

Voices for Change

Issue # 29

A Statewide Newsletter of the Mental Health Community

Fall 2009

Susan Landy, Editor

Editorial Assistance
Howard Trachtman

Editorial Committee
Karl Ackerman
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Maura Pieciak
Fran Nadeau
Kimberley Warsett

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Veterans as Peers at Bedford VA

By staff

According to veteran activist Moe Armstrong, peer support at the Bedford Veterans Administration Medical Center started about seven years ago with funding from the Peer Educators Project at Vinfen. Since then, peer services at the Bedford VA have grown into a Peer Education Center with paid peers, peer volunteers and consultants. There are 5 full-time Peer Technicians and 15 volunteers. The peers are helping to make the Bedford VA a better place for mental health

and substance abuse recovery.

I visited the Peer Education Center on a Wednesday in August to attend the Peer Advisory Committee meeting. The meeting was

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Al Krull, Supervisor, Peer Support

Veteran Recovery Story by Staff

Redger Hennah is very much focused in the present in his volunteer job as Supportive Education Specialist at Middlesex Community College. But he began to tell me a

remarkable story about self-help and the help he got from others, especially his peers. Currently Hennah is on the Peer Advisory Committee at the Bedford Veterans Administra-

tion Medical Center.

Hennah grew up in New Haven, CT, in what he describes as “a bad neighborhood.” “There was poverty,

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Veterans as Peers

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a very friendly gathering. As veterans trickled in they introduced themselves to each other and to me. I attended at the invitation of Al Krull, Supervisory Peer Support Technician. Al has had his job for about four months. Al says the support from Psychology staff at the VA has been a key factor “to our evolution providing support to our veterans.”

Several of the peers (staff, consultant or volunteer) told me they had taken the Certified Peer Specialist Training through the Transformation Center. Other peers told me they had received training through the Depression and Bipolar Support Alliance or at Hanscomb Air Force Base. The majority of peers run support groups either at the Bedford VA or in the community. Some peers who work in transitional housing through the VA do one-on-one counseling.

During the meeting a full calendar was presented with (among other things) training and continuing education for the peers including a seminar by Moe Armstrong, “Hot Button Issues in Peer Support.” Moe is a long-time national mental health activist who has served on the Board at the Transformation Center. The issues at Moe’s training will include paid peers and volunteers, peers doing documentation, and, current and future innovations in peer support services in health care organizations. Regarding the Out-

reach Efforts Workgroup, there was a discussion of the “culture” of each war era and how to do outreach to different eras of veterans. There was also a strong feeling of unity with each era: “Bullets are bullets,” as a few of the attendees remarked.

The comradery among the peers was evident in the humor. When talking about which era veterans were from, someone joked that someone else’s era was “the Civil War.” After a peer had a lapse of attention, another peer said of him, “Could you please repeat that...my grandfather was asleep...” The peers go on the road all over the United States to introduce their program and encourage other VAs to start similar programs. Recently they have been to Virginia and they are soon going to San Diego, CA.

The variety of peer support groups (Primary Care, Outpatient and Inpatient) run by the peers at the Bedford VA is remarkable. Among the 20-odd groups are: Women’s Empowerment Group; Latino Veterans Peer Support Group; Lesbian, Gay, Bisexual and Transgendered Peer Support Drop-in Group; Peer-led Meditation Group and there is still a Peer Recovery Group sponsored by the Vinfen Peer Educators Project. There is a recreation group specifically for veterans of Operation Iraqi Freedom and

Operation Enduring Freedom.

Al Krull co-runs several inpatient groups as well as providing supervision for other peers. He found his way to supervising at the Peer Education Center through the Bedford VA system. He was an Aviation Electronics Technician in Vietnam and then was home, then “on the street” as he said. “Life became unmanageable for me in my late 40s when mental health issues along with substance abuse depleted my spirit into hopelessness,” he explained. He went into the VA system. He lived in transitional housing at the Crescent House in Lowell, where he became a Peer Counselor for two-and-a-half years. He recently was awarded custody of his 11- and 13-year-old daughters, and several months ago became a supervisor of peers at the Peer Education Center. He has been active in peer support for over 5 years.



