved you, darling one. How I felt your soul touch mine, and when you'd stroke my hair and smile, there was not one trace of guile.

We became one from two, I let you in, you entered to my soul. Because of love I trusted you, regardless of the toll… Were we wrong, my darling one? If so, I didn't care; for in the end all I desired was to see you, my love, standing there.

Your eyes were my diamonds. Your arms were my pearls. Your laughter – bars of gold. Your hands held my world.

When you loved me so true you let your real self show through. Then time froze there for us, so we'd never grow old. For true love is immortal and so is the soul. Love is joy's portal and trust is its toll.

But my fear of loss was so great, oh, me of little faith. No faith in my self's value, to make you want to stay. So with each second of my bliss came an hour of fear: the fear that you'd go far away. Fear of losing this man I so loved, this man I held so dear.

But you promised me, "Sweetie, I'll never ever leave you; please rest in my arms, and please believe in me."

And so I did as the years passed by, and you continued to bless me with love. Then the dream of your staying with me became the reality I really could see.

We slow-danced that Christmas to Kenny G, while the stars burst like diamonds in the sky for you and me. My heart full of love was as full and light as the sun – the noonday sun, and I dared not doubt or ever question why.

I cried tears of joy that you even loved me still, and that you loved me freely with the decision of your will. We went off to Paris, London, Venice and Rome, Berlin and Moscow were all our second homes, but we named Lake Como our final, final home. Then we rested and held hands by this lake we named our own.

This gorgeous home we chose, this home in the heart of a rose; then with love and holy water, you held me and anointed me "your own." And you gave me my real name, and for the first time in my life, I felt my own heartbeat – right, the heartbeat of my true soul.

I realized I'd come "alive" and I realized I'd "come home."

I cried with the joy of belonging to you, to belong to the one that I loved. Then you reassured me, "never worry, sweet – I'll never, ever go away – you'll forever have my love," and my heart flew to heaven on the wings of your love. In your arms, and in your eyes, I am certain I saw true love.

A love, perhaps, that made you fear; yet you kept on loving me despite the risks, despite the odds, my fears, my tears, the adding years until I could breathe. My wings began to grow and expand and spread – but never to fly from you, but just along side. For I found that after all, the only place I wanted to fly was back to the "palace of me and you" – back, back to your side.

When I touched your face, I touched the treasures of all the worlds born and unborn, and you hand holding mine – a thousand diamonds.

And then one day, an explosion! A quake! I still cannot explain! A horrible, tragic, nightmarish story, some aberrant, horrible mistake. Then in one day, just one awful day, I lost you, and all things alive. I lost everything I lived for in this life, in just one moment on just one day for just one horrible mistake.

Oh, please, take me back – back – back to that one moment in time; that one cursed moment when you decided to rip your love apart from mine. Please give me one chance to reverse whatever it is I'd done, someway, some day, somehow – or else the unredeemable loss of your sweet precious love will leave the whole of my being. Undone.

Please, oh fate, who has yet forever betrayed me, be just to me, just this once, and take me back to that moment in time, so I can redeem and reclaim my love. Redeem and reclaim my beloved as mine, just once more, to hold my beloved as mine; to feel the warmth of your arms around me, as my heart bursts with joy and sunshine.

Vida Wilson is from Brattleboro.

2009 Winners

Writing –

***Tied for First Place* ($75 each)**

Not a Chance, by Sue Hohman

A Schizophrenic's Guide To the Art of Being Lost In the Woods, by Ron Potts

***Third Place* ($25)**

A Love Story for All Time, by Vida Wilson

~ ~ ~ ~ ~ ~ ~ ~ ~

***Poetry – First Place* ($50)**

His Gift of Love, by Natalie Hope Rallis

***Second Place* ($20)**

Deception, by Maria Cecilia Cunningham

***Third Place* ($15)**

The Red Tide, by Dennis Rivard

Poetry winners and 'Not a Chance' were published in the summer issue of Counterpoint. Deadline for the 2010 contest is April 10.

POETRY RUNNERS UP

Mommy

Mommy, were you in the dark?
Did you not see?
Did you not hear?
The things he did to me!
Mommy, footsteps that crept
downstairs in the night,
Mommy, how could you leave
your little girl alone in her fright?
Mommy, I remember the time
I came to you, to say ~
to tell you of my pain
and you chose to run away!
Mommy, why didn't you hold
and comfort me in my time of need?
Why couldn't you see I was
the victim, not the bad seed?
Mommy, why didn't you
love your little girl?
Why didn't you take me away
to a safe and loving world?

Sharon M Young, Manchester Center

MoRning

tHis SmouRning
I fEll iTO Wake
sMaShed My
MuG to ThE Mug
mUrKy bLacKneSs
wiTH a StEncH Of
GuNPowDer
An assault oF
bRiGht WhiTE
SkY MorNIng
wINninG oVEr
NiGHt rAnSacKed
mY dIrTY lAunDry
sTraPped oN mY
CoMbAt bOots
anD ThReW oUt
A mOuNd oF GaRbaGe
WaLkEd uNevEn
SiDEwaLks tO
wAkE uP.

Kelley Murray
Jamaica

Louise Wahl Memorial Creative Writing Contest Winners

A Schizophrenic's Guide to the

(Continued from page 17)

with a mouthful of exhaust to suck on. You've been lost. You haven't had a bath in days. What do you think you look like? Nobody is going to want your filth stinking up the inside of their fine automobile. A good Samaritan might roll his window down long enough to give you directions to the nearest Salvation Army.

