

Voices for Change

A Massachusetts-Statewide Newsletter of the Mental Health Community

Published by the Transformation Center

Summer 2011

Editor

Susan Landy
Susanl
@transformation-
center.org

Editorial Assistance

Howard
Trachtman

Editorial Committee

Amy Dahlberg-
Chu
Fran Nadeau
Kimberley Warsett

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Trauma-Informed Care



In this issue, we look at mental health care for people with lived experience of psychological trauma. We look at a few issues related to trauma and also at what the Transformation Center is doing to promote “Trauma-Informed Care.”

Trauma and the Deaf Community

By Mary O'Shea

I attended a three day Conference which focused on recovering from trauma and addictions through wellness. **Peggy Swarbrick, PhD** discussed the concepts of personal wellness, recovery and quality of life. **Candace Tate, PhD** discussed her paper entitled **Trauma in the Deaf Population; Definition, Experience, and Services** for Deaf and Hard of Hearing adults who have experienced trauma in the United States. In addition, a Deaf woman named **Diane Squires** and I led a group discussion with Deaf and Hard of Hearing adults on their experiences with mental health diagnosis or addiction. We also discussed barriers encountered and suggestions for improving mental health services.

In her lecture, Dr. Tate brought out the issue that Deaf individuals receiving services in a mental hospital have a high rate of language “dysfluency.” This means that they are unable to communicate in either spoken English or American Sign Language. As Dr. Galuti, a Deaf psychiatrist points out, since social and emotional development depend on learning a language, Deaf individuals who have language dysfluency may not develop the emotional and social skills needed to prevent traumatic experiences. Language also helps to increase trauma resilience during recovery.

It was rather shocking to learn

that trauma is significantly higher in the Deaf population than in the hearing population. According to Dr. Tate, **“Deaf children are more than twice as likely to experience physical and sexual abuse compared to their hearing peers. In addition Deaf female undergraduates experience physical assault, psychological aggression, or sexual coercion at twice the rate of hearing female undergraduates. It is therefore clear from scant research that the prevalence of trauma in the Deaf community is a significant issue and much higher than in the hearing community.”**

More research is needed to examine the risks of trauma and the resulting symptoms in the Deaf community. Deaf individuals face major challenges in obtaining behavioral health system treatment for trauma because of misunderstandings about Deaf culture and treatment. There is also an alarming lack of service providers who are culturally and linguistically competent to provide treatment and a lack of sign language interpreters for basic communication.

Candace Tate made several recommendations for improving mental health treatment services for the Deaf and Hard of Hearing population including more intensive research on the risk

and preventive factors of traumatic events, symptoms of trauma and evidence based trauma assessment and treatment.

Diane Squires and I also had the opportunity to lead a group discussion with several of our Deaf and Hard of Hearing peers on their experiences within the mental health system. We also discussed wellness tools we used to empower ourselves. Many of us enjoyed hobbies such as art, knitting, crafts, computers, laughter yoga, meditation, music, karaoke. Photography, comics, reading, movies, vlogs (video blogs), kayaking, and deep breathing were other wellness tools mentioned during the discussion.

We also asked the group what services they found most helpful in the mental health service de-



livery system. Some peers found the Recovery Learning Communities very helpful in their recovery. Others enjoyed having peer support and wish for Deaf Peer Specialists to be incorporated in their treatment plan. Deaf forums and discussions were viewed as being very helpful and

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Deaf Community

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supportive. A few peers mentioned that WRAP, Wellness Recovery Action Plan was very helpful in their wellness initiatives.

Many stated that transportation posed a dilemma and wished Deaf and HH peers could get together more often to go on social outings. They stressed sober gatherings as a chance to network because many Deaf go to bars where alcohol is provided to socialize.

Diane asked the group what barriers they encountered in their personal life. A few said they had patronizing bosses and couldn't find support groups with interpreters. There is a lack of signing therapists and often those who are culturally and linguistically competent go into private practice and insurance doesn't cover the cost. Treatment centers not willing to provide interpreters for communication access was a barrier experienced by many. Another problem that has been encountered is going into the emergency room for a non mental illness related condition and being immediately evaluated by the crisis team because the psychiatric records are in the computer data system.

