



University of Massachusetts Medical School Center for Mental Health Services Research

Annual Report

To the Massachusetts Department of Mental Health
2011-2012

To view this Annual Report online and to access more detailed information regarding recent publications, trainings, and presentations, please visit us at: www.umassmed.edu/Annual_Reports.aspx

The Center for Mental Health Services Research (CMHSR) is a Massachusetts Department of Mental Health (DMH) Research Center of Excellence. The Center is also an important component of the UMass Department of Psychiatry. Our mission is to use cutting-edge research and innovative dissemination strategies to accelerate the translation of research findings into policies and practices that support the mission of DMH to enable individuals of all ages to live, work, and participate in their communities.

The work of CMHSR is guided by three core priorities:

- **Culturally competent research and evidence-based practices**
- **Consumer involvement in research**
- **Dissemination of research findings to accelerate the adoption of evidence-based practices**

excellence & innovation in mental health services research



Executive Summary

We are grateful to the Massachusetts Department of Mental Health for its continued support of the University of Massachusetts Medical School (UMMS) DMH Research Center of Excellence, the Center for Mental Health Services Research (CMHSR). We continue to leverage the DMH investment into innovative, recovery-oriented, state-of-the-art psychosocial and systems research that informs and advises individuals with lived experience and their families, providers, administrators and policy-makers navigating the behavioral health landscape in the Commonwealth and beyond. Highlights of Fiscal Year 2012 include an increase in the number of research grants and contracts awarded and launching new initiatives including a strategic planning process to guide our growth and trajectory over the coming years. DMH and UMMS Psychiatry leadership partnered with CMHSR faculty to sharpen our focus on research priorities that support the DMH mission to provide the best possible patient-centered, recovery-oriented care to those it serves.

Under the leadership of our Director, Dr. Carl Fulwiler, his Executive Team, and the guidance of the Chair, Dr. Doug Ziedonis, and Vice Chair, Dr. David Smelson, of Psychiatry the Center embarked on new partnerships within and outside of UMMS, sought to enhance and diversify our funding base, and revisited the core vision, mission and values of the Center. We have received research and training dollars from new federal funders, developed new partnerships resulting in grant submissions and awards, and have begun to create capacity in new arenas of psychosocial and systems research, most significantly recovery supports and trauma-informed care.

CMHSR Overview

The Center for Mental Health Services Research conducts research to enhance services, improve the quality of life, and promote recovery for people with behavioral health conditions. CMHSR was created in 1993 when it was designated a Center of Excellence for Psychosocial and Systems Research by the Massachusetts DMH. Our mission mirrors the DMH commitment to collaborating with other state agencies, consumers, families, advocates, providers, and communities. We strive for the broadest possible dissemination of our research with the goal of informing all stakeholders as to the state of the science. DMH and CMHSR are aligned in their vision of promoting mental health through early intervention, treatment, education, policy and regulation to provide opportunities for citizens of the Commonwealth to live full and productive lives.

Our faculty are internationally recognized in psychosocial therapies development and implementation, services research, multicultural issues, clubhouses and vocational rehabilitation models, wellness and mindfulness, forensic/legal and human rights issues, child and family mental health issues, transitional youth, and co-occurring disorders. We collaborate across UMMS Departments of Psychiatry, Family and Community Medicine, and Pediatrics, as well as with Commonwealth Medicine and other national and international institutions to optimize our resources and relationships to build a bigger and stronger Center.

Research Portfolio

Fiscal Year 2012 was a healthy year for the Center.

- We received 2.8 million in new research funding
- We had 25 grant submissions
- We were awarded 18 new research grants and contracts (see Appendix A)

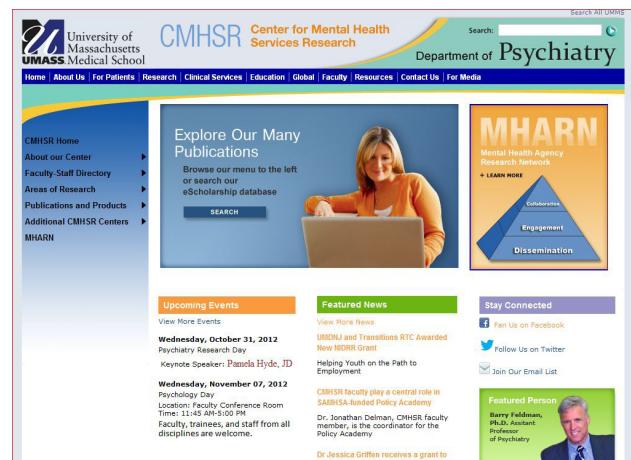
The Center continues to provide a positive return for the DMH investment: every \$1 invested by DMH yielded a return of \$7 to the Commonwealth to fund research, training, and service delivery.

New Initiatives

One of the most exciting new initiatives of FY 2012 was the development of the CMHSR Recovery Research Program, part of a Psychiatry Department-wide enterprise to become a national leader in recovery-oriented services and research. This program of research is dedicated to enhancing the well-being of people with serious mental illness, studying and refining new models of care generated through state and federal health care reform, and developing, assessing and disseminating models of enhanced mental health consumer participation across all aspects of healthcare. This innovative work builds on our existing efforts of training and working side-by-side with adult and adolescent consumers and conducting community-based participatory action research. Recovery Research Program faculty are part of the Interagency Council on Substance Abuse and Prevention, a joint project of MA DMH and the Department of Public Health, which was selected to participate in the prestigious SAMHSA-funded Policy Academy to bring recovery supports to scale in Massachusetts and enhance the role of peer services and recovery coaches in health care services.

CMHSR leadership has also spearheaded the Behavioral Therapies Initiative to increase awareness and implementation of the many psychosocial therapies developed by our faculty and within the larger UMMS Department of Psychiatry. Treatment manuals, training materials, outcome tools and other information will be made available through our website and our well-developed and tested MHARN dissemination strategies.

Finally, we went live with the new CMHSR website. Our development process was inclusive of and responsive to the needs and suggestions of CMHSR stakeholders including consumers, Central Massachusetts area providers, and transitional age youth. The resulting website has great functionality, expanded information on CMHSR faculty and staff, and, perhaps most importantly, an instant portal to all CMHSR dissemination products (as described in Dissemination/Community Engagement Highlights below). We hope you can visit us at <http://www.umassmed.edu/cmhsr/index.aspx>.



Research Highlights

- CMHSR faculty, staff and DMH leadership and hospital administrators collaborated to design a study of the transition of patients and staff from Worcester, Westborough, and Taunton State Hospitals to the new Worcester Recovery Center and Hospital (WRCH). This involves not only a relocation of patients and staff, but a systems change in the provision of public inpatient psychiatric care. This study is designed to examine the process of transition, the system-wide implementation of the recovery model, and outcomes for persons moving from existing hospital settings to the new facility. Baseline data were collected in early FY 2013 from 46 patients and 58 staff at Worcester and Taunton State Hospitals. Next steps include data analysis, further data collection, and developing an ongoing, iterative feedback loop to share findings with DMH and WRCH administrators to provide real-time knowledge regarding challenges, successes and strategies to facilitate the transition.



- We began to study and adapt Open Dialogue, a treatment approach for individuals experiencing acute psychiatric crises that integrates the “dialogic process” that has led to shorter and fewer hospitalizations, less recidivism, the use of less neuroleptic medication, improved likelihood of employment, and greater improvements in functioning among a range of populations, including older adolescents and young adults. We will develop a clinical practice training manual to guide clinicians, an organizational change manual to guide the system changes needed to support the clinicians, and fidelity tools to guide clinicians and program leaders.
- Tom Grisso and Laura Guy continued advancing the use of risk/needs assessment in juvenile probation agencies in an effort to improve decision-making, decrease chances of future delinquencies, and reduce costs.
- Jessica Griffin and Melodie Wenz Gross worked with the Massachusetts Department of Children and Families on an Administration of Children and Families grant to provide training, consultation, and evaluation expertise on Trauma-Focused Cognitive Behavioral Therapy in the Commonwealth.
- Carl Fulwiler continued work with Dr. Debra Pinals and representatives from the DPH Bureau of Substance Abuse, the Department of Corrections, and the Department of Youth Services on the Bureau of Justice Assistance grant to DMH to implement MISSION services for women with trauma, mental health and substance abuse histories who are returning from prison.
- The 2011 DMH Consumer and Family Member Satisfaction Survey had 651 completed telephone interviews (486 adults, 165 families), 875 completed paper survey (761 adults, 114 family members), and 198 completed adult inpatient surveys.



Consumer Voice Highlights

- The Mental Health Experienced and Years of Understanding (MHE & You) Advisory Council led, for the first time, the development, planning, and facilitation of the 2012 DMH Research Centers of Excellence Conference. With the theme, “Relationships and Recovery: Advancing the Research,” 103 attendees spent the day hearing from researchers and consumers about the role of relationships in treatment settings with a specific focus on the value of peer relationships for adolescents and young adults. Conference evaluations, 26% of which were completed by consumer attendees, highlighted a high level of satisfaction and interest in the format and content of the day.
- The MHE & You Advisory Council produced 36 stigma fighting video statements (<http://mhenyoustigmafighting.wikispaces.com/>) to raise awareness during the national “May is Mental Health Month” campaign. Videos featuring consumers, researchers, providers, administrators, and family members reading mental illness stigma fighting facts were distributed via listservs, Facebook, YouTube, and CMHSR emails lists. In May 2012 alone these videos received over 1,600 hits and views, reaching 15

counties and six continents. The stigma fighting videos are currently airing on Worcester's public access station, WCCA-TV, and have been highlighted at conferences throughout the Commonwealth.

- MHE & You has a growing social media presence. Our Facebook page has 186 members and 37 "likes" while our Twitter feed has 15 followers.
- The Transitions Research and Training Center (RTC) Young Adults have been busy. In FY 2012 they developed two Tip Sheets, one on disclosing your mental illness in the workplace, and a second on vocational rehabilitation programs for young adults. They worked closely with the DMH Youth Council, participating on various committees (Central Massachusetts Youth Council, Statewide Young Adult Council, Youth Development Committee) and presented at the Central Mass Youth Council "Information and Inspiration" event attended by over 100 young adults. Young Adult Gillian Simons shared her lived experience and recovery story at the Northeast-Suburban Area Citizens Legislative Breakfast, and the RTC Young Adults received certificates of appreciation and recognition for their special contributions to the Young Adult mental health community at DMH's Youth Development Council Award Ceremony. The Young Adults are beginning work on a research study examining the perspectives of college students with mental health conditions with regards to accommodations, stigma, and involvement on campus.



Gillian Simons

Dissemination/Community Engagement Highlights

- CMHSR co-sponsored the 28th annual UMMS Public Sector Psychiatry Conference, "Moving to a Recovery-Based, Patient-Centered System of Care." This conference showcased the transition to an encompassing recovery model of care, and considered how this will change the focus of care delivery as it reshapes thinking about interdependent roles in inpatient and community settings. The conference's recovery focus is an intentional companion to the Center's Recovery Research Program and the interest and study of the transition to the new WRCH.
- We launched a new e-journal, *Psychiatry Information in Brief*, that showcased 16 new dissemination products including Psychiatry Issue Briefs, Research in the Works, Research You Can Use, and a variety of products from the Transitions Research and Training (RTC) Center (<http://escholarship.umassmed.edu/pib/>). Topics included research and recommendations around perinatal depression, informed consent, vocational rehabilitation, advocacy, mental health rights of college students, supported employment, and traumatic brain injuries. (see Appendix B)
- CMHSR and RTC websites received 27,878 hits from 14,712 visitors, resulting in 29,897 Psychiatry Information in Brief product downloads.
- Our CMHSR and RTC social media sites continued to do well. Our Facebook pages had 436 "likes" and we had 168 followers on Twitter, an increase of over 100% from last year.
- The CMHSR listserv reached 1,601 members, a 50% increase from FY 2011.
- Center faculty and staff educated and informed constituents regarding the dissemination work of our DMH Research Center of Excellence at nine conferences/meetings in the Commonwealth, including the Association for Behavioral Healthcare, the Berkshire County Systems of Care Committee, NAMI Massachusetts, the Parent Professional Advocacy League, and the U.S. Psychiatric Rehabilitation Association. 1,235 unique individual products from our Psychiatry Information in Brief catalogue were distributed.

- The Transitions RTC hosted a series of webinars focused on issues of young adults on a range of topics including employment, cognitive behavioral interventions, early parenthood and functioning, and medication decision-making processes. Maryann Davis was interviewed on WBUR, Boston's NPR radio station, on concerns for transitional age youth, and appeared on the cable show, "Picking up the Pieces, Dare to Persevere" in recognition of Children's Mental Health Awareness Day. Maryann discussed the specific needs of transition age youth and young adults with serious mental health conditions and why they are a unique population in need of age-appropriate services.