Other than that, the only people who'll stop for you will be a truckload of drunken yeehaws looking to have some sport with you. They'll beat you senseless, rob all the money you put aside for an emergency, and leave you for dead.

Then they'll go buy some more liquor and yeehaw all night long about how lucky they were to have found you out in the middle of nowhere, and how funny it was stomping your guts out at their leisure without any witnesses.

Meanwhile, while you're lying all bloodied and half submerged in the drainage ditch, cars will be zipping on by, thinking you ain't nothing but shapeless roadkill, if they even notice you at all.

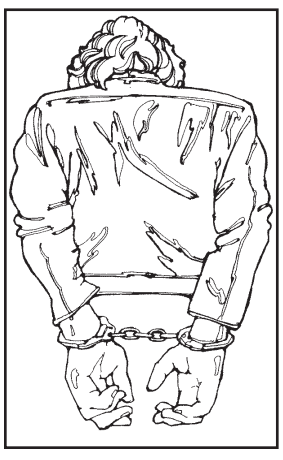
Maybe trying to reach the highway isn't such a good idea after all.

Okay, let's try Plan B.

Hike five miles in a straight line in the opposite direction and end up in somebody's backyard.

The residents will gasp at your appearance, run inside the house, triple-bolt the doors and lock all the windows. The old man will load the pistol he's been keeping for just such a contingency, while the old lady frantically dials 911.

Within seconds the yard will be filled with squad cars, sirens and flashing blue lights. At least a dozen cops will have their guns pointed at you while they're screaming at you to get on the ground. Four or five of them will then pile on top of you, kneeing you in your kidneys, planting boots on your neck, and violently twisting your hands behind your back while ramming your ribs with a nightstick and ordering you to be still.



Once tightly cuffed, they'll haul you roughly to your feet, manhandle you forcibly to a cruiser and unceremoniously heave you into the back seat, making sure that you don't bump your head on the door and hurt yourself.

And then, once securely shackled and in need of medical attention, they'll saturate your eyes with pepper spray for your safety and theirs.

And now, by God, you're going to jail, because this is America where there is zero tolerance for anything, especially not lost prowlers stumbling out of the woods into decent citizens' backyards.

All right! That's it! I don't even want to get rescued anymore! I might as well jump off the next cliff I come to.

Except I probably won't die. I'll probably just break all my bones and end up as a paralyzed cripple at the mercy of the secret facility they'll take me to, where they'll implant tiny electronic receivers in my head while turning me into a cyborg because all they want me to do is Kill! Kill! Kill!

Ahem. I think it might be appropriate at this juncture to take a brief time out. There. I'm all better now. So, putting things into perspective, worse misfortunes can befall you other than getting lost in the woods. In fact, being lost is pretty safe in comparison. At least nobody is going to bother you for awhile.

No nagging spouse, no smart-mouthed kids, no boss who thinks he's God and makes you crawl like a slave, no clamor of the everyday rat-race pushing you inexorably to your grave, where you'll die in helpless frustration because life's circumstances never afforded you the opportunity to live up to your potential or fulfill your dreams. Enjoy the merciful solitude before somebody accidentally finds you.

I know. I know. You don't want to be lost simply because you didn't choose to be lost. And if you didn't choose it, it's little better than rape. The woods are violating your sense of order. The forest is forcing you to do dirty things against your will like camping out without a tent and no supper.

Jeez, ladies, I'd really like to help, but I don't know where your camp is either. In fact, I don't even know where my own camp is.

So it looks like we're going to spend this lesson being lost together. Which is what it's all about anyway. You hardly need advice on the art of being found.

Yes, being lost in the woods is a form of high art. You can either paint messy water colors fit for the refrigerator door, or you can paint enduring oils worthy of a place in the Louvre. The picture is yours.

How do you want the search party to find you? Quivering and whimpering in the puckerbrush, or shaking your good and true spear in front of the magnificent wigwam you built with your bare hands, ordering the rescuers off the land you claimed by right of Manifest Destiny?

I say let's claim these woods we're lost in. All mine. Now let's explore our new-found property we didn't have to kill any Indians to own. At least until the sheriff shows up with eviction papers.

Sadly, I'm not lost in the woods with artists. I'm lost in the woods with brilliant members of the Mensa Society who are so smart that they didn't see fit to tell anybody where they were going, so now everybody thinks you're out just drinking and whoring as usual, so why bother looking for you?

And, of course, you didn't bring a compass because you know these woods like the back of your hand. And why, in God's name, would you ever carry a lighter when you don't even smoke?

Well, just look at the stars, and you'll find that you're lost in the time/space curve, which will eventually curl back around upon itself, locating your position exactly. Depending on where you're standing, of course.

But we don't need to grasp cosmic theoretics.

After all, we're just lost in the woods; the woods being a tiny infinitesimal speck of planet hurtling through space a million miles a second. Boy, I'm really lost now. Especially if this rolling ball of noxious gas really turns out to be flat. So, at this point in the time/space curve the best advice I can suggest is that you sit yourself down on that log right there, hang your head way down low, make far-off wailing harmonica train sounds out of your mouth, and start singing, "Lawd, I ain't got no matches, an' I ain't got no hambone to chew... Yaw Lawd, the night's comn' on me an' I even got a hole in my shoe... Yaw Lawdy, Lawdy, Lawdy, what's this cotton-pickin' hillboy gonna do?"

Don't forget the faraway train sounds. It lends to the ambience of the forest at dusk.