It was suggested that one write a letter to the Department of Public Health to file a grievance regarding these types of incidents. It was stressed that one must know one's five fundamen-

tal human rights as a psychiatric patient because many Deaf and Hard of Hearing persons do not understand the posted rights in the hospital settings because of the English barrier. One person recommended adding advance care plans to the WRAP and teaching the ATRIUM model, Addiction Trauma Recovery Integration Model.

One Deaf peer would like to see a respite care facility run by Deaf and Hard of Hearing peers in her geographical area of Massachusetts. It was also noted that many of us have dual roles both as a professional provider in the mental health care system and as clients ourselves and the difficulty we encounter because of it. The group was very informative helpful and supportive.

The conference was an uplifting and informative one. We learned that trauma and addiction is high in the Deaf Community, but we can as peers strive for recovery by using wellness tools to seek a greater balance in our lives. This in turn will give us greater resiliency to cope with life's challenges and reduce the impact of trauma and mental illness on our social and behavioral health.

The ACE Study

By Marina Colonas

What is it?

The Adverse Childhood Experiences (ACE) Study is one of the largest studies done to assess the connection between child-



hood maltreatment and later life health and well being. More than 17,000 members of a Health Maintenance Organization (HMO) going through thorough physical exams provided information on their childhood experiences of abuse, neglect, and family dysfunction.

The ACE interview is also a series of questions about past physical, emotional and sexual abuses, household histories of alcohol or drug abuse, imprisonment, mental health issues, and parent(s) not being present.

The ACE study research states that certain risk factors from our childhood affect our later life through illness and death and poor quality of life. Understanding that adverse childhood experiences affect us helps provide information in preventing and recovering from our worst health and social problems. Many trauma-related problems include heart disease, cancer, lung and liver disease, and skeletal fractures, to name a few. Social issues such as homelessness, prostitution, delinquency and criminal behavior, failure to finish school or an inability to hold a job, stem from the effects of trauma.

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ACE Study cont'd

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This study affirmed childhood trauma had later widespread affects on adulthood and that trauma was more widespread than thought previously. The impact was cumulative and this trauma hid a range of problems. Dr Vincent Felitti, a co-founder of the study states, “In our detailed study of over 17,000 middle-class American adults of diverse ethnicity, we found that the compulsive use of nicotine, alcohol, and injected street drugs increases proportionally in a strong, graded dose-responsive manner that closely parallels the intensity of adverse life experiences during childhood.”

What does this mean for people with trauma histories who have used drugs, alcohol, and other coping mechanisms in their lives to deal with their pain?

With understanding of what happened in our past we find we no longer need to use these behaviors as coping mechanisms as they no longer fill that need. Other appropriate coping mechanisms are developed. We no longer need to linger in the past but can look at more positive ways to live our lives. With this understanding and research findings that the brain has elasticity, people are living healthier, happier lives.

This does not mean that trauma affects disappear. They will appear in other developmental stages as we grow and change, but we have found positive ways of living our lives.

We are no longer held hostage to our pasts.

www.cdc.gov/ace/

www.goodworksintrajtrauma.org

www.witnessjustice.org

www.theannainstitute.org

Bodies, Creativity and Healing By Marcia Webster

As a shy and painfully insecure young woman, I found concrete ways to be in the world, even though I did not believe I was “good” at expressing myself. By creating artifacts of my experience (photographs, doodles, poems and physical memories of dancing and music) I have things I can see, relate to, and talk with - then and even years later. At expressive arts therapy school, I learned more about why making art of my confusion, pain and pleasure is so important to healing.

It seems that the human body “remembers” everything at chemical and physical levels. Experiences that my conscious mind cannot digest or make sense of stay fresh in my body. When those intense, unfinished experiences are triggered, my whole being wants to seize the opportunity to act and then come to rest - regardless of what the here and now demands!

In my recovery, I came to respect the images that my body and mind put out into the world.