Collaborations with DMH and Other State Agencies

- CMHSR faculty and DMH leadership continued research projects focused on improving services for people with mental illness and co-occurring disorders involved in the criminal justice system. Following-up on their studies using the Maintaining Independence and Sobriety through Systems Integration, Outreach and Networking (MISSION) model for jail diversion and reentry services, they have been awarded a new Reentry Planning Grant from the Bureau of Justice Assistance (PI: Stephanie Hartwell of UMass Boston, CMHSR Associate Faculty member). The new grant "Jail Diversion across the Continuum: Opportunity for Reflection and Planning (JD-CORP)," is a collaboration between DMH, the Department of Correction, the Department of Public Health, and the Department of Youth Services, and will lead to a roadmap of services and future directions for police-based, court-based, and re-entry services to reduce involvement of individuals with mental health and co-occurring disorders with the criminal justice system.
- Maryann Davis worked with DMH on their new SAMSHA grant, "Plan for a Statewide Transition Age Youth and Young Adult System of Care," providing training and consultation to the system of care expansion planning team.
- Kate Biebel and Joanne Nicholson drafted the Executive Summary from the "Mental Health is Family Health" planning meeting at DMH Central Office. Eight-five participants from seven state agencies, contracted provider representatives, and consumer leaders/advocates from mental health, substance abuse, and child welfare domains engaged in an active discussion of the needs of parents with mental health and co-occurring conditions and their children.
- Carl Fulwiler continues to work closely with Drs. Deb Pinals (DMH) and David Smelson (UMMS) on the MISSION-DIRECT VET project to develop court-based jail diversion programs for veterans. Criminal defendants who are veterans with co-occurring mental health and substance abuse challenges are provided service and treatment options as alternatives to incarceration, as well as service coordination between providers, courts, jails, attorneys, and houses of correction. To date, 166 individuals have been screened and 79 diverted for treatment by the courts at four sites around the state. Outcomes evaluation to date indicate improvement in linkages to benefits and appropriate services, increased social connectedness, and significant decreases in number of individuals who met PTSD diagnostic criteria as well as in severity of PTSD symptoms. Results highlight the effectiveness of a wrap-around, trauma-informed jail diversion program in reducing trauma-related symptoms in veterans.
- CMHSR faculty and staff continued to serve on number of DMH committees including the Central Office Research Review Committee, the Central Area Research Monitoring Committee, the Multicultural Advisory Committee, the Youth Development Committee, the Statewide Planning Group on Parents with Mental Illness, the Advisory Committee to Child Behavioral Health Initiative, the Task Force on Staff and Client Safety, and the Clubhouse Family Legal Support Project.
- Carl Fulwiler, Kate Biebel, Val Williams, and Lisa Fortuna provided consultation and technical assistance to Chris Fluet of DMH and Jack Simon of EOHHS regarding analysis of the statewide Child and

Adolescent Needs (CANS) data as part of the Child Behavioral Health Initiative (CBHI). The assistance focused on trajectory analyses of children participating in CBHI and psychometric properties of the CANS.

- Doug Ziedonis continued his work addressing the needs of veterans in collaboration with David Smelson, Vice Chair for Clinical Research, with a specific focus on the treatment of tobacco dependence and improving services for co-occurring mental health and substance abuse disorders to reduce homelessness. With a grant from the Veteran's Health Administration (VHA), Dr. Ziedonis continued implementing the Addressing Tobacco through Organizational Change (ATTOC) model of organizational change through VHA substance use disorder programs. Dr. Ziedonis also continued his work developing a structured toolkit to assist case managers with housing placement and treatment of homeless veterans with clinical needs.
- Gina Vincent and Tom Grisso presented at the Juvenile Detention Alternatives Initiative Conference with the Massachusetts Department of Youth Services on the development of a risk for failure to appear tool.
- Al Grudzinskas and Barry Feldman worked with Department of Public Health to train Sheriff's Department personnel on crisis intervention and risk management, suicide prevention, and identifying and managing stress in the workforce.

Fiscal Year 2013 is off to a great start. We have a number of new grants funded, are anticipating an increase in our National Institutes of Health funding, and are exploring innovative opportunities to help us diversify our funding portfolio. We will be welcoming some new faculty members and creating new partnerships with faculty across UMMS. We will be refining and implementing our strategic plan, with a clear focus on priorities and action items that support the shared DMH and CMHSR goal of providing the best, state-of-the-art, recovery-oriented, patient-centered care to all citizens of the Commonwealth. We look forward to another productive year of partnering with DMH.

Fulfillment of DMH Contract

Research Activity

These numbers represent both ongoing and novel new research activity at CMHSR during Fiscal Year 2012.

Performance Measure	Accomplished in Fiscal Year 2011	Accomplished in Fiscal Year 2012
Number of research projects approved by DMH ¹	38	50
Number of research proposals submitted and approved by an IRB ²	9	7
Number of grants submitted ³	29	24
Number of grants approved ⁴	15	18

Summary of New Grant Funding

The ongoing financial support provided by DMH confers CMHSR the ability to leverage monies from a variety of other sources in support of research and training. The figure reported below includes the portion of each grant/contract awarded in the 2012 Fiscal Year, not the total funds for life of the grant. The total is inclusive of both direct funds (monies which go directly to the project) and indirect funds (monies that support overhead on the project, the operation of CMHSR, the UMass Department of Psychiatry, and the University of Massachusetts Medical School).

Performance Measure	Accomplished in Fiscal Year 2011	Accomplished in Fiscal Year 2012
External Funding Obtained	\$8,092,114	\$5,593,093

¹The number of ongoing CMHSR research projects during the 2012 fiscal year.

²The total number of projects that received initial IRB approval during the fiscal year.

³The total number of grant applications that CMHSR submitted during the 2012 fiscal year, regardless of their approval status. That is to say some submitted grants may have received funding during the fiscal year, some may receive funding next fiscal year, and some may receive no funding.

⁴The total number of new grants that either received money during the 2012 fiscal year or are approved for funding in the upcoming 2013 fiscal year.

Summary of Publications

CMHSR faculty and staff publish in a variety of different venues. Although the majority of publications appear in peer-reviewed journals, CMHSR faculty and staff also publish books, book chapters, monographs, conference papers, and reviews of academic manuscripts.

Performance Measure	Accomplished in Fiscal Year 2011	Accomplished in Fiscal Year 2012
Number of papers submitted and accepted for peer review publication	63	71

Summary of Other Dissemination Efforts

CMHSR continued to conduct trainings and give presentations at a wide variety of venues throughout Fiscal Year 2012. The following numbers represent the efforts of CMHSR to distribute and disseminate information to DMH state and provider clinical workforce as well as consumers and family members.

Performance Measure	Accomplished in Fiscal Year 2011	Accomplished in Fiscal Year 2012
Number and types of forums used by CMHSR to share information with DMH State and provider clinical workforce, consumers and family members	51	36
Number of state and provider workforce members and consumers and family members with whom research information was shared ¹	3,530	3,625
Number of individuals with serious mental illness who were affected by the research conducted and/or received treatment	2,351	2,432

¹This represents the number of individuals attending CMHSR faculty and staff presentations at conferences and trainings in Massachusetts during FY12. This does not include Massachusetts individuals accessing research information through other CMHSR mechanisms (i.e., website, listservs, social media).

Appendix A

New CMHSR Funded Research

2012 Program for Clubhouse Research

PI: Colleen McKay, M.A., CAGS

Funding: Commonwealth Medicine

Budget: \$250,000

Time Frame: 6/1/2012 - 5/30/2013

Description: The PCR conducts research that describes clubhouse services and evaluates the effectiveness of the model. PCR activities include developing an agenda of research projects and activities including the design, distribution, implementation, analyses, and presentation of findings of multi-site studies and/or quality improvement efforts involving clubhouses. The PCR engages the ICCD, clubhouse programs, staff and faculty at UMMS and other academic institutions, and/or consultants to assure timely performance of project work. The PCR educates the international clubhouse community about research and research methods. In addition, the PCR provides technical assistance, training, and/or consultation to clubhouses, mental health administrators, students, and/or researchers considering participation in research projects involving clubhouses.

Adapting the Open Dialogue Model in the United States: Developing and Piloting an Organizational Change Approach and Behavioral Therapy

PI: Douglas Ziedonis, M.D., M.P.H

Funding: Foundation for Excellence in Mental Health Care, Inc.

Budget: \$100,000

Time Frame: 6/15/2012 - 9/15/2013

Description: Recovery is a process of revival and resiliency, grounded in hope, empowerment, and a supportive network, with which a productive and meaningful life is restored and prevails. This perspective grows from the knowledge that people can and do overcome many challenges thought to be posed by mental health issues or addiction. Open Dialogue is a recovery-oriented psychosocial approach that has been found to be effective with persons in acute psychiatric crisis. The approach emphasizes patient-centered care and engaging an individual's family and social network. The Open Dialogue approach (therapy and organizational change) has been found to improve outcomes for acute psychosis, such as fewer and shorter hospitalizations, less recidivism, reduced neuroleptic medication dosage, improved likelihood of employment, and greater improvements in functioning. Dr. Douglas Ziedonis is leading a multi-disciplinary team at the University of Massachusetts Medical School/UMass Memorial Health Care to develop implementation tools (manuals, fidelity scales, etc.) that are needed to implement and evaluate the Open Dialogue approach in the United States. The manuals and fidelity scales the project will develop are needed in the field and will help the implementation of the Open Dialogue approach in new settings. We already anticipate adapting the Finnish model to fit with the US culture and system by including peer specialists and recovery-oriented language and concepts.

Advancing Use of Risk/Needs Assessment in Juvenile Probation

PI: Laura Guy, Ph.D.

Co-I: Thomas Grisso, Ph.D.
Funding: U.S. Department of Justice/MacArthur
Budget: \$500,000
Time Frame: 10/1/2011 - 9/30/2013

Description: The purpose of our Demonstration project is to assist two juvenile probation agencies to improve their decision-making about youth processing in line with Risk-Need-Responsivity principles to reduce costs and reduce the chance of further delinquency. Two state probation agencies will be selected to implement an evidence-based risk/needs assessment (RNA) tool and the MAYS-2, a well-validated mental health screening tool used widely in juvenile justice, along with a decision-making model for case planning that integrates information about mental health variables and risk for reoffending. Investigators will guide the agencies through the implementation process using a model tested in the MacArthur Foundation's Models for Change Initiative that includes assisting in the selection of an evidence-based RNA, developing policies, categorizing available service options, training staff, modifying existing case plans, and advancing agencies' data management systems. Two experimental and two control sites will be selected in each state to conduct an evaluation using a quasi-experimental design to determine whether out-of-home placement and maximum levels of supervision were decreased, and whether services to high risk youth were increased, without jeopardizing public safety.

Creation of a Legal Data Base on State Involuntary Inpatient and Outpatient Civil Commitment Laws

PI: William Fisher, Ph.D.
Co-I: Albert Grudzinskas, Jr., J.D.
Funding: Robert Wood Johnson Foundation
Budget: \$49,245
Time Frame: 9/1/2011 - 8/31/2012

Description: The goal of this project is to map the current state of statutes, regulations and case law governing involuntary civil commitment to both inpatient and outpatient mental health treatment across 50 states. Development of a database that captures the "state of the law" across the US would provide a baseline for research on such changes. The resultant legal dataset will provide data on inter-jurisdictional differences that will facilitate cross-sectional research on commitment practices and also provide key contextual variables for research assessing the role played by commitment law on other aspects of the delivery of treatment to persons with serious psychiatric illnesses.

Designing a Failure to Appear Risk Tool

PI: Gina Vincent, Ph.D.
Funding: Massachusetts Department of Youth Services
Budget: \$31,000
Time Frame: 6/30/2012 - 6/30/2013

Description: This is a prospective study where we will aid the Department of Youth Services, Juvenile Court, and Worcester Juvenile Probation in creating and validating a research-based, risk assessment tool for failure to appear. The tool will be used by probation officers to help them determine which arraigned youths are not likely to show up for their court adjudication date and, therefore, may warrant pre-trial detention. The goal is to have research-based and structured decisions for which youth are placed in pretrial detention.

Integrating Trauma-Informed and Trauma-Focused Practice in Child Protected Service

PI: Jessica Ludy Griffin, Psy.D.

Funding: Administration for Children & Families

Budget: \$189,380

Time Frame: 9/1/2011 - 8/31/2016

Description: UMass will comply with all aspects of the project documented in the Department of Children and Families award from Administration of Children and Families (ACF) Children's Bureau as assigned to the University of Massachusetts Medical School. UMASS will provide a minimum of three (3) trainings utilizing the Trauma-Focused Cognitive Behavioral therapy (TF-CBT) model and a minimum of 72 consultation calls. UMass Medical School will also provide trauma informed trainings based on the NCTSN Resource Parent Curriculum and Child Welfare Toolkit, and 10 trauma-informed trainings will also take place.

Integrating Trauma-Informed and Trauma-Focused Practice in Child Protected Service - Evaluation

PI: Melodie Wenz Gross, Ph.D.

Funding: Administration for Children & Families

Budget: \$352,000

Time Frame: 9/1/2011 - 8/31/2016

Description: UMMS will provide project evaluation as outlined in the Massachusetts Department of Children and Families grant application to the Administration of Children and Families Children's Bureau. UMass will provide data entry and support to the project to the extent necessary to comply with the data and evaluation expectations of the Administration of Children and Families Children's Bureau.

MISSION-Vet HUD VASH Implementation Study

PI: David Smelson, Psy.D.