What we're going to do is very simple. Break out the brushes and mix up the paint. We're going to create a masterpiece out of being lost in the woods. When that search party finds you, the old-timers will be talking about it around the pork barrel for years to come.

"Wadn't that the damndest thing you ever saw, Rusty Bob?"

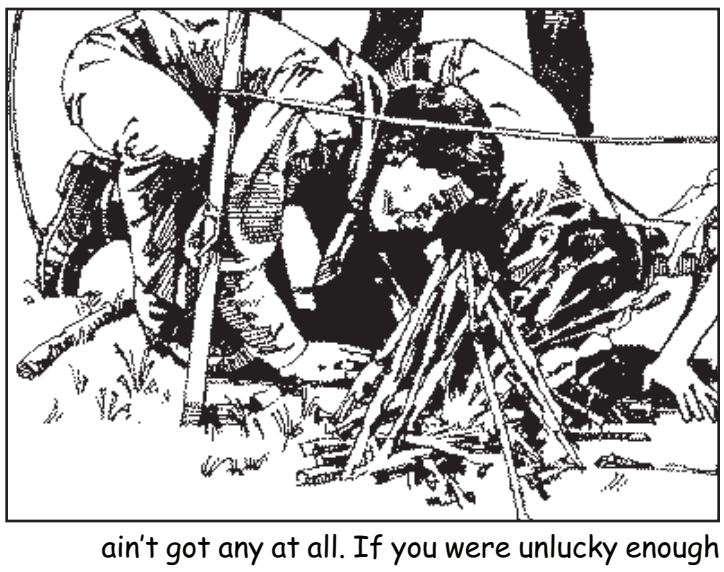
"Ayup, that's the God's honest truth, Skeeter. Sixty years in these here woods, an' that's the damndest thing I ever saw." Yaw Lawd.

So you took a trip into the woods without any matches. Boy, are you screwed, blued and tattooed. That tells me right there how you came to be lost in the first place.

But don't panic just yet.

It's possible to start a fire without matches, but most survival manuals neglect to tell you that the conditions need to be near perfect, and the effort is going to require maddening patience coupled with infuriating repetitions of trial and error. And, of course, the conditions aren't going to be perfect.

Luck is a fickle thing. When you got it, you got all kinds of it. When you ain't got it, you ain't got any at all. If you were unlucky enough to get lost, you're also going to get rained upon with a torrential downpour, soaking the woods so thoroughly that not even the most experienced survivalist would be able to get a fire started.



Back to the wailing, far-off harmonica train sounds. Add a few lines to that last stanza.

But let's suppose it's a bright sunshiny day, and everything is bone dry. There's always the

Louise Wahl Memorial Creative Writing Contest Winners

Art of Being Lost in the Woods

trusty firebow and drill. Did I say trusty? That's a laugh.

Unless you've actually ever started a fire with this abominable contraption, I'm not going to go into the specifics of it, because your efforts to make and use one will make you so mad that you'll want to beat me up when you get back to civilization.

Your standard Boy Scout manual will clearly tell you the components you need. What they won't tell you is that you need precisely the right kind of dry, seasoned wood; none of which can be found in your immediate vicinity. The bow has to be just the right length, the cord has to be looped with just the right tension around the drill, and the tinder under the fireboard has to be so dry that it'll practically ignite itself.

It takes a high degree of skill to manipulate all these parts and pieces. Then again, if the conditions are so perfect that a firebow and drill will work, you won't need a fire because it'll be so hot and dry that there'll be a forest fire raging in the district somewhere anyway.

So much for starting a fire without matches. You should have asked for a lighter the last time you were in the store.

I'm going to assume for a moment that you have matches, you are really and truly good and lost, and you really want to be found. (Lord only knows why).

In that case, don't take another step, except to move yourself to the most open spot available. And then build a fire.

And I don't mean no little peckerwood stick fire good for boiling tea. I mean a fire into which you can see the devil laughing from the flaming pits of hell. I'm talking about the smokiest, roaringest bonfire you can manage.

Just pile on all the brush and deadfalls you can get your hands on. You'll attract some attention all right, and not just from the people looking for you.

You might entertain the silly notion that you are lost amidst vast natural resources, set aside for you and your family to enjoy for generations to come. But you didn't read the articles of Manifest Destiny as carefully as the timber companies did. And those giant corporations are very protective of your inheritance.

Ever vigilant of your interests, they can spot smoke in the middle of the profits from miles away, and will quickly respond to the threat, armed with a handful of subpoenas to serve on the culprit so inconsiderate as to endanger America's designated clear-cut areas.

You'll be found alright, but your public defender is going to get slaughtered in court by the high-powered legal team Georgia Pacific sics on you. Maybe you'll get out of jail in time for Thanksgiving.

Now I don't know whether to discuss starting fires or not. I might get charged with conspiracy to commit arson with a portable accelerant found concealed upon my person in a suspicious manner in my pants pocket.

Damn that Bic! Now I'm going to go to jail. Why didn't I just stay lost? As a survival expert, I have to weigh my responsibilities in view of getting hosed by the fire department. And arrested.

Well, just build a fire. And don't tell anybody I told you to. A cheery fire will keep your mind off your deadly predicament.. .until that helicopter flies over and dumps a million gallons of chemical water on your head.

But, of course, if it's a bright sunshiny day you're not going to be interested in a fire. You're going to want to find your way out of the woods before there's any need for a fire. Good luck.

The funny thing about the woods is that everything looks exactly the same. See that old, gnarled tree you thought you passed a while ago? Well, by golly, ain't there a hundred of them around here that look just like it. How are you supposed to know which direction to take when every direction looks the same?