Recovery Story con't'd

crime...there were shootings,” Hennah said. “There was black-on-black racism.” After Hennah finished high school he went into the Army where he worked in Combat Arms (the infantry). He later went from the Army into the Marines. Hennah said that he started to have trouble with mental illness while he was in the service. He experienced paranoia and mood swings. After he got out of the Marines, he worked in security. At this time he started to escape from his mental illness through substance abuse.

He also had some trouble with the law and ended up going to jail for three and a half years. Hennah emphasized that “society is not geared to help someone that comes out of jail,” and “marginalizing excludes and punishes people that come out of jail.” Hennah reflected that some of his substance abuse came from traumatic experiences that he had in jail.

When he got out, he began to receive treatment at a clinic in West Haven and also had his first experience of peer support. He was in a support group where “they recognized fears and they were able to tell when things were breaking down.” His social workers felt, however, that Hennah would be better served by the Bedford VA, so he went there to receive treatment. He was eventually diagnosed with bipolar disorder and Post Traumatic Stress Disorder.

Hennah stayed in “Dorm 7” where he met Dr. Bill Alexander, who had a great impact on his life.



Redger Hennah, Supportive Education

Alexander was African American like Hennah, so there was a ready connection. “He showed me there could be possibilities,” said Hennah, “I was able to relate to him.” .

Hennah is also grateful to Enrique Arroyo and Aida, who were also “ethnic minorities.” Hennah was persuaded by them because they had been through the same experiences that he had. Most of the doctors, Hennah said, “didn’t hit home” with their “bureaucratic big words.” Hennah said that Arroyo and Aida had suggestions and thoughts for him every day that were able to help him. For example, they stressed not leaving “gaps” or too much down time in his schedule, and “accessing positive things. Do positive things every day to gain something successful through work or respect.” Hennah said they told him he should “get on, not get off.”

Hennah got his experience in

human services by working at the places where he had been treated. He attended a therapeutic community in Maine where he started leading groups. He also did outreach and ran groups at Soldier On, a multi-service organization for veterans in Northampton. He got a Nursing Assistant Licence in 2004. He graduated to the Crescent House in Lowell, a VA residential treatment program, then moved out on his own into assisted living.

Hennah has been through a number of treatment programs and he has some strong opinions about what works. He believes that life experience (of the patient) can’t be “replicated on a professional level,” and that “surveys and essays are not based on people.” The way he grew up and the “core beliefs” that he developed gave him an “aggressive worldview” and a “traumatized worldview.” Being incarcerated

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was “a ghetto” that added to his troublesome core beliefs. Professionals were not able to be very helpful because “They didn’t live the life and they didn’t try the drug.” Hennah was helped the most, he says, by working with people with lived experience, by “people who came from rough neighborhoods.”

To do his job now, Hennah has some specific ideas about what it takes. “You have to have a presence about yourself,” he says, “and be clean. You have to have something to show your success like an apartment, a car, a girlfriend.” He says he is glad to be an “ethnic person” in the program because he believes that people of color have lacked role models in the VA system. He says his several volunteer jobs also convince people that he works with that he has come a long way and they can profit by following his example.

WETH Peer Support Group By Phil Broyhill

Over 2008 and going forward, Murray and Phil have co-facilitated a group at the West End Transitional Housing (WETH), in Lindeman Center, downtown Boston, a shelter for 50 or so homeless mental health consumers awaiting more permanent housing or placement in group homes. We have felt very gratified and appreciated by resi-

dents in the course of our work here. But from early on, we were both struck by the volume and intensity of complaints about services at the shelter.