Co-I's: Douglas Ziedonis, M.D., M.P.H., A. Gifford, D. Kalman, Marsha Ellison, Ph.D., M.S.W.

Funding: Veterans Administration

Budget: \$1,098,800

Time Frame: 10/1/2011 - 9/1/2015

Description: This project tests an implementation platform – Getting to Outcomes (GTO) – designed to assist in the delivery of an evidence based intervention (MISSION-VET) for Veterans with co-occurring mental health and substance use disorders in the HUD-VASH program. The proposed study serves a dual function of comparing implementation of the MISSION-Vet currently being planned through the VA Office of Patient Care Services to an enhanced implementation approach using the GTO model. The proposed research will help to guide policy and practice about the most effective methods to ensure implementation of MISSION-Vet with fidelity and effectiveness.

Implementing a Failure to Appear Tool in MA Juvenile Probation

PI: Gina Vincent, Ph.D.

Funding: Massachusetts Department of Youth Services

Budget: \$113,944

Time Frame: 5/1/2012 - 9/30/2013

Description: The objective of this project is to cross-validate and implement an empirically-developed

tool which informs the determination that a youth is more or less likely to appear for their court ordered appearance dates. This is a risk assessment for failure to appear tool. Once the tool is cross-validated it will be implemented statewide in Massachusetts probation offices.

Technical Assistance Collaborative, Inc

PI: Thomas Grisso, Ph.D.

Funding: Substance Abuse and Mental Health Services Administration

Budget: \$46,000

Time Frame: 1/1/2012 - 3/31/2013

Description: This subcontract assists juvenile justice sites in eight states to develop programs for diverting arrested youth from juvenile justice processing, thus increasing their access to community services. CMHSR's role involves training and technical assistance at 2 two-day "policy academy" events that train the states to develop and plan mental health and risk/needs screening for use in their diversion programs. It also provides for state-by-state technical assistance as they implement those plans.

Using Evidence to Improve Medicaid Mental Health Services for Massachusetts Children & Youth

PI: Kathleen Biebel, Ph.D.

Funding: W. T. Grant Foundation

Budget: \$68,518

Time Frame: 10/1/2011 - 9/30/2012

Description: This grant continues a study examining the ways in which research evidence comes into play as children's mental health services are transformed and implemented in the provider community through the Massachusetts Children's Behavioral Health Initiative (CBHI). Activities focus on understanding provider agencies' internal processes for using research evidence as they make decisions related to the CMHI. Four provider agencies representing a range of characteristics (e.g., size, location) participated. Findings are currently being translated into peer-reviewed journal articles, and products to brief provider agencies and state policy makers regarding strategies for promoting the use of research evidence in the transformation of services for children and youth, and recommendations for states and other organizations involved in systems change initiatives to build effective, productive bridges among research, policy, and practice sectors.

New CMHSR Funded Trainings

Assessing and Managing Suicide Risk: Core Competencies for Navy Personnel

Personnel: Barry Feldman, Ph.D.

Funding: Education Development Center/VCA/AMSR Navy Contract

Budget: \$3,600

Time Frame: 9/28/2011 - 10/2/2011

Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professional

Personnel: Barry Feldman, Ph.D.

Funding: AdCare Educational Institute

Budget: \$6,800
Time Frame: 9/14/2011 - 11/9/2011

Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals

Funding: AdCare Educational Institute
Budget: \$6,400
Time Frame: 3/15/2012 - 5/17/2012

Child/Teen Therapeutic-Communication: Training Model for EMTs

Personnel: Barry Feldman, Ph.D.
Funding: AdCare Educational Institute
Budget: \$25,000
Time Frame: 10/1/2011 - 2/29/2012

EMT Suicide Prevention Training Curriculum

PI: Barry Feldman, Ph.D.
Co-PI: Albert Grudzinskas, Jr., J.D.
Funding: AdCare Educational Institute
Budget: \$28,790
Time Frame: 11/1/2011 - 6/30/2012

Risk Identification and Management Training for Sheriff's Department Correctional Personnel

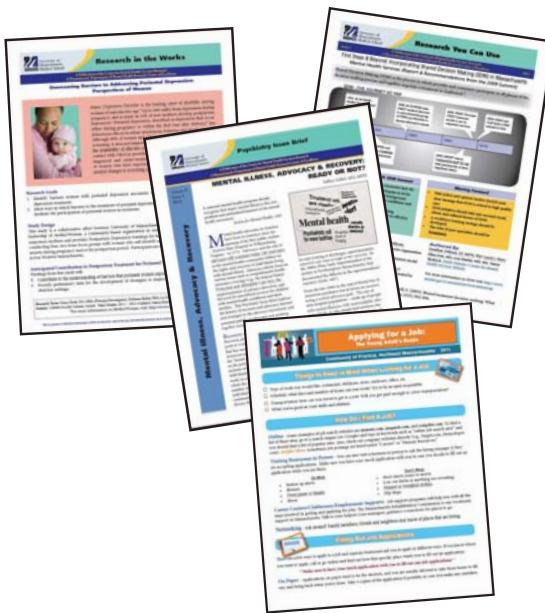
Co-PI's: Albert Grudzinskas, Jr., J.D., Barry Feldman, Ph.D.
Funding: AdCare Educational Institute
Budget: \$33,866
Time Frame: 1/1/2012 - 6/30/2012

Suicide Watch: Assessing and Managing Suicide Risk in Schools and on Campuses

PI: Barry Feldman, Ph.D.
Funding: Department of Criminal Justice-Virginia
Budget: \$2,500
Time Frame: 8/2/2011 - 8/2/2012

Appendix B

CMHSR Dissemination Products



Psychiatry Information in Brief

Psychiatry Issue Brief

- The Impact of Suicide Calls on Police
- Brain Injury Resources
- Mental Illness, Advocacy & Recovery: Ready or Not?

Research You Can Use

- Young Adults Getting Involved: Participatory Action Research and Transition Age Youth
- Informed Consent and the Clinician-Client Relationship

Research in the Works

- Addressing Tobacco Through Organizational Change (ATTOC)
- MISSION Community Re-Entry for Women (MISSION-CREW) Program Development and Implementation
- Harmonizing Databases? Evaluating Effectiveness of A Statewide Public Mental Health Reentry Program

Transitions Research & Training Center

- TTYL: Keeping in Contact With Your Professional
- Applying for a Job: The Young Adult's Guide
- Becoming an Adult: Challenges for Those with Mental Health Conditions
- My "Must Have" Papers
- Teens on IEPs: Making My "Transition" Services Work for Me
- My Mental Health Rights on Campus
- Supported Employment Adapted for Young Adults with Peer Mentors: A Feasibility Study
- Vocational Rehabilitation: A Young Adult's Guide



The Impact of Suicide Calls on Police

Barry N. Feldman, Ph.D., Albert J. Grudzinskas, Jr., J.D., Bernice Gershenson, MPH,
Jonathan C. Clayfield, MA, LMHC, Richard P. Cody, J.D.

Data collected in 2007 by the Centers for Disease Control and Prevention revealed that suicide occurred at rates nearly twice that of homicide. For all age groups combined, suicide ranked as the eleventh leading cause of death in the US and among the top five causes in several age groups in 2007 (CDC, 2011), (table 1). Police officers are the first responders to crises, yet little is known about the impact and stressors of responding to completed suicide calls.

Table 1. Suicide Rank as Cause of Death

Age Group	Suicide Rank
10–14	4 th
15–24	3 rd
25–34	2 nd
35–44	4 th
45–54	5 th

Centers for Disease Control [CDC], 2011

Police Stressor Survey

In a preliminary study of over 225 officers in Massachusetts, we identified issues and circumstances reported by officers dealing with suicides. We asked police officers to identify the issues or specific circumstances related to responding to suicide calls that could cause/have caused them to feel the most stress or anxiety.

A total of 225 usable surveys were obtained, with 684 issues/circumstances identified. Findings suggest that suicide calls present personal and professional challenges, with short and long-term impact for police officers, their departments, and their

Table 2. 10 Most Common Stressors for Police	
Stressor	% Reporting Stressor
Dealing with survivors	39
Emotional impact on officer	35
Young victim	30
Managing crime scene	29
Emotional impact on survivors	26
Victim known to officer	19
Suicide method	16
Reason for suicide	15
Graphic/gruesome death	13
Officer safety	13
Death notification	12

communities. These data show that suicide calls are often critical incidents in police officers' careers and are among the highest anxiety- and stress-provoking circumstances to which police officers must respond (table 2).

“Normal” Work Stressors

Policing is a high-demand and high-stress profession (Miller, 2008), in which police officers are exposed to a wide variety of stressors. “Normal” work stressors typically fall into two categories: (1) stressors on-the-street (e.g., dealing with extremes such as weather and high risk situations, shift changes, experiencing “high impact” crime areas, and fear of serious injury or death); and (2) departmental stressors (e.g., lost promotional opportunities, mistrust of management, punitive discipline, and police brutality issues).

Critical Incident Stressors

In addition to these routine ongoing stressors, officers often experience critical incident stress. A critical incident (CI) is any event that has an unusually powerful, negative impact on police personnel because the event exceeds the range of ordinary work-related stressors or hassles (Everly & Mitchell, 1997; Miller, 2008). In one report, 26% of officers involved in CIs experienced some form of Post-Traumatic Stress Disorder (PTSD) one month later (Martin, McKean & Veltkamp, 1986; Koch, 2010; Pienaar, Rothman & Van De Vijver, 2006). This was seen to be especially true after a call involving a death. Significant literature exists to support the idea that police officers experience high-level stress when arriving on-scene at a traumatic incident (Brown & Campbell, 1994; Kirschman, 1997; Paton & Violanti, 1996).

Impact of Critical Incidents

Failure to acknowledge and address the emotional impact of CIs may result in serious, and sometimes devastating, personal and professional consequences for those officers involved, both on individual and departmental levels. Research on predictors of police suicide (Violanti, 2004, Cross & Ashley, 2004) has demonstrated that CI exposure and PTSD symptoms seem to significantly increase:

- Alcohol Use
- Suicidal Ideation/Suicide
- Mood Disturbance
- Domestic Violence
- Use of Excessive Force

Suicide of a police officer represents a major CI. The CDC reports a suicide rate for the general population of nearly 12 per 100,000 (Heron et al., 2009). Police suicide rates are estimated to be significantly higher at 18 per 100,000 (Ritter, 2007). Studies have documented that within a specific period, some law enforcement agencies have had more officer deaths from suicide than from line-of-duty homicides (Hackett & Violanti, 2003).

Barriers

Despite the tragedy of suicide and its toll among police officers, a major barrier for dealing with this issue is the pervasive code of silence consistent within the law enforcement culture. Stigma surrounding mental health problems prevents officers from self-reporting depression or other problems, fearing that they will be

perceived as being weak. Reluctance to self-disclose emotional problems stems from fears of reassignment and loss of weapon-carrying privileges. Co-workers are often hesitant to turn in a troubled officer despite concerns about a comrade's need for help (Miller, 2008). Even with the high rate of police suicide, "experts estimate that less than 10 percent of the 18,000 police departments nationwide actively work to prevent suicides within their ranks" (Antlfinger, 2008).

Recommendations for Police Training and Mental Health Providers

The Special Commission on Massachusetts Police Training (2010) found that Massachusetts spends only \$187 annually per officer for training in general. By comparison, New Hampshire spends \$933, and Vermont spends \$1,525. The expertise to provide such training and to help officers manage CI stress currently exists. Despite this, it is implemented in only a few departments. Based on feedback we have received, we recommend that officers receive mandatory training to:

- Detect suicidal risk in officers and the public
- Facilitate appropriate referrals for help
- Develop/enhance skills to communicate with surviving family/friends
- Understand challenges inherent in suicide calls
- Recognize signs and symptoms related to CI stress associated with responding to suicide calls

Delivering mental health care to the law enforcement community is challenging. Police officers often resist counseling for reasons including officers being skeptical of outsiders and having difficulty trusting mental health professionals. Conversely, therapists sometimes do not understand police work, nor can they comprehend the daily stresses officers encounter (Kureczka, 1996).

We recommend that counselors have a thorough understanding of policing, as well as comprehensive knowledge of the police force and its demographics. Therapists must be familiar with the organization of the police department and its power structure to understand the work environment of affected officers. Further, building rapport and assuring officers of the confidentiality of information revealed is essential and requires time and diligence by mental health professionals. Through such efforts, the therapeutic effects of counseling can be realized.



Brain injury, occurring when physical trauma causes brain damage, either closed-head or penetrating, contributes to one third of all injury-related deaths annually and places approximately 275,000 people in the hospital each year (Faul, Xu, Wald, Coronado, 2010; Center for Disease Control and Prevention, 2012). Approximately 1.7 million people in the US sustain a traumatic brain injury (TBI) yearly (Faul, et al, 2010). It is estimated that TBI related medical costs, both direct and indirect, totaled \$76.5 billion dollars in 2010 (Center for Disease Control and Prevention, 2012).