Well, a compass might have been a prudent idea, but we've already discussed the virtues of negligence. If you have an inclination as to which direction to take, that's all it is — an inclination. Your inclinations will lead you around and around.

It's so easy to get turned around in the woods that it's eerie. Nobody has an inherent sense of direction. Any guide who can lead you through the woods knows exactly where he's going. He'd be lost in somebody else's woods.

Even the old time experienced woodsmen get lost sometimes. They just call themselves a mite befuddled. See? Putting the proper perspective on things.

The reason people get lost is because the Earth is spinning so fast it throws your internal compass out of whack. You might have been facing North a minute ago, but suddenly the Earth has hurled you way off to the West. And the trees end up looking like they did in the South.

Now how in the hell are you supposed to find your way out of these damned bushes and thickets without a global positioning satellite? (If you do have a GPS, for God's sake don't turn it on. It emits microwaves into your brain, which are then fed through sophisticated CIA computers.)

Criminy, you need a degree in quantum physics just to find your way to the outhouse. Unless the Earth really is flat. Of course it's flat. Otherwise people in the South Pole would be standing upside down, and people in Florida would be standing sideways.

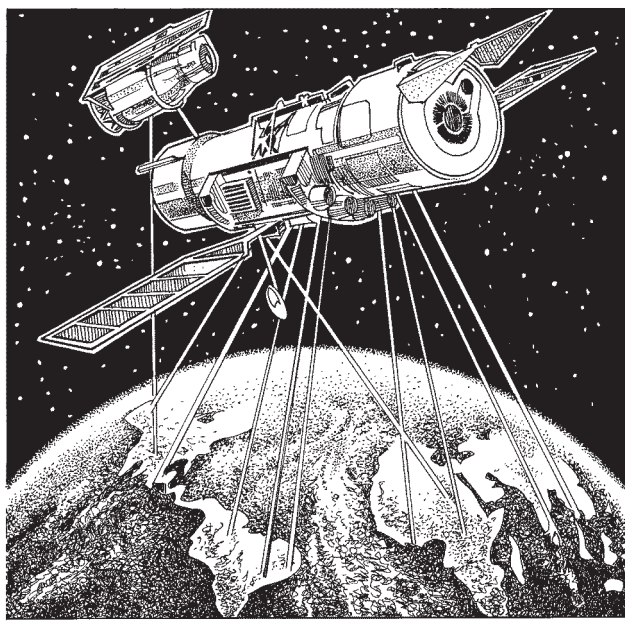
What kind of sense does that make? The reason why people circle the world is that they just keep going around and around.

Hmm. Maybe another time out would be in order. There. I'm all better now.

But it's flatter than a pancake, I tell you. Never mind all those lies from the space shuttle and Hollywood. They're out to get me anyway.

Think about it. If the Earth is really spinning all the time like they say it is, how come you can't put your car in neutral, let the Earth spin under the tires until you get where you're going, then put on the brakes?

And the reason you can't reach the end of the world is the same reason why you can't

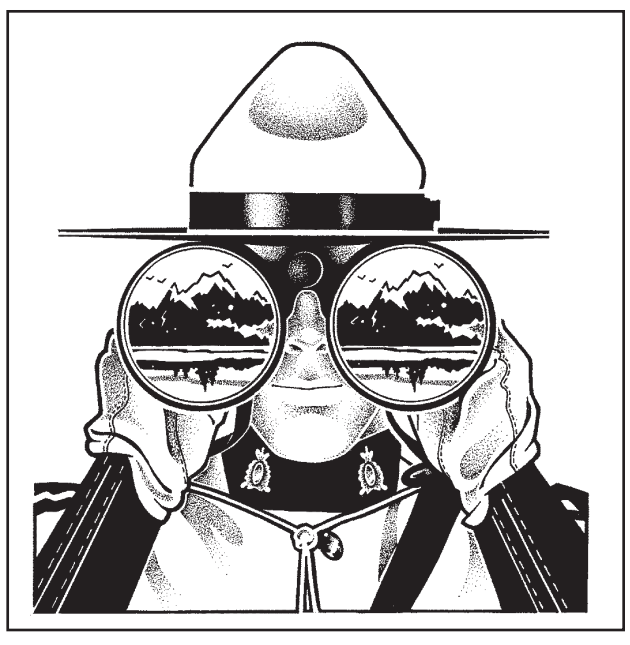


find your way out of the woods. No matter which direction you take, you always end up back where you started. It's eerie.

This all presents an interesting dilemma. Your inclinations might lead you out, but they also might lead you deeper into the wilderness. In fact, if you follow your present course, you might get so lost that nobody would ever find you in a million years.

Unless you're an escaped convict. If you're an average, everyday Joe lost in the woods, they couldn't find you with a battalion of Airborne Rangers and the Hubble telescope. But if you're an escaped convict, they'll be all over you with heat-seeking helicopters, laser probes, and dogs before you can even cross the next creek.

Maybe you ought to commit a serious crime while you're out there being lost. I'll gaildan-



ged guarantee they'll find you in short order. And now you'll be spending Christmas in jail.

Now see what you made me do? You made me complicate the simplest of problems. Why is it that people have to make a big deal out of simplicity itself? Do you want out of the woods? Well, for cryin' out loud, just find North.

Everybody knows camp always lies to the North, no matter where you are. A Cub Scout could've told you that. As for me, I ain't lost. I'm just a mite befuddled.