When I encounter something I have made, the dialogue between that image and my grounded self can be trusted. By noticing the power of these encounters and carving out a time and place to give the meeting space, I engage the things that need attention. For example, waves were the first things I painted in my first day treatment art therapy group. For years, I was embarrassed because waves were all I seemed to draw, over and over. Now, I look forward to playing with them in many forms - color, movement and words. In fact, I still have long, meaningful encounters with waves!

Healing through creativity, in my Buddhist practice and with the peer recovery movement have all taught me that I am the authority on what, when and how to digest my experiences. I have also learned to choose my relationships, who I want standing by. Rather than the observations of others, the actual connection between my life, my environment and the artifacts I have placed in it are my best guides for how to live. My relationships with people, also artifacts I have created, are some of my most valuable sources of learning.

The “fight, flight or freeze” response is something else I’ve learned a lot about. It is what we mammals do when the essence of our life, or someone we love, is threatened. Once it is activated, this surge of action takes over my whole system, interrupting everything else. Memory, learning, expression and vulnerability of any kind are not possible once I am primed to protect

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Bodies, Creativity and Healing cont'd

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life itself. But growth and learning are exactly what calls up those intense experiences that I haven't fully digested, like trauma and neglect. So "freeze" is a response I often have when staying flexible and open is needed most! I find that art-making is an effective place for the encounter between my reactive body and the pressing moment. All the conflicting needs of my hurt self, my responsible self, and my compassionate heart can meet in one image.

For me, all of these bodies, brains and objects interacting mean recovery can be real for anyone anywhere. It takes individual and collective effort to craft recovery, to see what is real, and to live as well as we all deserve to live.

A thing is not seen because it is visible.

It is visible because it is seen.

Plato, quoted by Diane Arbus



The Hour is Striking

The hour is striking so close above me,
so clear and sharp,

That all my senses ring with it.

I feel it now, there's a power in me
to grasp and give shape to the world.

I know nothing has ever been real
without my beholding it.

All becoming has needed me.

My looking ripens things
and they come toward me to meet and
be met.

No thing is too small for me to cherish
and paint in gold, as if it were an icon
that could bless us

though I'll not know who among us
will feel this blessing.

---Rainer Maria Rilke

T-Cup Grant at the Transformation Center By the Transformation Center Mass Leadership Academy Training Team

Research shows that minorities have trouble accessing good health care services in their communities. Research also has indicated that peer support works very well with people with mental health concerns as well as their providers and the larger health system. The Transformation Center is making ongoing

efforts to expand cultural competence within the health community in Massachusetts. Our peer support community can play an integral role in improving quality of care.

Although there are peer-run mental health services in Massachusetts, as well as peers working within the clinical mental health system, the services need to develop improved accessibility. By "accessibility," we mean that the services need to be accessible to people with a variety of disabilities as well as to people from a variety of cultures and languages. In addition, peer services need to offer *trauma-informed care* in a way that is accessible to a variety of cultures, languages and people with disabilities. In other words, peer services (as well as clinical services) need to offer support or care that is informed by the knowledge that many mental health peers have experienced psychological trauma. In turn, all mental health services *for trauma* need to be sensitive to the ways in which trauma is understood within different cultures.

The need for peer support models that are responsive to those who have experienced trauma is a concept that is new to many. Clinical service providers may be hesitant to employ mental health peers as supporters for trauma survivors because of concerns that the employee will be "triggered" by hearing about the trauma survivor's experience. Peer-run support services may also

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T-CUP Grant

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be concerned that graphic descriptions of trauma may be harmful to other participants in the program, and so, restrict the content that a trauma survivor may discuss in a group. However, because of new recognition of the relationship between mental health and previous trauma experiences, developing peer support and recovery services, communities, networks, advisory groups, advocacy groups, etc., that are sensitive to trauma recovery is crucial.

The Cross Cultural Unity Project of the Transformation Center (inspired by the Transformation Center Board of Directors) was started in order to eliminate health care disparities in Massachusetts. Within the Project, we have worked on various tasks in the past three years to reach out to diverse communities such as the Deaf and Hard of Hearing, Latinos, Members of the African Diaspora, LGBTQQI (Lesbian, Gay, Bisexual, Transgendered, Queer, Questioning, Intersexed), Young Adults and Older Adults. Our first project was a three-day Multicultural Leadership Academy on April 28-30, 2010. The theme was “The Power of Culture and Language to Unite Us.”