Amongst the veteran population, TBI is often associated with psychological difficulty and increased risk of substance abuse (Department of Veterans Affairs). More than 203,019 individuals in the US forces had sustained TBI from combat and non-combat related causes (Defense and Veterans Brain Injury Center, 2012). This is approximately a 26% increase in medically diagnosed cases of US soldiers since 2000 (Rand, 2008). Many of these soldiers suffer from deficits in cognitive and motor functions, as well as emotional difficulties, plaguing these persons with tremendous hardships and frustrations (Forrest, Schwam, & Cohen, 2002). These deficits commonly leave patients unable to hold employment or function properly in social surroundings; in turn, incurring serious social and economic costs to both the patients and relatives.

More troubling, individuals with TBI may receive improper or no treatment, despite self-reports of persisting deficits post-injury (Huebner, Johnson, Miller Bennett, & Schneck, 2003). While some community-based rehabilitative supports exist (e.g. vocational rehabilitation services, or case management), these programs are not widely available for persons with TBI in

Colleen E. McKay, MA, CAGS & Meghan E. Heffernan, BA

Brain Injury Resources



all communities. In all, there is an inadequate service array to support individuals with brain injuries.

Efforts of the University of Massachusetts Medical School (UMMS)

The Brain Injury Academic Interest Group (BI-AIG) in the UMMS Psychiatry Department aims to engage faculty and staff from the department and Commonwealth Medicine, researchers and providers at local and state agencies, and other academic institutions around multiple issues relevant to brain injuries. The BI-AIG explores ongoing work and interests within the BI-AIG to generate projects and priorities for the future.

The BI-AIG discusses issues related to TBI from clinical and research perspectives. BI-AIG goals include developing protocols for TBI follow-up that will standardize assessments and will lay the groundwork for research. The BI-AIG is developing a regional resource list that providers, researchers and individuals with brain injuries can use to access supports in Massachusetts. Below are some resources identified by the BI-AIG that provide information about brain injuries.

Resources for Information about Brain Injury

- **The Brain Injury Association of American** (www.biausa.org) is a nationwide network advocating for TBI awareness and quality health care.
- **Brain Line** (www.brainline.org) provides information on preventing, treating, and living with traumatic brain injury (TBI).
- **The International Brain Injury Association** (IBIA) (www.internationalbrain.org) works with professionals, advocates, policy-makers, to improve TBI-related outcomes.
- **The Brain Injury Recovery Network** (www.tbirecovery.org) provides practical information for brain injury survivors and families.
- **The International Brain Injury Clubhouse Association** (www.braininjuryclubhouses.net) is a collaborative network of programs that serve persons with brain injury and stroke.
- **The Defense and Veterans Brain Injury Center** (DVBIC) (www.dvbi.org) serves active duty military, and veterans with TBI through clinical care, innovative research, and educational programs. The DVBIC website has information and resources (e.g. TBI clinical tools).

Resources for Researchers

- **Center on Outcome Measurement in Brain Injury** (COMBI) (www.tbims.org/combi) provides information on outcome measures and scales for rehabilitation and assessment of brain injury.
- **The TBI Model Systems Knowledge Translation Center** (www.msktc.org/tbi/) provides information for consumers, a database of research articles, reviews of TBI research, and current research activities.
- **The Traumatic Brain Injury Model Systems National Data & Statistical Center** (TBINDSC) (www.tbindsc.org/) provides technical assistance, training, and methodological consultation to the TBIMS centers.
- **The National Institute of Neurological Disorders and Stroke** (NINDS) (www.ninds.nih.gov/disorders/tbi/tbi.htm) conducts and funds research on the causes, prevention, diagnosis and treatment of neurological disorders and stroke.

Resources in Massachusetts

- **The Acquired Brain Injury (ABI) & Traumatic Brain Injury Commission** (www.mass.gov/hhs/braininjurycommission) was established to

investigate the rehabilitative residential and integrated community-based support services for persons with acquired brain injury.

- **The UMMS ABI Waiver** is a collaboration of UMMS, MassHealth, and the Massachusetts Rehabilitation Commission. The Waiver team conducts participant outreach, clinical eligibility screenings, transition, home and community-based services and case management (www.mass.gov/eohhs/consumer-insurance/more-programs/acquired-brain-injury-waivers.html)
- **The Brain Injury Association of Massachusetts** (www.biama.org) is a not-for-profit organization that supports brain injury survivors and their families, that offers educational information, advocacy, and programs to prevent brain injuries.
- **The Statewide Head Injury Program** (SHIP) (www.mass.gov/veterans/health-and-well-being/tbi/state-tbi-agencies/ship.html) maintains a network of community-based services and supports that assist individuals with head injuries in maintaining or increasing their level of independence at home, work and in their communities.

Additional Information For Family Members & Persons Suffering From TBI

Many family members and persons suffering from TBI do not receive help in how to cope with TBI-related deficits. We recommend that persons with TBI and their caregivers seek treatment from trained TBI professionals in order to learn how to live with the brain injury, and the resources listed here provide useful information which may help to inform those choices. It is critical to note that only a medically licensed professional can diagnose a person with TBI.

For TBI Service Providers & Researchers
The continued efforts of the BI-AIG include developing resources and stimulating collaborations between researchers and providers. We offer a standing invitation for providers and researchers interested in TBI to attend a BI-AIG session and become a member. For further information regarding the BI-AIG, please contact the authors of this issue brief listed below:

Colleen.McKay@umassmed.edu
Meghan.Heffernan@umassmed.edu

We appreciate your feedback: Please click here to answer our brief survey



MENTAL ILLNESS, ADVOCACY & RECOVERY: READY OR NOT?

Jeffrey Geller, MD, MPH

A national mental health program should recognize that major mental illness is the core problem and unfinished business of the mental health movement.

Action for Mental Health, 1961

Mental health advocates in America have been in existence since the opening of the first public asylum – Eastern State Hospital in Williamsburg, Virginia – in 1772. Advocacy and the role of advocates still continues today, 240 years later, as the mental health community lobbies for the rights and concerns of individuals living with mental illness. Advocacy efforts focus on various issues such as comprehensive health insurance coverage (e.g., the federal Patient Protection and Affordable Care Act), the implementation of advance directives, and the need for specialized services for children with mental health conditions and their families. This Psychiatry Issue Brief explores the history of recovery and advocacy, barriers and strategies to the advocacy movement, and potential pitfalls of advocates not working together toward shared goals.

Recovery as Central to Advocacy

Recovery, probably the fundamental focal point in contemporary advocacy, is a concept that has waxed and waned in its centrality to American psychiatry since the golden age of the “lunatic asylums,” which were founded on the principle of recovery. Psychiatrists in asylums were focused on removing suffering individuals from the sources of stress (families, work) to a healing environment (asylum) where the superintendent, assisted by small number of staff, could pursue the cure of each individual patient and return the patient to the community. By viewing insanity as an acute disease that could be cured at each episode, and



by only looking at discharges, superintendents reported cure rates as high as 90+ percent. By the 1880s, Pliny Earle, Superintendent of the asylum in Northampton, Massachusetts, had documented the fallacies in the superintendents' statistics (Earle, 1887).

From the late 1880s to the end of World War II American psychiatry lost its focus on recovery being a central advocacy goal. The size of state hospital populations – made up of people with mental illnesses, with neurosyphilis, who were elderly, or who simply had nowhere else to go – grew beyond anyone's expectation – to single state hospitals with 16,000 to 18,000 patients. The focus on recovery reappeared in the 1950s with an emphasis in state hospitals on social skills, work, and returning patients to the community and the workforce (Geller, 2000). Before recovery could gain a foothold, hospital-based recovery was lost to the new focus of just getting patients out of the hospital, retrospectively labeled, “deinstitutionalization.”

In more recent years the concept of recovery has again been highlighted within professional and grassroots psychiatric and mental health communities. The American Association of Community Psychiatrists was the first

professional group to focus on the modern version of recovery, as evidenced by the guidelines the organization established on Recovery in 2003 (AACP 2003). Recovery became an American Psychiatric Association focus with the adoption of a position statement on recovery in July 2005 (APA 2005). The Substance Abuse and Mental Health Services Administration has, of late, pushed the recovery agenda with all the tools within its portfolio.

As in any movement, there are some who are out front. Some leaders of the rebirth of the focus of recovery include Judy Chamberlin (deceased) and Dan Fisher, MD, PhD, of the National Empowerment Center; Pat Deegan, of the Institute for the Study of Human Resilience; Fred Frese, PhD, of the Northeast Ohio Medical University; and William Anthony, PhD, of the Boston University Center for Psychiatric Rehabilitation. Anthony was the first person not self-identified as being or having been a person with serious mental illness to call for a fundamental shifting of psychiatric treatment to a recovery model (Anthony, 2000).

Barriers to Advocacy

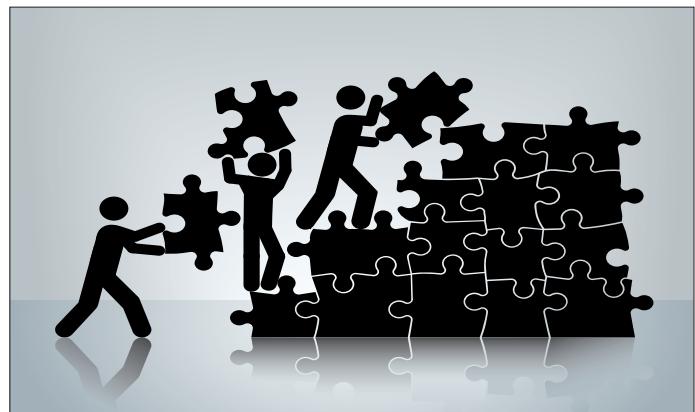
Impediments to effective advocacy for improved treatment and community-based services have remained largely unchanged for 50 years. One barrier to successful advocacy has been the lack of cooperation, which can deteriorate to strident antagonism and open hostility, between the three major cohorts of mental health advocates: professionals, persons with mental illnesses/consumer groups, and families and other supporters of persons with mental illnesses. The other barrier to advocacy is the infighting within the cohorts, e.g., between psychiatrist and psychologist, patients for and against psychotropic medication, and family members for and against involuntary medications for outpatients.

Only when these different cohorts can consistently advocate together for improvements in the system of care for persons with mental illness will advocacy for this population emerge from its marginalized state, and movement toward government reform be achieved.

Advocacy Strategies

The three cohorts of advocates emphasize different methods of advocacy. Professionals focus on lobbying through organizations that often have a paid lobbyist to inform legislators, consumer groups utilize rallies and protests, and families organize to educate and lobby policymakers. The emphasis on multiple methods of advocacy has tended to mask the common agendas of

these separate cohorts. For example, consumer groups protest against the use of restraint, while professionals work to reduce restraint to an absolute minimum. Given that these groups have fairly comparable objectives it could be assumed that these two groups could sit down to address the reduction of restraint with a shared goal - but this rarely happens.



Advocate Together

Each of these advocacy groups have a legitimate point of view, but only when people who populate the world of psychiatry – patients, doctors, consumers, nurses, victims and beneficiaries – advocate together, can the resources for recovery be fully mobilized to achieve positive outcomes. As recommended in the World Health Organization's 2003 publication, Advocacy for Mental Health, these advocacy groups "should establish a dialogue with representatives of all groups involved in mental health advocacy in the countries or regions concerned. It is important to understand their needs, motivations and diverse methods of advocacy. Helping them to find common issues and goals can contribute to the formation of alliances and coalitions. Helping them to identify their similarities can give them more strength and power to advocate both with the general population and with policy-makers, without the loss of their identities." (p. 61) Advocates need to come together to develop consensus positions on:

- a non-discriminatory, inclusive health insurance schema,
- a campaign to end stigma,
- a plan for prevention of comorbidities,
- places for rehabilitation/recovery and
- a system of workforce development geared toward both treatment providers and employment specialists who assist persons with psychiatric disabilities to enter or return to competitive employment.

The choice is ours. Are we ready or not?

We appreciate your feedback: Please click here to answer our brief survey

Young Adults Getting Involved: Participatory Action Research and Transition Age Youth

Why?

- Enhances relevance of research questions and methods
- Generates actionable results
- Widens dissemination of research findings

Challenges Faced

- Distrust between:
 - Consumers and non-consumers
 - Experienced researchers and new researchers
 - Adults and young adults
- Different from traditional research training and methods
- Funding or infrastructure needed for team building
- Young adults may lack employment experience
- Young adults may have turbulent lives

How?

- Research leadership's commitment to active participation of young adults
- Promoting young adult self-efficacy and empowerment
- Adults and young adults working together
- Establish relationships with community stakeholders
- Naturally occurring adult mentoring of young adults
- Availability of developmentally appropriate vocational supports

Positive Outcomes for Young Adults

- Vocational/skill development
- Self-efficacy that instills empowerment to act
- Self-confidence and a sense of hope
- Improved health outcomes
- Life-long civic participants



Visit us online at <http://labs.umassmed.edu/transitionsRTC>

See also: www.cqi-mass.org

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This publication can be made available in alternative formats upon request through TransitionsRTC@umassmed.edu

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Informed Consent and the Clinician-Client Relationship

Informed consent creates a continuing dialogue and promotes a clinician-client relationship that fosters mutual respect, shared decision-making and client autonomy. Informed consent done correctly involves clinicians providing clients with the information necessary to make informed decisions about their treatment.