At first, last winter, complaints centered about the men’s bathrooms. Of the two group bathrooms (for 40 men), residents claimed one had been closed for repairs for several months, and, even in the other, several toilet stalls and showers were non-functional, causing an enormous tie-up in the morning. Most male residents had to find off-shelter bathrooms on other floors of the Lindeman. Residents also complained about unsanitary conditions—biowaste strewn on the floor faster than the maintenance staff (who come only twice daily) could clear it away. Rolls of paper towels found soaked, floating in the toilets. Residents had been making weekly complaints to staff, but nothing improved.

Murray and Phil collected details about the bathroom situation from group members over a period of several weeks, and a group member acted as recording secretary. Then we addressed a letter to DMH state human rights coordinator Crystal Collier, whose name was suggested by Monica Briggs, the Transformation Center’s peer program supervisor. We asked for a meeting with Crystal, which a few shelter residents could attend with us, and to our surprise, the response was very cordial.

Just a few days before our meeting, residents told us that the second bathroom had been opened, which they attributed to staff having heard repeatedly about our intentions for over a month, and wishing to forestall official complaints. But we went ahead with

our meeting anyhow. Monica and WETH resident Martin Kohler joined us at Crystal’s office in Lindeman Center. Crystal promised action. Shortly thereafter, we heard that a small party of bigwigs had inspected the shelter bathrooms, and decided that the women’s room could use some repairs as well. Residents were elated. Crystal advised us to address any further complaints to shelter staff first, and then, in case of inaction, to the Lindeman site director, Michelle Anzaldi. Residents reported that with two men’s rooms available again, the irresponsible residents voluntarily used one bathroom (as had been the case before one bathroom had been closed), leaving the remaining room relatively clean for everybody else. The success of this first project led to an outpouring of other complaints from residents over the next month. Once they saw success was possible, the lid blew off. I (Phil) took home a raft of 15 complaints covering all facets of shelter operation, and typed it up for the shelter staff and the Lindeman site director. These included disrespect and neglect by staff; lack of communication between shifts resulting in medicine changes being ignored; and scanty and unhealthy cafeteria meals with special dietary needs ignored; The daily menu is not announced ahead of time, so that residents do not have a chance to decide whether they should eat here or elsewhere. By the time they know whether the

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Peer Support Group con't'd

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offering is something they like and within their dietary guidelines, it is too late to go elsewhere.

There was a lack of promised recreational/rehab groups on the unit and lack of a van to take residents on recreational trips. The premises were crowded and noisy, with almost total non-use of the most luxurious room on the unit, the carpeted piano room, which has a telephone that could supplement the busy dayroom residents' phone.

Residents claimed they are there many months before obtaining meaningful one-to-one meetings with staff to pursue their needs. One resident complains that WETH insists on finding her a place which she could not share with her boyfriend, a choice she refuses to consider, another resident that he is being directed to a neighborhood he knows is unsafe, as he previously lived in it. It was claimed that the sickest residents got the most housing attention—they are sent to group homes—while the residents who are serious about straightening out their lives get little attention.

There were various other problems with care. Residents said that staff insisted on watching the Olympics on TV despite a 5-4 resident vote in favor of a movie. The shelter had no microwave, and supplied very few kinds of toiletries compared to other places such as Center Club, where people don't even live. A silex I donated for boiling water for tea was misplaced; staff did not know where it was.

Residents said drinking and drug dealing go on on the outdoor prem-

ises, making the area unsafe, and unauthorized persons intrude on the unit. The DMH police at the entrance lobby do not have authority in the parking area immediately outside, but neither do Boston police respond.

When a resident complains about another resident, the staff do not address the specific issue, but merely send the offender outside for an hour or two. Thus residents say, recidivism is rampant, and the complainant is afraid to go outside for fear of retaliation. Residents say begging, picking fights, and stealing are rampant. If a resident reacts to the aggressor, the resident gets punished.