Later, the Transformation Center convened a Community Voice Task Force to ask the mental health community what our priorities should be in the next three years and how we could better reach out to all members of our community.

The Task Force held town meetings across the state in community mental health settings such as clubhouses, hospitals and peer-run support groups. From these meetings and various projects, the T-CUP grant was born. In 2010 the Transformation Center was awarded a three-year grant from the Substance Abuse and Mental Health Services Administration for the purpose of promoting Accessible Peer Support and Trauma-Informed Care.

The Transformation Center has commissioned a Task Force on Accessible Peer Support (TAPS) to kick off the grant. This Task Force had its first training at a Leadership Academy, May 24-26, 2011, co-sponsored by the Mass. Behavioral Health Partnership. Participants explored the concept of “accessible peer support” and continued the theme of a former series of trainings: introducing and practicing affinity group and ally skills. Now the group will meet once-a-month to build on our understanding of underserved populations such as those mentioned above. We think these populations may benefit from accessible peer support that is trauma-sensitive.

One project of the Task Force will be to use Dusty Miller’s Addictions and Trauma Recovery Model (ATRIUM) as a pilot training project. Twelve people from diverse communities will be trained with the curriculum and they will also give feedback on what needs to be made more accessible in the curriculum. The curriculum needs to be accessible (initially) to the following communities: Deaf and



What do you think makes peer support accessible?

Hard of Hearing, Latinos, Persons with Disabilities, LGBTQQI, African Americans and men.

TAPS is a substantial project. Partly because of years of prior experience reaching out to diverse communities, we at the Transformation Center feel that the project can be accomplished. By working together and building connections with our community, carefully listening, encouraging each other and having hope, we can accomplish our goal of making peer support more accessible to everyone.

Note: a Pdf version of this article will be placed on the Voices for Change Facebook Page. Please comment and tell us what you think.

<http://www.facebook.com/pages/Voices-for-Change/178746332156169?ref=ts>

Trauma-Informed Care and “Safety”

By Lyn Legere

Over the past few years, there’s been a lot of talk about providing “trauma-informed” services. This is an important move within the mental health system, but has often only concentrated on the use of restraints & seclusion or addresses individual trauma in one-on-one therapy.

At the same time, the sad and tragic murder of Stephanie Moulton, a mental health worker, by a person using DMH residential services has led to increased discussion and debate around “safety” and “risk.”

It’s unclear if these two topics are being discussed together. “Trauma,” “safety” and “risk” share the common thread of violence and its’ impact on people and communities. Looking through the lens of “trauma” to evaluate the needs of individuals and communities, including people using and providing services, creates the roadmap to increase “safety” and diminish “risk” in mental health settings.

The statistics tell the story. According to the National Center for Trauma Informed Care, 90% of people diagnosed with Borderline Personality Disorder or Dissociative Disorders, 80% of people using services in psychiatric hospitals, and 66% of people using services for substance abuse experienced or witnessed trauma and neglect. Boys who witnessed violence were also found to have a 1000 times greater risk of committing a violent crime.

Research also indicates that children and adolescents from minority backgrounds are at increased risk for trauma exposure and development of Posttraumatic Stress Disorder (PTSD). For example, African American, American Indian, and Latin American children are over-represented in reported cases of child maltreatment, and in foster care. (Department of Health and Human Services, Administration for Children and Families 2002).

In addition, many providers have their own trauma histories, and are witnesses to trauma on a daily basis in their work. This means that our treatment communities have a huge elephant in the room – the majority of people are viewing and responding to their world through the lens of trauma.

The trauma histories of people using (and often providing) mental health services tend to be repeated, long-term assaults on the person’s sense of safety in the world and in relation to others. Our brain, that always wants us to survive, actually rewires itself. Seeing that a person is repeatedly left on his/her own to find safety and cannot rely on others to protect him or her, the brain shifts to a “fight or flight” stance. This heightens a person awareness of the environment and allows the person to respond immediately, without thought, to any sign of danger. This danger response becomes a person’s usual response, and at the slightest perception of danger, a person responds by some form of “fight” or some form of “flight.”