Two Models of Implementing Informed Consent

The Traditional Approach to Informed Consent: The Event Model

The event model of implementing informed consent treats it as a discrete act to be performed once in each treatment course. While satisfying the legal requirements of providing complete and accurate information, this model can lead to unintended consequences including:

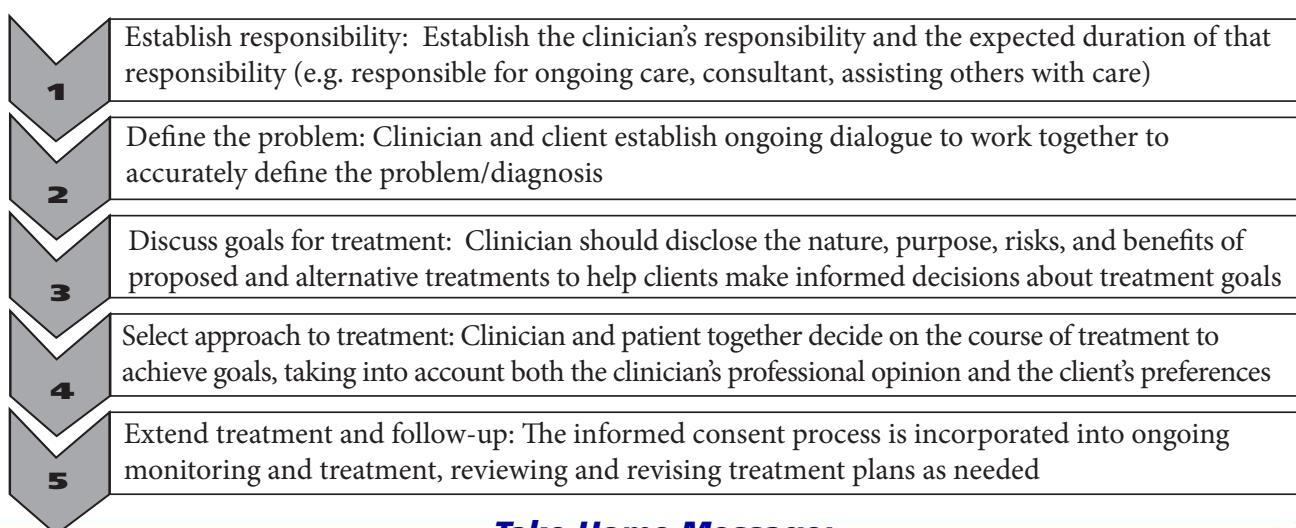
- Not improving a client's comprehension of the treatment process
- Creating a more bureaucratic and less humane clinician and client interaction
- A client sensing that participation in the decision-making process is not desired

An Alternative Approach to Informed Consent: The Process Model

The process model engages the clinician and client in a continuing dialogue to:

- Promote ongoing communication throughout the course of treatment regarding client and clinician expectations for treatment; thus, informed consent is a process, not a single event
- Ensure that the client is able to integrate information into a well-organized understanding of their clinical situation
- Build on a vision of active client participation in treatment decision making

How to Incorporate the Process Model of Informed Consent:



Take Home Message:

Traditionally, the Event Model enabled clinicians to obtain informed consent for the primary purpose of addressing legal protection and ethical concerns. However, the Process Model of implementing informed consent establishes clinician and client as partners in an ongoing dialogue about treatment needs and choices.

Addressing Tobacco Through Organizational Change (ATTOC)

- People with mental illness smoke 44% of all cigarettes produced in the U.S.
- Up to 75% of individuals with serious mental illnesses or addictions smoke cigarettes
- 30-35% of treatment staff smoke
- Almost half of the 435,000 deaths that occur each year from smoking are among people with mental illness and/or substance use disorders
- Although the burden of illness and economic costs of nicotine addiction are elevated in mental health and drug treatment populations, treatment programs rarely address co-morbid nicotine addiction

The Value of ATTOC

ATTOC is an intervention that provides services and ongoing support for agencies and organizations that are interested in learning how to initiate, improve, and or provide treatment for tobacco addiction; reduce tobacco addiction amongst employees; restrict or eliminate tobacco use on campus; and change the work environment to promote health and wellness.

3 Main Components of ATTOC

1. **Preparation** - Acknowledge the challenge; establish leadership committee; create a written change plan, and implement a timeline.
2. **Implementation** - Conduct staff training; provide treatment assistance; incorporate patient education; integrate treatment groups & develop on site meetings.
3. **Sustainability** - Communicate with 12-step groups, colleagues, and referral sources regarding system changes and develop policies addressing tobacco use.

Outcome of the ATTOC Approach

- ATTOC is utilized as the model for organizations such as West China Hospital to create Tobacco Free environment and other organizations to initiate Tobacco Free policy and nicotine dependence treatment.
- The ATTOC approach has resulted in an Organizational Change Toolkit, Clinical Treatment Toolkit, Staff Training Toolkit and the establishment of the UMass Consult and Training ATTOC Institute.
- ATTOC has been evaluated in NIH studies, statewide initiatives, and local performance improvement evaluations. Articles and presentations regarding ATTOC have appeared in professional forums.

Current ATTOC Projects:

- **Massachusetts:** Researchers led a major initiative in supporting the Dept of Mental Health Tobacco Free Campus Initiative providing training, and technical assistance.
- **Connecticut:** Hiring and training tobacco counselors & champions for organizational change; implementing tobacco cessation education, pre-treatment, treatment, and behavioral counseling programs; website and social media to disseminate information; and providing training aimed at other local mental health authorities.
- **China:** Adapted clinical tools and organizational change infrastructure materials from English into Chinese language and culture. Researchers worked with Sichuan University West China Hospital's Mental Health Center to help it become one of the first smoke-free hospitals in China.

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MISSION Community Re-Entry for Women (MISSION-CREW) Program Development and Implementation



A study by faculty of the Center for Mental Health Services Research of Massachusetts on arrest patterns of individuals with serious mental illnesses receiving DMH services showed female DMH clients at greater risk of arrest than women in the general population.¹ Additionally, women with mental illness are more likely to violate probation and parole and be lost to follow-up within three months post-release.² To date, gaps in gender-sensitive programming are apparent with respect to women's unique employment challenges, health related issues, and housing needs related to their social relationships and family responsibilities.^{3,4} Another critical need area among female offenders

arises from trauma-related disorders associated with physical and sexual victimization.⁵ Mental health and other services needed to help address these issues when re-entering the community after a period of incarceration are typically inadequate or underdeveloped. The goal of this study is to examine the impact of MISSION-CREW on criminal justice outcomes for women released from MCI-Framingham and South Middlesex Correctional Center (SMCC).

About MISSION-CREW

Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking Community Re-Entry for Women (MISSION-CREW) model of care was adapted from the original MISSION program that helped formerly homeless veterans with Co-Occurring Disorders (COD) re-establish their lives in the community.⁶ MISSION-CREW seeks to promote successful community reentry and care coordination among female inmates with CODs by employing a model of evidence-based practices that integrates trauma-sensitive treatment, COD treatment, care coordination and peer support.⁷ In addition, MISSION-CREW addresses gender-specific re-entry treatment service needs together with comprehensive transition planning and linkages to community based care.

Study Design and Methods:

Study Population

- Women incarcerated at MCI Framingham or SMCC for a non-violent index offense who have an open mental health case and a substance use problem, who will be released to the greater Boston area within 45 days to 6 months

Study Methods

- Compare outcomes of experimental & comparison groups:
 - Experimental group: women enrolled in MISSION-CREW services who complete evaluations at baseline and at 6 months follow-up
 - Comparison group: women receiving treatment as usual

Outcome Variables:

Primary Outcome Variable

- Re-arrest rates will be compared one year post-release

Secondary Outcome Variables (for the experimental group only):

- Change in medical, substance abuse, and psychiatric symptoms
- Participants' perceptions of and satisfaction with MISSION-CREW services
- Completion of MISSION-CREW and referral to other community services

^{*}Funded by Bureau of Justice Assistance (#2009-MO-BX-0037) to the Massachusetts Department of Mental Health (PI: Pinals), in collaboration with the UMMS Center for Mental Health Services Research, Department of Correction, Department of Public Health, and Span, Inc.

Research Team: Debra Pinals, MD; Laura Guy, PhD; Carl Fulwiler, MD, PhD; Andrea Leverentz, PhD; Stephanie Hartwell, PhD; Elisabeth Aaker Orvek, MS. **Funder:** Bureau of Justice Assistance, **Time Frame:** 2008 – 2011, **Contact:** Laura.Guy@umassmed.edu

Harmonizing Databases? Evaluating Effectiveness of A Statewide Public Mental Health Reentry Program

Background - A Bureau of Justice Administration study reported half of all prisoners have some form of mental disorder and approximately 16% of all those incarcerated in state prisons have Serious Mental Illness (SMI).¹ Evidence also suggests that prisoners with SMI are more likely to have had previous incarcerations,² are typically under insured and have limited coping repertoires that can have “spill-over” effects in the community when they are released.³ The costs of incarceration are increasing and there has been little progress in reducing recidivism among persons with SMI.²

The Value of “Harmonizing” Data – This study will establish a combined dataset “harmonizing” existing administrative databases to evaluate the effectiveness of the Massachusetts Department of Mental Health’s Forensic Transition Team (FTT). The FTT is a case coordinator-based reentry program that serves persons with SMI transitioning from prisons. As needed, the FTT coordinators advocate for clients by attending discharge-planning meetings, providing linkages to providers, and tracking clients’ progress for three months post-release.

Study Design and Methodology – The study design is longitudinal, retrospective and uses existing secondary data with comparative analysis based on a case-control/quasi-experimental design framework. Data will be obtained from state, criminal justice, mental health, and substance abuse agencies. All FTT transition cases released from Massachusetts state prisons and two of the state’s largest county House of Correction from July 2007 through July 2009 will be studied. The FTT cases will be matched with individuals with mental disorders receiving correctional-based mental health services at the time of release who were ineligible for the FTT program. Both groups will be followed using retrospective data for two years post-release through March 2011.

Final Study Analysis Will Include:

- A comparison of post-incarceration outcomes including re-arrest, re-incarceration and detoxification admissions of FTT clients with the comparison group
- Determine factors that may affect disparities in post-incarceration outcomes (i.e. demographic factors, housing status, substance abuse and age of participants), after controlling for most recent governing offense and geographic region

Anticipated Contributions to Research & Public Policy:

- Inform development of policies and practices that address the reentry needs of individuals with mental disorders leaving correctional custody
- Provide an analysis of the costs and benefits of a case coordinator-based reentry program
- Assess the feasibility of agency collaborations and using administrative databases for program evaluation
- Provide information to determine if more resources for intensive interventions linking individuals to services are appropriate for this population

Research Team: Stephanie W. Hartwell, PhD¹ (Principal Investigator); Xiaogang Deng, PhD;¹ William Fisher, PhD;² Carl Fulwiler, MD, PhD;² Debra A. Pinals, MD³

Funder: NIMH # 1RC1MH088716-01 **Time Frame:** Sept. 2009 – Dec. 2011 **Contact:** Stephanie.Hartwell@umb.edu

¹ University of Massachusetts at Boston; ²Center for Mental Health Services Research, Dept of Psychiatry, University of Massachusetts Medical School; ³MA Dept of Mental Health



TTYL: Keeping in Contact With Your Professional

Community of Practice, Northeast Massachusetts 2011

Keeping in communication with professionals (doctors/counselors/psychiatrists/etc.) is very important. It will help keep you updated on appointments, insurance issues, medications, etc. Here are some tips on simple ways to stay in contact! No matter what form of communication you are using, you should always give 24 hours notice if you are cancelling an appointment, unless if it's an emergency. Find out your offices policy about no shows (i.e., some offices will charge you or stop working with you for missed appointments).

Keeping in Contact by Phone and Text

Cell Phones

- Let all professionals know right away if you have to change your phone number.
- You can use your cell phone's calendar to put reminders in your phone for appointments with your providers.
- Use the address book in your phone to put in all your professionals numbers and an emergency contact number so they are easy to locate.
- Write down all professionals numbers so you have a backup if a phone breaks or is lost. (Some cell phone providers will keep a backup for you online for free).
- Make sure to set up your voicemail so professionals can leave you messages about appointments/insurance issues/etc.
- Keep your cell phone charged at all times so you are easy to reach, & keep it on you whenever possible.
- Ask your professional if they are allowed to use text messaging.

SafeLink Cell Phones

- SafeLink is a government supported program that provides a free cell phone and minutes to those who qualify for State or Federal Assistance Programs.¹ For example, Medicaid, SSI, Federal Public Housing Assistance, Food Stamps and low income Home Energy Assistant Programs, etc.
- To find out if you are eligible for a SafeLink cell phone go to: www.safelinkwireless.com, put in your zip code and you will receive information on benefits, qualifying and applying for SafeLink that are specific to your State.
- You can also text on a SafeLink phone. Check your plan to see how many minutes are taken up by sending or receiving each text.
- To purchase additional minutes for your SafeLink phone you can either go online (24/7) to www.tracfone.com, by phone (24/7) 1-800-378-1684, or at local retailers (Wal-Mart, CVS, Kmart or Target etc.).