Ron Potts is from Vergennes.

A Special Clip and Save Resource

The list of groups is compiled by Joan Knight at HowardCenter 488-6243.

Groups in the Burlington area (updated August 20)

HowardCenter-sponsored:

Every Day, Peer support group (not "12 step") for people dealing with drug and/or alcohol issues. 11 AM, including weekends and holidays. Location: Act 1, 184 Pearl St, Burlington. This is open to anyone. For info call 488-6425 (Calling ahead is not required.)

Day and Time To Be Announced, Spirituality and Self-Exploration Group Sundays from 10 a.m. to 11 a.m.; open to Assist clients and anyone else who would like to attend. Leader is Katrina. Call 488-6412 for more info.

Mondays,**Westview Orientation** 10:30 – 12. Open to anyone in HC's CRT/CSP program (case management).

Mondays,**Westview Community Meeting** 11 - 12. Each of these is at Westview @ 50 So. Willard St. Call 488-6023 for more info.

Mondays, **Self-help Recovery - WRAP Group -** 1 p.m. weekly. We gather in 300 Flynn's waiting room. Joan will meet you there and then we move to another space for the group. Free and open to anyone in HC's MHSA Services. Leader is Joan Knight 488-6243.

Tuesdays, Self-help Recovery Group - 11 a.m. weekly, meet in the waiting room at 300 Flynn Ave. and move to other spaces as needed. Share stories and skills, learn strategies and techniques, discover strengths and common bonds. Topics are chosen by those who attend. Leader is Joan Knight 488-6243.

Tuesdays, Smoking Cessation.11 a.m. at 300 Flynn Ave. Leader is Alice Spirito 488-6121. Staff can call to sign up a client, she can call the client being referred, or the client can call her directly. If the phone is a communication barrier for the client, she would be happy to accommodate for any needs to facilitate the intake process.

Wednesdays, **Art Group** 10:30 – 11:30. Westview @ 50 So. Willard St. Call 488-6023 for more info.

Thursdays, Budget Group 11-12 @ 300 Flynn. A new series starts every 5 weeks. For more information contact Naomi Risch at 488-6236 or your case manager.

Thursdays, Smoking Cessation 12:30 pm @ Westview. (See info for the Tuesday group – above.)

Thursdays, Policy Meeting 1 p.m. Westview members only @ 50 So. Willard St.. Call 488-6023 for more info

Thursdays, Grocery Shopping 1-3 p.m. Westview members only @ 50 So. Willard St. Call 488-6023 for more info

Thursdays, Doin' It: Self-help Recovery Skills - 1-2:30 (or sometimes 3) p.m. weekly, at 45 Clarke St. – rear entrance. Open to anyone in HC's CRT/CSP program (case management.) Share stories of small steps & successes, learn from each other, and practice personal skills to help you move toward your goals. Leader:Joan Knight 488-6243.

Fridays, **Mind - Body Therapy** 9:30 -10:15 a.m. weekly, meets in the Assist living room. Come to 300 Flynn – Lobby where someone from the staff will let you in, facilitated by Assist staff. All are welcome. Engage your life in a mindful manner. Become more skillful and creative in your responses to stress.

Day and Time To Be Announced, Grocery Groups on Pricing. Nutrition and Store Comparison. *Call Russ at 488-6227 for more info*

Not HowardCenter-sponsored. Therefore, HC cannot recommend them.

Every Day, "RU12" at 34 Elmwood Ave, Burlington - offers peer support for people dealing with gender and/or sexual preference issues of any type. Call 860-7812 or drop in.

Day and Time to be announced Vermont Psychiatric Survivors (VPS) Peer support groups. Call 1 800 564-2106 for information and assistance about starting or joining a group.

Day and Time to be announced "AWARE" – an incest-survivors anonymous group. Call 472-6463 for information or for pre-register appointment.

Mercy Connections. Website: http://www.mercyconnections.org/php/educate.php

Every weekday, Several types of groups are offered by Mercy Connections' Joseph's House.For information, contact Clorinda Leddy (Center Coordinator) at 399-9486 or Cathy Ainsworth (Administrator) at 846-7162. Education and Transition Center In the Old North End. 113 Elmwood Avenue, Burlington, Vt. - on the corner of Elmwood Ave and Allen Street (Use the Allen Street entrance)

The Turning Point Center- Call for info: 861-3150- 81 Main St. Burlington

Every weekday, Groups for people dealing with **addictions (behavioral or substance-related) and/or emotional challenges** are offered by the Turning Point Center – now at the corner of Bank and Center Streets in Burlington. Enter and turn right up the stairs.

Monday Meetings

Mothers In Recovery 10:30 a.m.
As Bill Sees It AA 12 p.m.
Chapter Two AA 5 p.m.
How It Works AA DBCOpen 6:30
Step into Recovery NA- 8 p.m.

Tuesday Meetings

Next Right Thing NA 12 p.m.
The Way of Life Group AA 5:30 p.m.
Proud and Sober PMGLBTPC BBDPC/Open 7 p.m.
Gamblers Anonymous 8:30 p.m.

Wednesday Meetings

Al-Anon 8 a.m.
A New Perspective 5 p.m. - NEW

a peer support recovery group for those with co-occurring MH/SA disorders. The group is facilitated and is built around a weekly video followed by a group discussion. Some of the topics will include: Addictions and Mental Illness, Recovery Stories, Dealing with Stress, Understanding Personality Problems and Emotions.. The Turning Point Center, 61 Main St. in Burlington.. For informations, call Marisol Velez, Substance Abuse Clinician, Safe Harbor Clinic, 860.4310 ext.280 (P), or 343.-3706 (C).