Healing comes only through relationship and safety in the world. Loving, compassionate

and understanding relationships is the only way that people can learn that others can be trusted, can be loving and not hurtful, and can be kind and not cruel. Being treated with human dignity, respect and humanity is the only avenue to healing the messages of abuse or neglect. Being

This means that our treatment communities have a huge elephant in the room – the majority of people are viewing and responding to their world through the lens of trauma.



allowed the right to make choices, learn through experience, and be mentored and supported through the trials and errors of human development is the only way that people can re-wire their understanding of the world.

Speaking as a trauma survivor and someone who spent many, many years in hospitals in the greater Boston area, I can per-

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“Safety” cont’d

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sonally attest to the many ways that the environment, itself, increased my own level of isolation, fear, and disconnection, often leading to behaviors that were unsettling for myself, fellow “patients” and other staff. For example, when I was hospitalized in Faulkner Hospital as a result of self-inflicted violence, I was told I had to stay in the mi-



lieu area and couldn’t go to my room, despite my sensations that the noise and chaos of the room was overwhelming me and I needed to be alone. I had no words to describe my extreme distress. I didn’t understand then how this directly related to my own trauma. I acted in the only way that I knew at the time – I punched the wall.

I’m sure there was an immediate response, which I don’t remember. But an hour later, I was called to a “meeting” in a room down at the end of the hall. I walked in to find a number of guards, ambulance drivers, a stretcher that had restraints on it and all my belongings in bags. I was told that I could do this the easy way or the hard way, but I

was going to Mass. Mental Hospital. I retreated inside myself and don’t remember anything until several days later as I lay in a bed on the floor of Mass. Mental with another man crawling in with me. It was a turning point to a downward spiral that lasted for years, and nearly ended my life. I had been so retraumatized by the situation. I was blamed and shamed for responses that I didn’t understand and didn’t know how to change. In the end, this only increased the very responses that staff was trying to alleviate.

Revisiting the factors that led to the tragic death of Stephanie Moulton is vitally important. But our response must be from the perspective of the prevalence of trauma in our service community. The question should not be, “how can we better control people?” Control simply increases everyone’s trauma

response. It should be “what happened to you?” and how is this impacting the moment? Responding by retreating to services that increase control and rigidity will only heighten the very situation we’re trying to resolve.

Hope Center

By Howard D. Trachtman

The Metro Boston Recovery Learning Community (MBRLC) is pleased to announce the opening of a fourth recovery learning center, called the Hope Center, located at the DMH Erich Lindemann Mental Health Center, Room P-9, Plaza Level, , 25

Staniford Street, Boston 02114. For more information about our location and schedules, please see our website: www.mbrlc.org

We are open to all, but especially people with lived experience of mental health and/or addictions treatment (peers) and we are peer-run. Our initial hours are Tuesdays from 11m-3pm, and Wednesdays and Thursdays from 2pm to 6pm. Peers from the NAMI Greater Boston Consumer Advocacy Network (NAMI GB CAN), North Suffolk, Vinfen, Bay Cove and the community will all help staff the center. Our main reception number is (617) 626-8687 and (781) 642-0368. Our email is info@hoperlc.org. Our website is www.HopeRLC.org and we are part of MBRLC www.mbrlc.org Executive Director Howard D. Trachtman can be reached at (617) 626 8694.

Suzanne Small is the point person on Tuesdays and is the NAMI GB CAN community relations and volunteer coordinator and can be reached at (617) 626-8691. As with other recovery learning communities, what we offer is driven by the people who come to our center. Initial groups scheduled include general support group, Spanish language support group, gym access and exercise, employment group, recovery is real, book club/short story discussion, Wellness Recovery Action Plan, financial literacy, pathways to recovery, stress management, one on one computer instruction, homeless/at risk of homelessness support and housing search, play with therapy dogs, poetry/expression

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Hope Center cont'd

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and creative writing group, and more.