Keeping in Contact by Internet

Access to computers

- If you do not have a computer and need to use one to check e-mails, etc, you can go to your town's library, or use one in your school's computer room.
- If you own a computer or wireless device but don't have internet, most libraries offer free wireless internet. A lot of restaurants or coffee shops (such as McDonalds) have free wireless for customers.

E-mail accounts and Social Media

- Ask your professionals if you can contact them through e-mail.
- You can get a free e-mail account from websites like Google.com, Yahoo.com, etc.
- Make sure to check your email every other day if possible so you don't miss important messages.
- Some professionals will allow you to contact them through Facebook or Twitter, but make sure you ask if it's okay before contacting them.

¹PCLs E-Government Services: <http://pclsegov.blogspot.com/2009/06/free-cell-phones-safelink-wireless.html>

Helpful Tips on Internet Communication

- Keep your passwords private & store them somewhere safe in case you forget them.
- Make sure your social media & e-mail addresses are appropriate. If you wouldn't be okay with someone like your parents seeing the picture, it shouldn't be posted. E-mail addresses should be rated PG.

Mail

- A lot of professionals send out notices & forms only through the mail. If your address changes, you need to let all of your professionals know as soon as it happens.

For Professionals TTYL*: Keeping in Contact with a Young Adult (YA)

Keeping in Contact by Phone and Text

Many YA's change cell phone numbers and carriers due to bills, better service, etc.

- Ideally it is good to get an alternate number (family member, long-term friend, etc.)
- Young adults often rely on texting before calling. It is important to check your agency policy if texting is possible. Discuss with the YA in advance what is possible and preferable.
- Many YA's don't like to leave messages. Let them know if your voice mail is confidential and if they can call anytime day or night.
- YA's often rely on caller ID rather than a message so be sure to check your missed calls.
- If you use your personal cell phone be aware if your number will be displayed.
- Many youth have very limited minutes on their cell phone. Check if this is a concern when communicating.

Keeping in Contact by Internet

- YA's have access to the internet many places however, be aware that email is not always used on a regular basis.
- Check with YA's about how/when they use email and if it is a good way of communication.
- Most agencies do not allow professionals to be friends with YA's on Facebook/Twitter and other social media websites. Check your agency policy.
- Be aware of your own Facebook/Twitter and all social media privacy settings.
- Have a plan if a YA request social media contact in alignment with your agency policy.
- Be mindful that email can be a great way to communicate however HIPPA still applies and email is not fully secure.

When you cannot get in touch

- Call the emergency, friend, or back up number
- Try email
- Send a letter
- Depending on your relationship drop by the home if possible
- Be clear when you need contact by i.e., date, time of day, etc.
- Remember that YA's are learning how to communicate and manage appointments. Discuss ahead of time expectations on what the plan will be if an appointment or call is missed
- Be as flexible as your agency will allow and that will help YA's reach their goals

* text talk for "talk to you later"

Download at <http://labs.umassmed.edu/transitionsRTC/Resources/Publications.html>



The contents of this tip sheet were developed with funding from the US Department of Education, National Institute on Disability and Rehabilitation Research, and the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (NIDRR grant H133B090018). Additional funding provided by UMass Medical School's Commonwealth Medicine division. The content of this tip sheet does not necessarily reflect the views of the funding agencies and you should not assume endorsement by the Federal Government.





Applying for a Job: The Young Adult's Guide

Community of Practice, Northeast Massachusetts 2011

Things to Keep in Mind When Looking for a Job

- Type of work you would like: restaurant, childcare, store, outdoors, office, etc.
- Schedule: what days and number of hours can you work? Try to be as open as possible.
- Transportation: how can you travel to get to a job? Will you get paid enough to cover transportation?
- What you're good at: your skills and abilities.



How Do I Find A Job?

Online - Some examples of job search websites are monster.com, snagajob.com, and craigslist.com. To find a list of these sites, go to a search engine (ex: Google) and type in keywords such as "online job search sites" and you should find a list of popular sites. Also, check out company websites directly (e.g., Target.com, Homedepot.com). **Helpful Hints:** Sometimes job postings are listed under "Careers" or "Human Resources."

Visiting Businesses in Person - You can also visit a business in person to ask the hiring manager if they are accepting applications. Make sure you have your mock application with you in case you decide to fill out an application while you are there.

Do Wear

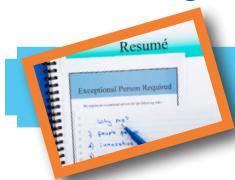
- Button up shirts
- Blouses
- Dress pants or khakis
- Shoes

Don't Wear:

- Short skirts, jeans or shorts
- Low cut shirts or anything too revealing
- Stained or wrinkled clothes
- Flip-flops

Career Centers/Clubhouses/Employment Supports - Job support programs will help you with all the steps involved in getting and applying for jobs. The Massachusetts Rehabilitation Commission is one vocational support in Massachusetts. Talk to your helpers (case managers, guidance counselors) for places to go.

Networking - Ask around! Family members, friends and neighbors may know of places that are hiring.



Filling Out Job Applications

There are a few ways to apply to a job and separate businesses ask you to apply in different ways. If you know where you want to apply, call or go online and find out how that specific place wants you to fill out an application.

****Make sure to have your mock application with you to fill out any job applications****

On Paper - Applications on paper tend to be the shortest, and you are usually allowed to take them home to fill out, and bring back when you're done. Take 2 copies of the application if possible, in case you make any mistakes.

Online - Some companies require filling out your application online. Here are some **Helpful hints:**

- * In order to fill out an application online, you will most likely need an e-mail address. You can get one free on websites such as yahoo, hotmail, etc. You will need to be able to check your e-mail by computer or cell phone. Make sure your e-mail address and voicemail message are PG and your cell phone has no background music.
- * Have all of your information ready before you start to fill in the application. Go through the application first to see what you need.
- * If you are filling out an application on a job search website (ex: monster.com), you may need to create an account. Make sure to keep your user name and password somewhere safe so you can go back and track your applications, and apply to other places later on.
- * Most online job applications give you the option to save the application and come back to it later.

In Store - A lot of businesses are using what are called "kiosks," which are computers that are located in the store that you must use to apply for the job. **Helpful Hint:** Bring someone along who can help you. Allow a good amount of time to fill kiosk applications out since they can be very long.

After Applying

Checking In: Don't get upset if you don't hear back from the place you applied to right away. Wait for about a week, and then call them and make sure they have your application, and ask if they have started interviews yet.

Top Ten Interview Tips That Will Get You Hired!

1. **Learn About The Job** - Show that you've done your homework, and looked at the company ahead of time.
2. **Flexibility** - Keep your availability as open as possible. However, keep school in mind, as well as doctor/therapist/psychiatrist appointments.
3. **Be Prepared** - Bring important documents with you (license, Social Security Card, resume), as well as a pen and paper in case you need to take notes.
4. **Positive Attitude** - Don't bring up negative experiences from your past jobs or volunteer positions. Be the kind of person you would want to work with, i.e., friendly, engaging, enthusiastic.
5. **Be on Time** - Give yourself extra time to get to your interview in case you get lost or have transportation issues, etc. Give yourself at least 20 minutes extra.
6. **Clean and Neat Appearance** - Wear appropriate business clothes, be clean and look neat (hair brushed and shaved). Follow the "Gap Rule" - you should have no skin showing because of gaps in the top and bottom! Find more tips and tricks on what to wear by visiting this website: <http://www.career.vt.edu/Interviewing/InterviewAppearance.html>.
7. **Ask Questions** - Prepare 3-5 questions to ask your employer. For example: "What would my day-to-day responsibilities be?"
8. **Follow Up** - Write the person who interviewed you a thank you letter, making sure to: 1) thank them for taking the time to interview you, 2) let them know you are still interested in the job, 3) Let them know you look forward to hearing from them, and supply your contact information again, i.e., e-mail and phone number.
9. **Practice Makes Perfect** - Practice mock interviews with family and friends so you aren't as nervous when the actual interview takes place. You can find examples of interview questions at <http://www.jobinterviewquestions.org>.
10. **Know Your Strengths and Weaknesses** - Why should they hire you, and what are you still working on?

Download at <http://labs.umassmed.edu/transitionsRTC/Resources/Publications.html>



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Introduction

The transition to adulthood is a continuous process of rapid developmental change that starts accelerating at age 16, and for most, is completed by age 30. It is an important and exciting time for all young people. During this period, most individuals take steps to live more independently and to depend less on family support. These steps, which involve completing school and training, launching work lives, and developing relationships with others, can greatly influence much of their future adult life. However, for youth and young adults with serious mental health conditions the changes during this stage of life are challenging and complex.

Serious mental health conditions (SMHC) are psychological in origin and result in significant functional impairment. SMHC include both serious mental illnesses and serious emotional disturbances.¹ SMHC do not include developmental disorders, substance use disorders, or mental disorders caused by medical conditions. It is estimated that 6-12% of transition-age youth and young adults struggle with a serious mental health condition (2.4-5 million individuals).²

During the transition to adulthood individuals are neither children nor mature adults; their development, functioning, and service needs are different from those who are older or younger. This brief will describe psychosocial development and family life cycle changes during the transition to adulthood in typical youth and youth with SMHC. We also describe additional challenges this population faces, and what can be done to support them and improve their outcomes.

Typical development

Psychosocial development occurs in five main areas:

- Cognition (thinking)
- Moral reasoning
- Social cognition
- Sexual orientation and gender identity
- Identity formation



Images in photographs contain professional models

Psychosocial development begins in infancy and reaches maturity in adulthood. Increased maturity in these areas underlies increased functional capacities. For example, increased abilities for abstract thinking are needed to have the ability to put oneself in another's "shoes", which is necessary for the development of empathy and embracing the golden rule, which is needed to have increasingly sophisticated relationships, or appropriate social interactions at work. Recent research also indicates that the expression of maturity in these areas is modified by peer presence and impulses, and that this influence diminishes with maturity.^{3,4} Table 1 summarizes the changes in each area of psychosocial development.

Unique aspects for those with serious mental health conditions (SMHC)

As a group, young people with SMHC are delayed in every area of psychosocial development that has been examined to date.¹ Table 1 highlights the typical features of each stage of psychosocial development in adolescence and young adulthood, and describes some of the additional challenges that young adults with SMHC often face. It is important to note that the descriptions below depict this population as a group. Individuals will vary in their level of maturation.

Table 1. Stages of Psychosocial Development in Adolescence and Young Adulthood

Stage of Development	Highlights of each stage	Consequences of developmental delay & potential additional challenges for those with SMHC
Cognitive Development	<p>Increased capacities for</p> <ul style="list-style-type: none">• Thinking abstractly• Thinking hypothetically (if X, then Y)• Having insight or self-awareness• Simultaneous consideration of multiple ideas• Future planning• Calibrating risks and rewards• Regulating undue peer influence on judgment	<ul style="list-style-type: none">• Delays can impede abilities to:<ul style="list-style-type: none">○ develop & execute plans○ weigh pros and cons of actions○ make changes based on self-awareness○ regulate peer influence on judgment• Additional challenges; High rates of co-occurring learning disabilities and developmental disorders, which challenge cognitive development & learning
Social Development	<ul style="list-style-type: none">• Friendships become more complex, involving mutuality, intimacy and loyalty• Increased perspective taking• Influence of peer relationships peak, then decline into adulthood• Social context shifts from lots of daily contact with many classmates to smaller social networks and work social settings	<ul style="list-style-type: none">• Delays can impede abilities to:<ul style="list-style-type: none">○ Participate in the increasingly complex peer relationships○ Put themselves in others' shoes○ Think hypothetically about social actions (i.e. plan and anticipate consequences)○ Negotiate the nuances of workplace social rules• Combination of social immaturity and symptoms can inhibit quality and quantity of relationships across settings (e.g. school, work, family)• Social repercussions can produce emotional pain
Moral Development	<ul style="list-style-type: none">• Increased ownership of own set of rights & wrongs• More able to understand "mitigating circumstances" of moral rules• More empathic responses/use of Golden Rule• Ability to see and act on rationale for sacrifice for the greater good	<ul style="list-style-type: none">• Delays in understanding and acting on the nuances of peers' social rules and society's moral standards may contribute to:<ul style="list-style-type: none">○ Compromised success in school or work○ Increased criminal behavior○ Reduced quality and quantity of friendships
Social-Sexual Development	<ul style="list-style-type: none">• Provides new forms of emotional intimacy• Skills to negotiate sexual relationships typically on par with social development• Sexual behavior can impact roles in peer groups• Sexual orientation and gender identity resolves	<ul style="list-style-type: none">• Delays can impede abilities to:<ul style="list-style-type: none">○ Have healthy sexual relationships○ Practice safe sex• Sexual abuse histories can additionally impede abilities to form healthy sexual relationships• Individuals who have alternative gender identities or sexual orientation are at greater risk of physical abuse, homelessness, and suicide
Identity Formation	<ul style="list-style-type: none">• Seeking answers the question...Who am I?• Is a prerequisite for feeling unique while feeling connected to others• Produces boundary pushing• Some experimentation needed to try out aspects of identity• Rejection of authority facilitates ownership of identity choices	<ul style="list-style-type: none">• Delays can contribute to:<ul style="list-style-type: none">○ Prolonged experimentation and rejection of authority beyond typical ages○ Difficulty making role choices; occupation, friend, spouse⁵○ Undue influence of others on self evaluation (not sufficiently distinct from others)⁶• Self-image is often poor^{7,8}

Typical Family Life Cycle Stages

The transition to adulthood also represents changing dynamics in family functioning. As adolescents begin to exert increased levels of independence and move into adult roles, the role of parents in decision-making and nurturing shifts, parental focus on child-rearing diminishes, and changes in family structure occur.⁹ These changes vary depending on family cultural background and other factors such as divorce or blended families. Many parents or parental figures of youth with SMHC face additional challenges and family relationships may be complicated by youth involvement in public systems. Overall, the issues that face many families of youth with SMHC can make this challenging stage of the family life cycle even more difficult. See Table 2 below for more details.

