



University of Massachusetts Medical School Center for Mental Health Services Research

Annual Report

To the Massachusetts Department of Mental Health
2012-2013

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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. Highlights of Fiscal Year 2013 include an increase in research dollars awarded through new grants and contracts and launching our three-year Strategic Plan to guide our growth and trajectory over the coming years.

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. Our research 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. 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 and supports 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 Preventive and Behavioral Medicine, as well as with Commonwealth Medicine, other UMass campuses, and other national and international institutions to optimize our resources and relationships to build a bigger and stronger Center.

Research Portfolio

Fiscal Year 2013 was a healthy year for the Center.

- We received 5.8 million in new research funding
- We had 23 grant submissions
- We were awarded 14 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 \$6 to the Commonwealth to fund research, training, and service delivery.

CMHSR Strategic Plan

January 2013 marked the launch of the CMHSR Strategic Plan. Developed by the CMHSR faculty and staff, in consultation with UMMS Department of Psychiatry and DMH leadership, this three-year plan is a roadmap to realizing our vision of helping people living with mental health challenges lead happy and productive lives.

Strategic Goals

Goal 1: Increase national and international recognition of the CMHSR.

Goal 2: Increase long-term financial stability through diversifying our funding base and increasing revenue generating capacity.

Goal 3: Broaden and deepen collaborations within Psychiatry and with other departments at UMMS, DMH, Commonwealth Medicine, other UMass campuses, and state agencies.

Goal 4: Assure an organizational structure, resources, and facilities to meet demands going forward toward the other three goals in the strategic plan.

Our core areas of focus are very much aligned with the priorities of public mental health in general, and more specifically with the DMH. We recognize and are committed to the notion that for mental health services to be truly patient-centered and focused on recovery, more research is urgently needed about identifying patient-centered outcomes, measuring recovery, improving quality of care, workforce training, and the development of policies on this new model. We are excited to build on our strength of close partnerships with individuals with lived experience in an effort to understand what outcomes they identify as important, and to develop the best research strategies for exploring these issues. Another urgent priority for mental health care in general and certainly for DMH is the alarming issue of health disparities for people with serious mental illness. Our patients die on average 25 years earlier compared to the general population from illnesses including cardiovascular disease, diabetes and cancer. By partnering with specialists in preventative medicine and lifestyle change we can disseminate information about evidence-based interventions for modifiable risk factors and conduct studies of how best to adapt and implement these interventions for our population.

CMHSR faculty and staff are working collaboratively on each of the goal areas, with support and resources from a Strategic Planning Leadership Team. We have developed processes to monitor our progress, and have built-in feedback and support loops to help our work teams problem-solve as well as to ensure that we are maximizing the human capital of the CMHSR. We have developed action plans with targeted timelines, and continue to survey the context and environment of our work to see if and where modifications need to be made.

New Initiatives/Research Highlights

- Jessica Griffin and Melodie Wenz-Gross received a \$1.6 million SAMHSA grant to launch the Child Trauma Training Center (CTTC). Its goal is to improve the identification of trauma and to increase trauma sensitive care. The CTTC facilitates access to evidence-based trauma-focused treatments to front-line, child-serving professionals within pediatrics and primary care, public schools, law enforcement, and the court system, in Central and Western Massachusetts. The target population is youth ages 6-18 that have experienced trauma, including underserved populations and court-involved youth and youth in military families. The CTTC has established a Centralized Referral System with a network of mental health agencies and practitioners trained in evidence-based trauma treatments, with a toll-free number 1-855-LINK-KID. The CTTC also provides training in Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) to improve the quality of mental health treatment for children with trauma histories.