Came to believe AA 6:30 p.m.
CODA *(Co-Dependents Anonymous)*
A Way Out AA 8 p.m.
AA Candlelight Meeting SMPC/Open 10 p.m.

Thursday Meetings

Light Lunch 12 p.m.
CODEPENDENCE 12-STEPs 5 p.m.
At the Turning Point AA 8 p.m. SMPC/Open
Candlelight Meeting AA 10 p.m. LSPC/Open

Friday Meetings

Overeaters Anonymous 7:30 a.m.
Girl's Night Out Meeting AA 6:30 p.m. WDPC/Closed
Chapter Two COCAINE Anonymous 8 p.m.
Candle Light Meeting SDPC/Closed 10 p.m.

Saturday Meetings

10 a.m. AMGamblers Anonymous
12 p.m. Step /Tradtions Group AA
6:30 p.m. AA Big Book Meeting SMTPC/Open
Candlelight Meeting D/Open 10 p.m. BBDPC/O

Sunday Meetings

The Joy of Living AA 9 a.m. SM/Open
Into Action AA 6 p.m. SM/Open
Live and Let Live AA 8 p.m. DPC/Open

SMART RECOVERY 1 866 951 5357 CURRENTLY IN VT IS ON-LINE ONLY. No active groups. *www.**smartrecovery**.org*

SMART Recovery® (Self-Management And Recovery Training) helps people recover from all types of addictive behaviors, including: alcoholism, drug abuse, substance abuse, drug addiction, alcohol abuse, gambling addiction, cocaine addiction, and addiction to other substances and activities. SMART Recovery® sponsors more than 450+ face-to-face meetings around the world, and 16+ online meetings per week. In addition, our online message board is an excellent forum in which to learn about SMART Recovery® and seek support.

Alcoholics Anonymous (AA) in or near Burlington
Answering Service (Burlington, VT) Phone: (802) 860-8382; Answering Service (Montpelier, VT) Phone: (802)229-5100
St. Albans Answering Service (St. Albans, VT) Phone: (802)524-5444; Answering Service (Middlebury, VT) Phone :(802)388-9284

Al-Anon meetings (check for updates on the web, or call) TOLL FREE: 1- 866 972-5266; Local in BURLINGTON: (802) 860-8388

Narcotics Anonymous
To find a meeting in the area you are searching for please feel free to contact us via email at: **FSTeam@na.org** or call: (818) 773-9999 and ask for fellowship services.

24 Hour Champlain Valley Area Helpline * (866) 580-8718 *** or *** (802) 862-4516 *****

Gamblers Anonymous NATIONAL HOTLINE 888-GA-HELPS (888-424-3577) Saturday meetings 10 a.m. Turning Point Center, 61 Main Street, Burlington, VT Open MTG

Sex and Love Addicts Anonymous http://www.slaafws.org/ To get a meeting list for your area, you will need to contact the Intergroup closest to you.
Western New England Intergroup covers: Western Massachusetts, Vermont & some Connecticut meetings; P.O. Box 791, Northampton, MA 01061-0063 Phone: 800-749-6879
E-Mail: wneislaa@yahoo.com Web Site: www.geocities.com/wneislaa

Debtors Anonymous www.**debtorsanonymous**.org/ Debtors Anonymous General Service Office, PO Box 920888 Needham, MA 02492-0009, Toll Free: 800-421-2383

Adult Children of Alcoholics Anonymous www.AdultChildren.org
For info, call 310-534-1815 (message only). ….. A resource for all who suffer from being raised in an alcoholic or dysfunctional environment.

Overeaters Anonymous https://www.oa.org

If you know of other groups in the Burlington area, please let Joan Knight know. She updates this list. **joank@howardcenter.org 488-6243**

Arts

Poetry and Prose

Recovery

These lines I write
In the silence of the night

Have become my silent salvation
Have become my inner light-station
God's sweet gift to this creation...

Each word that flows
Like water from
My pen held tightly in
My hand

Seems to hold a form of comfort,
Some tiny "spark" to help me start again...

So I listen very closely
To the whispering words within
Buried deep within the
Hollows of my soul
And when they come together,
Just right,
Just right,
This ink I hold
Transforms itself to gold.

by Vida Wilson
Brattleboro

An Ode to Diane
On her 71rst Birthday

Dear Diane,
It's your 71rst Birthday
- And -
I wanted to Thank You
for:
Your wit
Contempt for the
psuedo-elite
Common sense
imagination
irony
spite
Love
etc. etc.
I, too, wanted "A Better Life"
A soul mate
A place in the sun
Not mine
Yet shared
Moonshine,
An Ocean View
A bright outlook
What more can I say?
Other than, "I, too, dislike
Joyce Carol Oates!"

Ocean Chance
Waterbury

Second Spring Celebrates Second Anniversary Picnic

by Matt Staley

WILLIAMSTOWN — Second Spring ranch is nestled on a pristine 45-acre farm in beautiful Williamstown. Recently it was host to a barbeque for an all day event that brought a smile to people's faces and joy to the hearts of many as it celebrated the second anniversary of Second Spring.

On Saturday, June 6, friends, family, staff and members of the community got together to become reacquainted and reminisce over old times, and others came to enjoy the day at Second Spring for the first time. Members of the Red Hat Society attended the picnic as well.