Why is it important to understand these developmental changes?

1. They help define why services for this age group need to be tailored to their developmental needs.
2. They help us design interventions that are developmentally appropriate.
3. They help differentiate between behavior at these ages that are “typical” aspects of healthy development and ones that are atypical.
4. They likely result in highly compromised educational attainment, under- and unemployment, limited friendships, increased homelessness, and higher rates of incarceration. (See next section)

What else is important to know about the transition period?

Individuals with SMHC face extra challenges to the typical bumps in the road most people face during the transition years. Because of developmental delay along with other contributing factors, successful movement into adult roles and adult role functioning for young people with SMHC is often compromised:

- High school dropout rate: 45% of special education students with SMHC¹⁰
- Post high school employment: Students with SMHC 42%, same age general population 66%¹¹
- Homelessness: 33% of adolescent discharged from residential treatment¹²
- Arrested during transition years: 69% of male, 46% of female intensive MH service users¹³

Effective developmentally appropriate & appealing services are rare.¹⁴ There are few established evidence based practices (EBP) for the full age range of the transition years. Some EBP's are only for adolescents, others are only for adults and have not demonstrated efficacy with young adults. Because of the developmental uniqueness of young adulthood, “adult” evidence based practices that have not tested whether they are effective specifically in this age group cannot be assumed so. There is also no research assessing the availability of EBP's or programs that follow systematically designed practice guidelines for this age

Table 2. Stages of the Family Life Cycle

Stage	Family Features	Changes	Potential additional challenges families of children with SMHC may face
Families with adolescents	Increasing flexibility of family boundaries for child's independence and grandparent frailties	<ul style="list-style-type: none">• Parent/child relationships shift to permit adolescents' dependence to wax and wane• Refocus on midlife marital and career issues• Shift toward caring for an older generation	<ul style="list-style-type: none">• Stresses of raising a child with a chronic health condition• Many youth involved with public systems have been in out-of-home care, which typically restricts parental roles during the time away, if not implicitly communicating parental incompetence• Higher family rates of:<ul style="list-style-type: none">○ Single parent household○ Poverty○ Mental health conditions○ Substance use○ Incarceration• Challenges can impede successful “launch” during transition years
Launching children & moving on	Accepting a multitude of exits from and entries into the family system (i.e. birth of grandchildren, passing of elders)	<ul style="list-style-type: none">• Renegotiation of marital system as dyad• Children and parents develop adult-to-adult relationships• Inclusion of in-laws and grandchildren• Loss of senior generation	

group (e.g. 15,16). However, findings about general age-tailored practices indicate that 25% of state child MH systems and 75% of state adult MH systems have no age-tailored services for this age group. The availability of these programs in states that have them are generally limited to a few geographic areas.¹⁷

For youth in transition, services and supports can end arbitrarily. Adolescents with SMHC are often in special education, child welfare, mental health, or juvenile justice systems. Children's systems can complicate the transition to adulthood by terminating eligibility for their services at a specific age designated as the end of childhood (typically age 18 or 21), while failing to adequately prepare adolescents for functional adult roles or ensuring accommodation in the adult service system.¹ The majority of adolescents with SMHC, however, do not receive any services for their mental health condition.¹⁸ Access to public adult mental health services is more restrictive than child services producing an arbitrary barrier to needed services when youth age out of children's services.¹⁹

TAKE HOME MESSAGE

The challenges:

- Young people with SMHC are in a unique stage of development during the transition to adulthood
- Their psychosocial development is often delayed
- Their successful entry into valued adult roles is often seriously compromised
- They need supports and interventions tailored to their unique developmental needs
- These types of services are rare and few evidence-based approaches have been established
- The bifurcated configuration of child and adult service systems pose arbitrary barriers

Remedies:

- More evidence-based practices need to be developed
- EBP's and other well-informed, developmentally appropriate approaches need to be widely available and accessible
- Policies need to ensure continuation of these supports from adolescence into adulthood until adult functioning is well established

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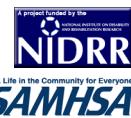


University of
Massachusetts
Medical School

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My “Must Have” Papers

Community of Practice, Northeast Massachusetts 2011

There are some papers that everybody must have. Here are some tips about keeping and protecting your important personal records and information.

Get a Binder or Folder to Keep Important Documents – an “accordion folder” works really well

What to Keep in Your Wallet or Purse

- State ID or Driver's License
- SNAP Card
- Health Insurance Card
- Important numbers
- Appointment Book / Calendar
- ATM Card (only if needed)
- Who to call in case of emergency
- List of medications & what doctor prescribes them.

What to keep in your Binder

- Education documents
- Medical information
- Housing / Utilities information
- Work information
- Financial information
- Learn more about these on the other side of this paper



Essential Documents to Have

These documents can help you get the other information you may need. You only need 2 of these to get a job and fill out the necessary paperwork.

Birth Certificate **Social Security Card** **State ID or Drivers License**

Passport: This document can replace all of the essential documents listed above

If you need to get your birth certificate: Go to the Town Clerk or City Hall in the town/city you were born in and request it. If you were born further away you can contact the Town Clerk/City Hall (via internet or phone) and ask how to get it. Most often there is a fee (up to about \$25). You may also ask a DCF/DMH/DYS worker if they either have a copy or can assist you.

If you need to get a License/ID/Permit: Go to the Registry of Motor Vehicles (RMV). You will need the required ID. Sometimes if you don't have enough forms of ID (such as a birth certificate and social security card) a letter from DMH or DCF may be helpful explaining your situation. MASS.gov/RMV has more info about this.

To get a social security card: You, or your representative payee, will need to present your ID to the Social Security office and request a new card. (there is a limit to the number of cards you can request in your lifetime so it is important you keep it safe). Don't keep your social security card in your wallet unless you are using it that day to apply for a job- store it somewhere safe. Try to memorize the number.

To get a passport: Go to your local post office or check with your state's Passport Agency for details.

If you keep information such as a social security number or bank information in your phone be sure to password protect it in case you get a new phone, or your phone is lost or stolen.

What to Keep in your Binder

Education Documents (these are important for school, college, vocational programs, etc.)

- A copy of transcript from all schools attended or GED Certificate
- Most recent IEP or 504 Plan
- Any other certifications (CPR/First Aide), Vocational, CNA, Etc.
- College information: Financial aid information (including passwords), & transcript
- Print copies of any email confirmations

Medical Information

- Copy of most recent physical & immunizations (important for school & jobs)
- List of doctors names & numbers (keep a copy in your binder & your wallet)
- List of medications, times, dosages, & who prescribes them (keep a copy in your binder & your wallet)

Work Information

- List of references – first & last names, their position, the company name, phone number, & dates worked
- Copy of letters of recommendations if you have them (don't give your last one away)
- Dates of places you have worked or volunteered & what your responsibilities were
- Work Permit – if you need it (you must get this through your school or city hall)

Housing / Utilities Information

- Phone billing contracts & the most recent 2 bills
- Copy of your Lease
- A copy of your current landlord's name, phone number and address
- Keep a list with your previous & current landlord's name, contact info, & the dates you lived there (a written reference from a landlord is even better)
- Most recent 2 gas, electric, cable bills & contracts
- Any housing list / subsidy information, copies of places you have applied

Financial Information

- A bank book or most recent statement
- Most recent Social Security award letter
- Keep all pay stubs
- Anything Social Security sends you
- All credit/debit card information
- Tax documents: Yearly W-2's, tax documents

You can also make folder on your computer or email and keep a lot of this information there – like important emails or confirmations.

What information You Should NOT Give Out

- Do not give out passwords (computer, PIN for Bank, Financial Aide, etc.)
- Keep passwords and logins in a safe place for your own personal use
- Social Security numbers (but sometimes it's OK, like on a job or housing application or for a bank application)
- Bank account information (unless for direct deposit of paychecks requested by employer)

Download at <http://labs.umassmed.edu/transitionsRTC/Resources/Publications.html>



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Teens on IEPs: Making My “Transition” Services Work for Me

Tools for School - Tip Sheet 4

TRANSITIONS RTC

October 2011

What is an Individualized Education Program (IEP) and “Transition” Services?

An IEP is an individual education plan written in public school for children ages 3 to 21 that by law, describes the special education services and goals for a student with an identified disability. Special ed services involve different techniques that help the student in a way that typical instruction cannot. Transition services are plans within the IEP that address your specific needs in relation to life after high school.



What Are My
School's
Responsibilities?

- Determine eligibility for special ed services (If you think you should be getting these services and aren't, ask for help)*
- To conduct an annual review of my IEP to identify my strengths, interests and needs (You can request meeting more often to review goals)
- Summarize my academic and functional levels
- Deliver accommodations decided by my IEP team
- At age 16, discuss with me my plans for after high school including “transition” services
- My attendance at IEP meetings on “transition” services or goals
- Identification of your interests and ideas for work or school after high school
- Measurable goals related to education, training, jobs and independent living
- Services or skills needed to reach goals
- Referrals or activities to link me up to adult services to meet my goals; i.e., vocational programs, supported employment or education and adult mental health services
- Depending on your state, a transition planning form specifically focused on transition services (Check your state laws for more information)

What Should
My IEP
“Transition”
Services
Include?

*For more information please visit: <http://ed.gov/parents/needs/speced/iepguide/index.html#process> & <http://fcsn.org/parentguide/pguide1.html>

If you would like information on “accommodations for college students” please see our Transitions RTC tip sheet: <http://labs.umassmed.edu/transitionsRTC/Resources/publications/Accomodationstipsheet2.pdf>

What Are My Rights on an IEP?

- To ask as many questions as I would like during the IEP meeting
- To personally consent to my IEP; some states require age 14, others 16; check with your school (younger teens need parent/guardian signatures on an IEP)
- When I or my parent sign off or consent to the IEP, services and goals stated will begin
- To request/refuse certain services on my IEP or request goals to be added/changed
- To ask for a team meeting if I want to make changes after the IEP is signed
- To reject any/all of my IEP (The school contacts the Bureau of Special Education Appeals)
- To withdraw from my IEP with documentation in two ways: 1) If I demonstrate during a reevaluation, that the services are no longer needed, or 2) My parent elects to take me out of the special ed program
- Being informed of my rights and responsibilities upon reaching age 18, such as viewing my records
- I must be invited to the IEP meeting starting at age 14; 16 by federal law (I have the right to attend my annual IEP meeting at any age, but some parents do not want their young children present)
- Special ed coordinator, teacher/s, parent/s or guardian, counselor, special ed advocate, friends, relatives, or community members (A Special Education Advocate is a representative that informs you of your educational rights and assists in negotiating and resolving disputes with the school district, also, there may be a cost involved in getting a Special Education Advocate) For information please visit: <http://www.ed-center.com/specialeducationadvocate>
- Other people or agencies that have special expertise or knowledge about me

Who Can Attend My IEP Meeting?

Sources

U.S. Department of Education: <http://ed.gov/parents/needs/speced/iepguide/index.html#process>
eHow family: http://www.ehow.com/way_5530520_can-withdraw-child-iep-program.html
UnderstandingSpecialEducation.com: <http://www.understandingspecialeducation.com/IEP-meeting.html>
LD.Org National Center for Learning Disabilities:
<http://www.nclld.org/college-aamp-work/post-high-school-options/transitioning-to-college/preparing-for-college>
Federation for Children With Special Needs: <http://fcsn.org/peer/ess/accomodationsfs.html>
Federation for Children With Special Needs: http://fcsn.org/pti/topics/iep/tools/iep_faq.pdf
Youth Empowerment Alliance: <http://www.md-council.org/publications/PDF/YEAMarch08.pdf>
National Dissemination Center for Children with Disabilities: <http://nichcy.org/schoolage/iep/team>
State of Washington Office of Superintendent of Public Instruction: <http://www.k12.wa.us/SpecialEd/Families/Teens/default.aspx>
Iowa Department of Education: http://www.iowa.gov/educate/index.php?option=com_content&view=article&id=1589&Itemid=2369



Visit Transitions RTC online at <http://labs.umassmed.edu/transitionsRTC>

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My Mental Health Rights on Campus

Tools for School - Tip Sheet 5

TRANSITIONS RTC

January 2012

Are you nervous about attending college if you have a mental health condition? If so, this information will give you the knowledge you need to address your rights, rules, and resources while at college.

Can my school discipline me for something I think happened because of my mental health condition? It depends...