Call us or visit our website for actual times of groups and activities. Volunteers and group leaders are welcome. We also operate a warmline, a peer-staffed compassionate listening and information and referral line toll-free (877) 733-7563 six nights a week Tuesday through Sunday from 4pm-8pm. For more information on our warmline and others, please see www.warmline.org

The Metro Boston Recovery Learning Community also operates three other recovery learning centers:

Boston Resource Center, 85 East Newton Street, Solomon Carter Fuller Building, Ground Floor. Contact Director Paul Styczko, paul@bostonresourcecenter.org, (617) 305-9991 or main number (617) 305-9900.

PERC, Peer Education Resource Center, 129 Portland Street, 3rd floor Boston. Contact Sarah Selkovits sselkovits@baycove.org, (617) 788-1034 or infoaboutperc@yahoo.com Sarah is the point person for the Hope Center's Wednesday schedule.

Cambridge/Somerville Recovery Learning Center, 153 South Street, 2nd floor; Somerville, MA 02143 Contact Janel Tan, tanj@vinfen.org, 617-863-5388. Janel is the point person for the Hope Center's Thursday schedule.

You say CommonHealth, I say Medicaid Buy-In...

The CommonHealth program in Massachusetts is for people with disabilities who get jobs. They may purchase Medicaid for their insurance at a sliding-scale rate. For more information on CommonHealth, just search "Massachusetts + CommonHealth."

Medicaid Buy-In programs across the U.S. help people with disabilities to go to work and become more financially independent:

- 48 states and Washington D.C. have a Medicaid Buy-In (MBI) to allow persons with disabilities to "purchase" health insurance through Medicaid.
- MBI allows enrollees to feel more financially secure.
- Enrollees earn more money, work more hours, contribute more taxes and rely less on food stamps than those with disabilities who are not enrolled.
- Enrollees earned an average of \$2,582.00 more per year.



- In spite of the benefits allowed, many or most people with disabilities still do not take advantage of the Medicaid Buy-In.

Compiled by the Medicaid Buy-In Study Group at Boston University Center for Psychiatric Rehabilitation. Innovative Knowledge Dissemination & Utilization Project for Disability & Professional Stakeholder Organizations/ NIDRR Grant # (H133A050006). For more information on the Medicaid Buy-In program across the U.S., see page 10, Disability Research Right to Know (DRRK).

Will you use this information personally or professionally? How? Did you find the DRRK site useful? Why? Please email the Editor at slandy@transformation-center.org and critique this information so we can know what was useful.

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

Email: info@transformation-center.org

www.transformation-center.org

Editor email:

susanl@transformation-center.org



Disability Research Right to Know (DRRK)

<http://drk.bu.edu>

DRRK fosters the everyday use of disability research.

Products include research results on mental health and :

Supported Housing
Supported Education
Peer Support
Medicaid Buy-In

Use this information to advocate for program funding or new programs!

Editorial: Possible Interview Questions for a Potential Therapist by Susan Landy

When I was interviewing therapists last year for the first time (instead of just taking whomever I got assigned or whomever was first to call back), I discovered a dilemma. It was not very useful to ask him/her "Do you have experience treating trauma survivors?" Probably 8 out of 10 therapists have experience with trauma survivors - there are a lot of us, as was mentioned in the article on the ACE Study. Your potential therapist could have been treating trauma survivors in a way that was not useful to them for decades.

Everybody selects a therapist (or other healer) in their own way and probably each selector would come up with a different list of questions for interviewing potential therapists. Please remember: You have the right to ask questions! You can think about it and come with prepared questions, and you can change your mind mid-interview and ask other questions that occur to you.

Questions that I myself have found more useful are among the following: What have you learned from working with trauma survivors that you use in your work now? Where did you get some of your best information on treating trauma survivors? What techniques have you used that have been effective?

Some studies have said that the relationship with the therapist is more important to consumers than the particular school of therapy. A frank admission of inexperience may mean more to you than an arrogant display of knowledge. The subject of the possible ways to interview a potential therapist deserves a lot more space. A potential therapist may merit a second look from you if you are comfortable with the way the therapist answers as well as the actual answers to your questions.