The first thing I noticed on Saturday were how well manicured the grounds were, beautifully prepared for the day. There was a large outdoor fireplace built out of granite, a miniature golf green, a festival tent and picnic table all arranged about the grounds wonderfully.

The food had been prepared for the day by the kitchen staff in the morning and was receiving rave reviews by early in the afternoon. Some of the menu items included roast pork, cold salads, hamburgers, hot dogs and other refreshments.

The activities on Saturday included golf, with a putting green that recently had been designed and built by the residents of Second Spring that became a major attraction. Some people played horseshoes and others relaxed socializing enjoyed socializing.

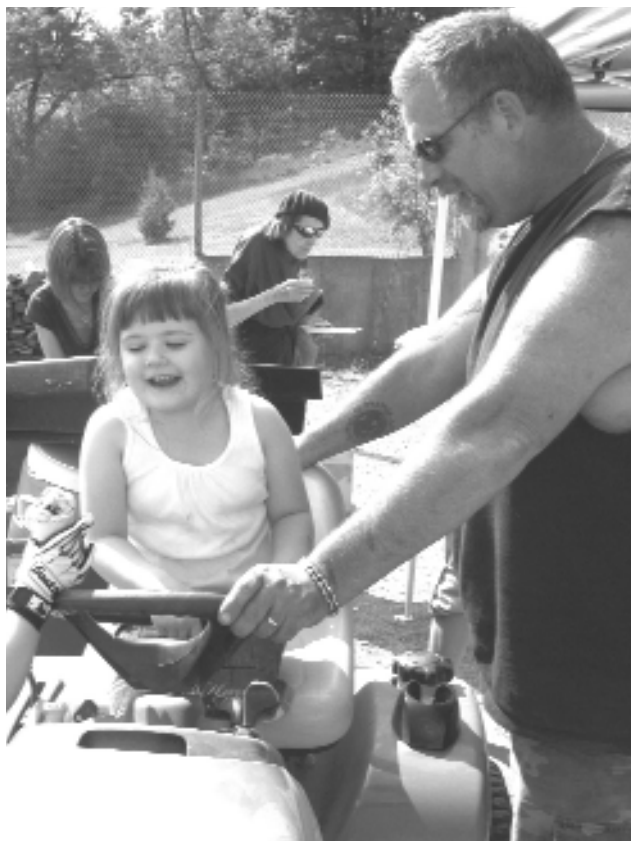
Two members of Second Spring entertained the audience with music. There was a beautifully painted golf cart "taxi" that looked like a miniature taxi cab and was available to chauffeur people to various locations around Second Spring.

Some people really enjoyed visiting the farm animals on the ranch.

One of the participants offered an off road jeep ride that took participants on a breathtaking trek through the back country trails of Vermont. There were ten jeeps with 20 participants in all.

The most important element of the day was the dedication and hard commitment of the people who worked tirelessly to make this event unforgettable for so many. The day of the barbeque was a major success, measured by the enjoyment of the day's participants.

Second Spring is a recovery residence.



RIDING HIGH — Faith Hickory, 4, of Barre tries out the lawn tractor at the first annual Second Spring cookout, which celebrated the second anniversary of the residential recovery program in Williamstown.

(Counterpoint Photo: Anne Donahue)

In My Life

Time goes by
In my life
Daily struggles

I'm high on life
The gospel of my mind
I find the lost

I'm addicted to pain
Stuck in the rain
Think it's insane

JESSE MILES
Rutland

Resource Directory

Vermont Psychiatric Survivors Support Groups

Northwestern
Call Jim at 524-1189 or Ronnie at 782-3037
St. Paul's United Methodist Church, 11 Church Street, St. Albans, 1rst and 3rd Tuesday, 4:30-6:30 p.m.

Central Vermont
Call Brian at 479-5485
Another Way, 125 Barre St., Montpelier
Tuesdays, 6-7:30 p.m.

Rutland: New Life
Call Mike at 773-0020
Rutland Regional Medical Center, Allen St, Confr Rm
2nd Mondays, 7-9 p.m.

Middlebury
Call 345-2466
Memorial Baptist Church
97 S. Pleasant St,
Every Thursday, 4-6 p.m.

Brattleboro:
Changing Tides;
Call 257-2375
Brattleboro Mem. Hospital
Wednesdays, 7-8 p.m.

White River Junction Peers
Turning Point Center
Olcott Drive
Wednesdays 10 a.m.-12

Vermont Psychiatric Survivors is looking for people to assist in starting community peer support groups in Vermont. There is funding available to assist in starting and funding groups. For information, call VPS at 800-564-2106.

Community Mental Health

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

Brain Injury Association

Support Group; 2nd Thursday at Middlebury Commons (across from skating rink), 249 Bettolph Drive, 6 to 8 p.m. Call Trish Johnson at 802-877-1355, or the Brain Injury Association at 802-453-6456; support1@biavt.org; web site www.biavt.org;Toll Free Help Line: 877-856-1772

Depression Bipolar Support Alliance

Bennington area chapter Monday nights at 7pm at the Bennington Free Library on Silver Street in Bennington. For more information call Sue at 802-447-3453

Bipolar Support

Brattleboro: For information call Dennise at 802-257-2375

NEW:
Vermont Department of Mental Health web site: www.mentalhealth.vermont.gov

Co-Occuring Resources

www.vtrecoverynetwork.org

Support Groups

Double Trouble
Bennington, Call 442-9700
Turning Point Club,
465 Main St., Mon, 7-8 p.m.
White River Junct
Call 295-5206
Turning Point Club,
Tip Top Building 85 North Main St., Fridays, 6-7 p.m.
Morrisville :**Lamoille Valley Dual Diagnosis**
Dual Recovery Anonymous (DRA) format;Call 888-9962
First Congregational Church, 85 Upper Main St.
Mon, 7-8 p.m.
Barre: **RAMI - Recovery From Mental Illness and Addictions,** Peer-to-peer, alternating format
Call 479-7373
Turning Point Center
489 North Main St.
Thursdays, 6:45-7:45 p.m.