- Not if the school is discriminating against you because you have a mental health condition resulting in a disability. You are entitled to request a hearing and/or appeal process in most schools if you think you are being discriminated against.

Disciplining you because of hospitalizations and related absences may be discrimination, and therefore, against the law. Get some legal help/advice if you want to appeal a disciplinary action.¹

- If your behavior violates a school's code of conduct, their disciplinary action may not be considered discriminatory as long as it is consistently applied to all students. Find out about the discipline policy and the disciplinary practice (such as "zero tolerance") in your school.

A school may be able to discipline you for disorderly conduct if it's in their rules, even if the behavior is caused by a mental health condition. Every school has different policies and the consequences of your actions may vary so find out the code of conduct at your school.*

- Having an education accommodation may help prevent behaviors that can get you in trouble. You can get an accommodation if you have a documented disability. See the tip sheet on accommodations at <http://labs.umassmed.edu/transitionsRTC/Resources/Publications.html>

Do not take on your school by yourself! You may need legal help to deal with these issues. You can get more information from the Bazelon Center for Mental Health Law: <http://www.bazelon.org/> and the National Disability Rights Network (NDRN): www.ndrn.org

Can my school require me to take a leave of absence? It depends...

- A school should not impose a leave of absence simply because you have a record of a mental health diagnosis. A leave should only be imposed after an individualized assessment has been made to determine that the school considers you to be at risk of harming yourself or others.
- The school should also provide you with the same withdrawal arrangements as if you were leaving due to physical health reasons. Check your schools' policies.
- If the school tries to make you leave involuntarily, due to your mental health condition, it should give you "due process protections." You can also file a complaint with the disability compliance officer and/or the civil rights office. See what your schools' policies are regarding appeals.

Due process protections include notifying the student of the action the school is considering and an explanation of why the school believes that such an action is necessary. The student and his or her representative should have an opportunity to respond and provide relevant information.

¹ Codes of conduct may also be called "Expectations of Students" or "Conduct Requirements."



Can I be forced to take medication?

- In most circumstances, you cannot be forced or ordered to take medication. However, schools may say that you need medication to comply with rules of conduct or to come back to campus. If you disagree, explain why and propose alternatives.

How do I get help for my mental health condition on my college campus?

- Most college counseling centers can provide free therapy visits. Check your school's website.
- If you are calling your college counseling center and it is an emergency, please let the receptionist know right away so that they can take appropriate action, which may include helping to get you an immediate appointment.
- If you are in crisis and need immediate help: call 911, go to the nearest hospital emergency room, or call the National Suicide Prevention Lifeline at 1-800-273-TALK - available 24 hours a day.
- Try ULifeline; this is an online college resource that provides information about mental health issues and professional resources on and around many campuses: www.ulifeline.org.
- See if there is a chapter of Active Minds in or near your school. Active Minds is a student-run organization dedicated to raising mental health awareness and decreasing stigma among college students: <http://www.activeminds.org/>.

What are my privacy rights in dealing with mental health professionals on or off campus?

- All mental health professionals are legally required to keep what you say during therapy sessions confidential unless you authorize the release of information. The only exception to this is if they are concerned for your safety or the safety of others.
- Most school counseling centers will not release your medical information without your written authorization. Ask your counseling center about their policy on confidentiality.

Adapted from: Your Mind. Your Rights. Campus Mental Health: Know Your Rights. A guide for students who want to seek help for mental illness or emotional distress.

<http://www.bazelon.org/Portals/0/pdf/YourMind-YourRights.pdf>

1. www.bazelon.org; <http://www.dlc-ma.org/contact.html>; <http://www.disabilitylawcenter.org/>



Visit Transitions RTC online at <http://labs.umassmed.edu/transitionsRTC>

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The Transition RTC is part of the Center for Mental Health Services Research, a Massachusetts Department of Mental Health Research Center of Excellence



Supported Employment Adapted for Young Adults with Peer Mentors: A Feasibility Study

Brief #4 Research in the Works

TRANSITIONS RTC

January, 2012

The mission of the Transitions RTC is to conduct cutting edge research and knowledge translation projects that support the transition of youth and young adults with serious mental health conditions (age 14-30) into rewarding lives as students and workers. One of these projects is the Thresholds-Dartmouth Research Center adaptation of Individual Placement and Support (IPS) for youth and young adults. The program and study is described below.

The Thresholds Young Adult Program

The Thresholds Young Adult Program (YAP) is a Transition to Independence (TIP) informed residential and transitional living program in Chicago for young people between the ages of 16 and 21. YAP provides residential, education, employment, case management and therapeutic services to young adults with serious mental health conditions, the majority of whom are wards of the state. In the past, YAP has used the evidence-based Individual Placement and Support (IPS) employment model to assist young adults with their vocational goals. IPS was developed for adult consumers with serious mental illness and emphasizes providing individualized, ongoing supports to consumers to obtain and maintain competitive employment.

Adaptation of IPS for Young Adults

The goal of this study is to specify and standardize modifications to IPS services to target the needs of this age group. Consistent with the version of IPS that was developed for mostly young adults experiencing their first episode of psychosis (IPS-FEP)¹, direct service staff provide support for consumers who are interested in either educational activities, employment, or both. This IPS-FEP model is augmented by use of Peer Mentors. Peer Mentors provide social support, encouragement, role-modeling and guidance to facilitate young adults' engagement in vocational activities that achieve their goals.

The Feasibility Study

This feasibility study includes manual development and a small trial to test: clinical issues, the clinical approach, research design, and appropriateness of the research measures. There are 35 participants.

For more information about IPS, IPS-FEP models and the current Peer Mentoring model at Thresholds, please contact Rochelle Frounfelker MPH, MSSW at rfrounfelker@tdart.org or visit:
<http://www.thresholds.org/explore-research/ongoing-studies>
<http://www.dartmouth.edu/~ips/>

For more information on the Transitions RTC please visit: <http://labs.umassmed.edu/transitionsRTC/index.htm>

¹Nuechterlein, K.H., et al., Individual placement and support for individuals with recent-onset schizophrenia: Integrated supported education and supported employment. *Psychiatric Rehabilitation Journal*, 2008. 31: p. 340-349.



Thresholds-Dartmouth
Research Center

The contents of this paper were developed with funding from the US Department of Education, National Institute on Disability and Rehabilitation Research, and the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (NIDRR grant H133B090018). Additional funding provided by UMass Medical School's Commonwealth Medicine division. The content of this paper does not necessarily reflect the views of the funding agencies and you should not assume endorsement by the Federal Government.



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Vocational Rehabilitation (VR): A Young Adult's Guide

The Word on Work - Tip Sheet 6

TRANSITIONS RTC

April 2012

Vocational Rehabilitation (VR) Agencies are located in every US state. VR helps people with physical or mental health disabilities achieve employment and live independently by offering vocational counseling and related individualized services. The information below explains how young adults with serious mental health conditions can take advantage of the VR services in their state.

What support services can I get from my state VR agency?



Transition Services: These are a variety of services students with disabilities use to make the adjustment from school to work after high school; VR can work with students and their special education teachers to develop an Individualized Education Transition Plan (IETP). VR will consider providing any service that is needed to achieve the agreed upon vocational goal.

Individualized Plan for Employment (IPE): This is the map for achieving your vocational goal, which when reached, will help you work and live as independently as possible. The IPE includes: work goals, steps and services to reach your goal, time frames, cost of services and who will pay, and your responsibilities for carrying out those plans.

Funding for Other Needed Services to Help You Work: The VR agency may be able to provide financial assistance for the services in your IPE such as training and post-secondary education, transportation, supplies, job search assistance, and assistive technology.

Vocational Counseling: VR can also help you decide what kinds of jobs or careers make the most sense for you. This could happen by talking it through with the counselor or taking tests to help you figure out how your interests and skills fit into different types of jobs.

Job Development: This includes job searching, skills training, resumé preparation, and placement into a desired position. Your VR counselor may refer you to job developers who work for the VR agency when you are ready to begin a job search.

Post-Employment Services: One or more short term VR services that help you to maintain, regain, or advance in employment.

Other services: To see information about more services offered by your state, contact your state Vocational Rehabilitation office or search for your state VR agency online. You can find a listing of state agencies at: Job Accommodations Network (JAN): <http://askjan.org/cgi-win/TypeQuery.exe?902>

What do I need to be eligible for VR?

Tips From People Who Found Jobs Through the VR Program:

Flexibility: Be flexible about what services you ask for.

Ask questions: Make a list of questions to ask whenever you meet with the counselor or other VR staff and find out about your options, both pros and cons, so you can make informed decisions.

Communicate with your VR Counselor: Ask for the best way to contact them: email, phone, texting, etc. Identify your needs and ask for help.

Advocate for yourself: Contact the office supervisor if you are having problems with your counselor.

Talk to your peers: See what their experience was like using VR services to get a job.

Be Organized: Make a calendar and mark appointments. Keep a folder for VR paperwork. Take notes during meetings.

- You need medical documentation of a physical or mental disability that causes significant barriers to working/employment.
- You need a determination that VR services are needed for you to get a job or keep working.
- Individuals who receive SSI or SSDI usually also qualify for VR services.
- The time frame to either deny or accept an application is usually 60 days. Certain groups of people with a disability may have priority to get services and there may also be a wait list for services.
- For more eligibility or application information, check out your state VR website or handbook.
- If you were determined not qualified, you can appeal the process using The Client Assistance Program (CAP). Please see additional information on the next page.

What is the VR process?

1. The VR counselor will outline available services during a group or individual meeting.
2. Once you are determined to be eligible, an initial interview will be scheduled with a VR counselor.
3. Your VR counselor and you will develop your Individualized Plan for Employment (IPE), which includes your chosen job goal and all the services needed to achieve that goal.
4. You meet periodically with your counselor to reach your goal.
5. VR services last until employment has been maintained for at least 90 days and you and your counselor agree that you are performing well on the job, **or** your case file is closed for lack of cooperation on your part or other reasons.



What are the Vocational Rehabilitation Counselors' responsibilities?

- Inform you of resources available to you and give you specific help in connecting with them
- Provide information on your rights and legal information, such as the appeals process, and the Client Assistance Program (CAP)
- Participate with you in the development of an IPE which you and your VR Counselor will sign. Give you a copy of the IPE and all subsequent amendments and reviews
- Assist in the coordination of IPE services and review your progress; at least annually
- Keep you fully informed throughout the VR process, including the opportunity to talk about why your case is being closed when that time comes

What can I do if VR services do not meet my needs?

Discuss your questions with your VR counselor.

Ask for whatever you think your needs are. As tax payers, the VR system belongs to all of us.

If dissatisfied, you can speak to the supervisor or request a change in counselors.

Contact your local Client Assistance Program (CAP), some decisions and problems can be appealed.

Get informed about your state VR agency. You can get help from advocacy organizations like the National Alliance for the Mentally Ill (NAMI).¹



Where Else Can I Get Help If Problems Occur With My VR Services?

The Client Assistance Program (CAP) is a program for persons with disabilities who are applicants or clients of Vocational Rehabilitation (VR) or Independent Living programs. CAP:

- Provides information about Vocational Rehabilitation Services
- Advises you on your rights and responsibilities and investigates your complaint
- Assists in resolving problems with your counselor during any part of the process
- Helps you write a formal request for appeal and move your concerns through the system²
- Represents you at administrative reviews, mediations and a formal appeals hearing

How do I find my state agency?

To find your state agency, a listing is available at Job Accommodations Network (JAN):
<http://askjan.org/cgi-win/TypeQuery.exe?902>

Sources:

Office of Special Education Rehabilitation Services:
<http://www2.ed.gov/about/offices/list/osers/rsa/index.html>

Division of Vocational Rehabilitation Youth and Transition Services:
http://www.maine.gov/rehab/dvr/youth_transition.shtml

Vocational Rehabilitation Services for High School Students with a Disability: <http://www.mass.gov/>

Vocational Rehabilitation Services: <http://dhs.sd.gov/drs/vocrehab/vr.aspx>

Consumer's Rights in the Rehabilitation Process: <http://www.ovrgov.net/consumer.aspx>

Individualized Plan for Employment (IPE):
http://www.ocfs.state.ny.us/main/cbvh/vocrehab_manual/06_IPE.htm

Department of Rehabilitation Services Client Assistant Program:
<http://www.dors.state.md.us/DORS/ProgramServices/cap/expect.htm>

Getting the Most from the Public Vocational Rehabilitation System:
http://www.communityinclusion.org/article.php?article_id=129

Massachusetts Consumer Handbook for Rehabilitation (VR) Services:
<http://www.mass.gov/eohhs/consumer/disability-services/vocational-rehab/consumer-handbook.html#3>

Vermont Policy and Procedure Manual: <http://vocrehab.vermont.gov/whoweare/policyprocedure>

California Department Of Rehabilitation Regulations: <http://www.dor.ca.gov/exec/proregul.htm>

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1. To find your local NAMI, please visit: http://www.nami.org/template.cfm?section=your_local_nami
2. Appeal processes in Vocational Rehabilitation programs differ by state; check with your local office. A good guide is available at www.dors.state.md.us/DORS/ProgramServices/cap/expect.htm