Residents complain regularly at the weekly unit meetings about these issues, but they say staff ignore them, including the human rights officer, saying merely 'complaints noted'. We peer facilitators, as well as experienced residents, provided far more information about useful community resources than was available from staff, and one resident described staff as doing 'nothing but sit there and look stupid'.

Site director Anzaldi invited DMH Metro-Boston recreational program director, Peggy Lester, to attend the next meeting, and WETH residents Julie MacKinnon, Dalcelia Sanders, Andrea Seaff and Paul J. Davis came, as did Susan Landy, Transformation Center Assistant Peer Facilitator Program Leader

Anzaldi wrote down a summary of our complaints in her own words, distributed copies, and set up monthly repeat meetings with residents and peer group facilitators to monitor progress on dealing with these issues. She also announced that a new shelter direc-

tor, Dianne Kenney had just been hired, to replace the acting director, and would lead the meetings. Dianne was very sympathetic to us, and determined to work on all issues starting immediately. These officials were unaware of most of the problems we catalogued, and it turned out that in many cases unit staff had not been implementing established policies. The unit did have a van, and it started getting used. Some community activities were already announced on bulletin boards, but staff never directed residents' attention to them. The piano room was supposed to be available whenever there was enough staff on to supervise it. Staff began leading recreational groups they were supposed to be leading. The supervisory staff ordered the human rights officer to report complaints to them, said more rights officers would be hired, and that residents could give complaints directly to higher level staff. It was determined that only state police had authority in the parking area, and they would be notified of the need to patrol it.

In short, we were bowled over by the cooperativeness and good will of the higher level staff, and congratulated ourselves on our success at self-empowerment. I encouraged the more experienced residents to start their own biweekly group to share community resource information with other residents and social work staff, and residents Dalcelia Sanders and Jose Del Valle offered to organize it. They would collect program literature and set

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Peer Support Group

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up bulletin boards. Several residents said they would return to participate and share their wisdom even though they would soon be leaving the shelter.

For the complete text of this article please go to www.transformation-center.org/news/newsletter/vfc.html

Smoking Ban at State Hospitals

By Rachel Klein

Secretary JudyAnn Bigby of the Executive Office of Health and Human Services (EOHHS) announced on August 14th that, as of December 11th 2009, Massachusetts state facilities will be completely smoke-free, including all of the DMH-run state hospitals. This is an unacceptable situation.

A total ban on smoking everywhere on EOHHS grounds has been in the planning stages for at least 3 years by the state government, probably up to the level of Governor Patrick. The main barrier to the EOHHS ban was the union representing the staff members, because the ban will apply to both patients and workers. No one will be allowed to smoke. There were no requests for input from peer-run advocacy groups to

the best of my knowledge.

The reason for the ban is supposedly for health concerns. Secretary Bigby said in her official announcement of the policy that "... sites still experience problems with secondhand smoke including smoke drifting into the workplace, smokers congregating at building entrances, and improper disposal of cigarette butts". But these are problems with implementation and enforcement of the current anti-smoking law enacted by the legislature, not justification for new policy-making.

There is a tendency of politicians to focus only on smoking when they have to show that they are doing something about the fact that we, as a community, die 25 years younger than the average, 54 years old.

They do not focus on the expensive and difficult issues that result in our early deaths like homelessness, lack of high-quality, consistent medical care, side effects of medication, metabolic syndrome and the chronically underfunded, unraveling mental health safety net. Just this year, huge cuts were made to the mental health budget like never before while over 1 billion dollars was spent investing in biotechnology companies.

Of course it is a great goal for all of us to live longer healthier lives. It is not clear that this ban will produce those results. And, as the old saying goes, "The Ends do not Justify the Means." To be sure, it will be difficult for people already burdened with the difficult experience of being committed to a state hospital for mental illnesses diagnoses to have the stress of forced nicotine withdrawal added.