Turning Point Clubs

Barre, 489 N. Main St.; 479-7373; tpccv.barre@verizon.net
Bennington, 465 Main St; 442-9700; turningpointclub@adelphia.net
Brattleboro, 14 Elm St.
257-5600 or 866-464-8792
tpwc.1@hotmail.com
Burlington, 61 Main St; 851-3150; director@turningpointcntervt.org
Middlebury, 228 Maple St, Space 31B; 388-4249; tcacvt@yahoo.com
Rutland, 141 State St; 773-6010
turningpointcenterrutland @yahoo.com
St. Johnsbury;
297 Summer St; 751-8520
Springfield, 7 1/2 Morgan St.
885-4668; spfturningpt@vermontel.net
White River Jnct, 85 North Main St; 295-5206; uvsaf@turningpointclub.com

Drop-In Centers

Another Way, 125 Barre St, Montpelier, 229-0920
Brattleboro Area Drop-in Center, 57 S. Main, Brattleboro
Our Place, 6 Island Street, Bellows Falls
COTS Daystation ,179 S. Winooski Ave, Burlington

Links to just about everything!
www.vermontrecovery.com
including ***Counterpoint***!
(four years of back editions available)

The Mental Health Education Initiative

Speaker's Bureau
Burlington: Speakers in recovery from mental illness, providers, and family members present experiences to promote hope, increase understanding, and reduce stigma. Information: call (802) 863-8755, email to MHEI@sover.net, or see www.MHEI.net.

Vet to Vet support groups:

Barre, Hedding Methodist Church, Wed 6-7 p.m. (802) 476-8156
Burlington, The Waystation, Friday 4-4:45 p.m. (802) 863-3157
Rutland, Medical Center (conf rm 2), Wed 4-5 p.m. (802) 775-7111
Middlebury, Turning Point, Tues 6:15-7:15 p.m. (802) 388-4249
St. Johnsbury, Mountain View Recreation Center, Thurs 7-8 p.m. (802) 745-8604
White River Junction, VA Medical Center, Rm G-82, Bldg 31, 1-866-687-8387 x6932; every 2nd Tues 3:30-4:30 p.m. (women); Wed 11:30-12:15 (men); Thurs 4-5 p.m. (men);Thurs 10-11 a.m. (women) Call the number listed for more information.

Veterans Assistance

Veterans Administrtion
Mental Health Services
(White River Junction, Rutland, Bennington, St. Johnsbury, Newport)
VA Hospital:
Toll Free 1-866-687-8387
Primary Mental Health Clinic: Ext. 6132
Vet Center (Burlington) 802-862-1806
Vet Center (WRJ): 802-295-2908
VA Outpatient Clinic at Fort Ethan Allen: 802-655-1356
VA Outpatient Clinic at Bennington: (802)447-6913
Veteran's Homeless Shelters
(Contracted with the WRJ VA)
Homeless Program Coordinator: 802-742-3291
Brattleboro:
Morningside 802-257-0066
Rutland:
Open Door Mission 802-775-5661
Burlington: Waystation / The Wilson 802-864-7402
Rutland: Transitional Residence:
Dodge House 802-775-6772
Free Transportation:
Disabled American Veterans:
866-687-8387 X5394

Rights & Access Programs

Vermont Legal Aid

264 No. Winooski Ave, PO Box 1367
Burlington 05402; (800) 889-2047
Special programs include:

Mental Health Law Project
Representation for rights when facing commitment to Vermont State Hospital, or, if committed, for unwanted treatment.
121 South Main Street, PO Box 540, Waterbury VT; 05676-0540;
(802) 241-3222.

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

Vermont Protection and Advocacy

Advocacy when 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.

Vermont Psychiatric Survivors

Contact for nearest support group in Vermont, recovery programs, and Safe Haven in Randolph, advocacy work,
publishes *Counterpoint*.
1 Scale Ave., Suite 52, Rutland, VT 05701.
(802) 775-6834 or (800) 564-2106.

Vermont Federation of Families for Children's Mental Health

Support for families and children where the child or youth, age 0-22, is experiencing or at risk to experience emotional, behavioral or mental health challenges. 1-800-639-6071
P.O. Box 507, Waterbury, VT 05676.
www.vffcmh.org

National Alliance on Mental Illness - VT (NAMI-VT) Support, education and advocacy for families dealing with mental illness. 1-800-639-6480, 162 S. Main St., Waterbury, VT 0567; www.namivt.org; namivt@myfairpoint.net

Vermont Division of Health Care Administration

Banking, Insurance, Securities & Health Care Administration/BISHCA;
Consumer Hotline and Appeal of Utilization Denials: (800) 631-7788 or (802) 828-2900

Health Care Ombudsman's Office

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

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

MindFreedom (Support Coalition International); www.MindFreedom.org
toll free (877) MAD-PRIDE; (541) 345-9106
Email to: office@mindfreedom.org

National Empowerment Center

Information and referrals. Lawrence MA 01843. (800) POWER 2 U (769-3728)