The Healthy Changes program, the official health and wellness program run by DMH, has never been given any funding. To help our peers in state hospitals live healthier, longer lives, they should fund the best treatment methods and programs possible to motivate and empower all people possible to quit. Giving people choices and supporting them in healthy decision-making is a recovery-based approach to this thorny issue.

Tobacco is a very dangerous and addictive substance and smoking is one of the most difficult addictions to break free from. I hope that every person stops, with any and all help that they need. This is the reason that all the necessary funds should be given to help people quit smoking and give them state-of-the-art addiction services. There are great recovery and evidence-based and treatment methods available but DMH is not providing those services at its hospitals.

The ethical and legal issues surrounding this decision will be discussed in the next issue of Voices for Change. Banning smoking at state hospitals is a cheap and easy move for the policymakers who want to be politically correct about smoking.

Peer-to-Peer at Downtown Boston Veterans Admin

While the Veterans Administration at Causeway St. Psychosocial Rehabilitation and Recovery Center is one of the newest ones, we are in the forefront of establishing peer-facilitated groups. We have many

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groups led by veterans trained by Moe Armstrong and others:

On the odd numbered Mondays I facilitate the Current Events Group, training Leon, Rich, and Rodz as facilitators. They will soon take over the group.

At 11AM Tim Peace facilitates a Free Time Period.

As editor of the colorful Causeway Chronicle (Newsletter) I facilitate the Production Period from noon until one, and then switch gears for the next hour with a newsletter staff meeting.

On Tuesday Tim, Richard, and Rodz help me lead the Music and Emotions group. Once again, they'll take it over soon.

At 9:30am on Thursday Dave Wilson and I lead the Vet to Vet (Peer to Peer) group. At the same time we train the new facilitators Tim, Rich, Rodz, Paul Brentlinger, Martha, and Arthur to emerge as our future primary facilitators.

Dave Wilson and Tim Peace lead the Thursday noon Spirituality Group, which they had been alternating with Mental Illness Anonymous. However, people want the two groups separated, so we need to sort that out.

Tim and I are planning a walk group.

We are hoping that Leon and Paul will give guitar lessons in the future, with Gary helping. I'm sure we'll figure out other new groups, too.

Support from Moe Armstrong for Vet-to-Vet and Melissa Wattenberg as head of PRRC has been essential.

Undermountain Road

By Naomiruth Pinson

Our hands locked together
are two bodies joined,
two birds
loving on the wing.

Trolls and fairies dance and sing
in these woods.
Their magic can't compete
with yours.

Sadness sometimes
has such sweetness,
It erodes
my bitter strength.

I dash away the tears
that flow hot
unlike the cold spring
that runs beside the road.

What does it mean
to be a man,
to be a woman?
To stand beside one another still?

The Parrot
Cathy A. Levin

First entering a home I encounter the maid
and must go through her to get inside.
She opens the door professionally and
courteously, but impersonally.

Inside the doorway, I meet the mother,
who is nice, but busy. Too harassed
and distracted to have a conversation.
She lets me pass by her.

As I move through the house, I see kids
running around like mad people,
paying no attention to the visitor.
What do they care what I have to say?

On the stairs, the father greets me.
He likes to think he's important,
but he really makes very few decisions
with no attention span to learn new things.

On the upstairs landing, is the grandmother in a night-
gown. She's sympathetic,
and wants to listen, but has dementia.
She can't remember, is not a good witness.

However, in an upstairs room is a parrot
in a cage. I know if I am successful
at getting to talk to him, he understands
everything I have to say.

Now, you sit quietly at the kitchen table,
my sweet, darling man, my lover.
After our argument, you are charmed
by my apology. Your blue eyes looking up
and your defenses down.

Now I can talk to your parrot,
telling him in a soft, low voice,
he's a good boy, attractive and sexy,
with no better thing to do than love me.

I love you, Parrot.
I wish everyone would say to me,
*"Be gentle with me
because you are talking to my parrot."*



WRAP Facilitator Training

The third annual WRAP Facilitator training sponsored by Transformation Center and MASS-WRAP will be held Oct. 18, 19, 20, 21, 22, 23, 2009 on the Cape.

Applicants must have; taken WRAP curriculum classes, written their own personal WRAP and use WRAP in their everyday lives.

Applications will be available soon. If you are interested contact Marina at 877-769-7693 or e-mail at

marinac@transformation-center.org.

Pls. leave your; name, address, phone number, email.

Consumer Quality Initiatives: Some Things We've Learned About Mental Health Services

© Jon Delman

I'm pleased to reintroduce Consumer Quality Initiatives (CQI) to people who are new to the community of peers. CQI is a consumer run and staffed mental health research and evaluation organization. Our two biggest contracts are with DMH and the Massachusetts Behavioral Health Partnership; we evaluate their service approaches and conduct research to help them design services. Most of our research is conducted through consumer surveys and focus groups. We also train consumers to conduct research and to better understand research in order to make more informed choices about their or a friend's care.

Of note, we grew out of an M-POWER initiative to improve managed care services, back in 1999. Also we are located on the floor above the Transformation Center's office in Roxbury, and though we are separate organization, we share some space share some space with them.

So what have we learned in 10 years? Here's what I summed up at a recent conference:

1. **Physical health status** is highly correlated with consumer outcomes (egs, ability to prevent crisis, daily activities, desire to work), significantly more than most other personal characteristics and circumstances.

2. **Difficulty with learning**

[cognition] is an unaddressed barrier to employment for many consumers, who may be dealing with serious anxiety and/or a learning disability. Recently, researchers have been looking into methods to help people improve their cognition.

3. A majority of the programs designated as providing **dual diagnosis services** are not doing so; it's either one or the other, and sometimes not the one the client needs most.

4. One of the most powerful and wasteful dysfunctions in the mental health system takes place at the **intersection between private hospital and outpatient services**. One sign: the very high rates of private hospital readmissions (eg, within 30 days). The greatest negative impact is on people who have addictions and/or no stable address.

5. The key pre-requisites to **quality** in services are 1) program director qualities, and 2) the hiring process (job descriptions)... along with accountability. If a team, then full staffing and agency supports are necessary.

6. **Peer specialists** can be integrated into a treatment team when there is commitment to doing so. Peer specialists truly inspire program clients to think that they can do better.

7. If there's any kind of treatment that people rave about, it is **DBT** (dialectical behavioral therapy). I can't tell you how many people swear by it. Can we provide more of that?

8. **Discrimination** is invidious in its subtlest forms, with regard to both consumers and people of color, and with both individual treatment and systemic policy approaches. Think, for example, about resources, neighborhoods, and leadership. I'm less concerned by how we are portrayed in the media.

9. It's all about the **hand-offs**.

10. Since I started in this in the mid-1990s, it's remarkable as to how far we've come in consumer-driven and peer services. As a statewide movement at that point, we had nothing, but for a few pockets. A true credit to people who have worked on this.

Feel free to send us your perspective on these issues, otherwise contact us at info@cqi-mass.org.

VOICES FOR CHANGE

Transformation Center
98 Magazine Street
Roxbury, MA 02119

Phone: 617-442-4111
Toll free: 1-877-769-7693
Fax: 617-442-4005
TTY: 617-442-9042

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Writers, Artists Wanted

Writers/Artists Wanted For Voices for CHANGE newsletter

Articles wanted on current issues related to mental health:

<ul style="list-style-type: none">• Alternative Treatment• Recovery Stories*• Current Issues	<ul style="list-style-type: none">• Cultural Issues• Peer Support• Advocacy ETC.
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Artwork in digital format wanted from members of the mental health community. Email to: susanl@transformation-center.org Queries may be sent to this email.

*Some suggestions for writing your recovery story are found on our website www.transformation-center.org/news/newsletter/vfc.shtml