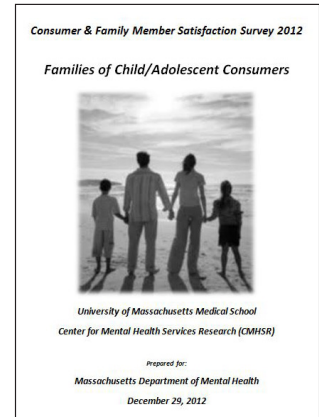


- CMHSR faculty, staff and Worcester Recovery Center and Hospital (WRCH) leadership continue to collaborate on the study of the transition of patients and staff from other DMH State Hospitals to the WRCH. This study examines the process of transition, the system-wide implementation of the recovery model, and outcomes for persons moving from existing hospital settings to the new WRCH. Phase II (6 month post-transition) data were collected in April-May of 2013 from 71 patients and 20 staff. CMHSR researchers developed 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. Preliminary findings from baseline and 6 month data were reviewed with the WRCH COO, Medical Director and WRCH Executive Committee. Resulting feedback regarding data collection instruments and processes were used to refine study procedures for future data collection. Phase III data collection is planned for FY14.
- Kate Biebel and Nancy Byatt continued their work on behavioral health integration for postpartum depression examining provider capacity to properly assess symptoms and access relevant services and supports.
- Rosalie Torres Stone completed work identifying unique and common perspectives of the general vocational needs of transition age youth and young adults ages 18 through 30. Findings suggest that supportive provider relationships, readily available workplace supports, effective educational supports and work experience, vocational guidance and preparation, and social skills training were all critical to obtaining competitive employment and were key features for program engagement.
- Carl Fulwiler and colleagues began work on their NCAAM-funded Mind Your Health study. Investigators will use fMRI to characterize individual differences in the brain changes associated with Mindfulness-Based Stress Reduction (MBSR) and their relationship to changes in depressive symptoms and health behaviors. Investigators will then conduct a pilot randomized controlled trial of MBSR to assess its impact on health behaviors related to maintenance of weight loss.
- Amanda Costa, Tania Duperoy, Kathryn Sabella, and Chuck Lidz are conducting a secondary analysis of a 2005-2006 survey of college students with a self-identified mental health condition. They are exploring the data in an attempt to describe the experiences and perspectives, including those of stigma, of young adult college students with mental health conditions and how they utilize campus supports and engage on campus as compared with older adults.
- Kate Biebel and Joanne Nicholson continue their work examining the use of research evidence during the implementation of the MA Children's Behavioral Health Initiative. Preliminary findings suggest barriers and strategies to facilitating the exchange and transfer of knowledge among stakeholders, and propose how this process is informed by research evidence.
- Doug Ziedonis, Mary Olson, Jon Delman, and Dan Fisher continue their study and U.S. adaptation of Open Dialogue, a treatment approach for individuals experiencing acute psychiatric crises that integrates the "dialogic process" and has led to shorter and fewer hospitalizations, less recidivism, and the use of less neuroleptic medication. They have developed content for a clinical practice training manual to guide clinicians, an organizational change manual to guide the system changes needed to support the clinicians, and corresponding fidelity tools to guide clinicians and program leaders. Year 2 of the project will focus on the expansion and refinement of manuals and fidelity measures. In addition,



Kate Biebel will lead a sub-study examining the experiences of providers trained in Open Dialogue, with an interest in understanding agency and systemic barriers and facilitators to implementation.

- The 2012 DMH Consumer and Family Member Satisfaction Survey had 1,174 adults, 269 family members, and 156 inpatient consumers completing surveys. This year marked several changes in the survey methodology, as adult and family member consumers were introduced to the option of completing the survey online via Survey Monkey. Additionally, we made use of optical mark recognition (OMR) software that allowed all completed paper surveys to be scanned into a computer database rather than entered (and double-entered) manually.



Consumer Voice Highlights

- The MHE & YOU Advisory Council, in collaboration with the Mental Health Agency Research Network (MHARN), successfully completed the 2013 May is Mental Health Awareness Month campaign. Thirty-one video statements were produced, focusing on the theme of wellness, and featuring individuals from the CMHSR, the UMMS Department of Psychiatry and local community mental health agencies and organizations (e.g. CHL, Genesis, NAMI, and Central Mass RLC). The 2013 video statements can be viewed here: http://www.umassmed.edu/multimedia_wellness.aspx.
- The 2012 Stigma Fighting Video Statements were shown at the UMMS Psychiatry Research Day (April 29, 2013), the UMMS Department of Psychiatry's monthly meeting (May 1, 2013), and at the 2012 NAMI MA convention. Video segments continue to be aired on WCCA-TV 13 and are available at WCCATV.COM. Al Grudzinskas and Jack Grillo were interviewed for the television segment "Soapbox."



- MHE & You continues its growing social media presence. Our Facebook group has 187 members and 42 "likes" on the page. Our Twitter feed has 30 followers, a 50% increase from last year.
- The Transitions Research and Training Center (RTC) Young Adults have been working on a new technical assistance project with Robert Walker, External Consumer Engagement

Liaison at the DMH Office of Recovery and Empowerment and TAY Peer Coordinator Alison Hunt. This project helps design and implement trainings for DMH Case Managers and other staff on how to work with young adults. The Transitions RTC Young Adults participated in numerous activities at the new WRCH, including the DMH Central-West Area Citizens' Legislative Breakfast and a Roundtable Discussion on Young Adult Roles in Youth-Serving Organizations. Amanda Costa and Gillian Simons, co-chairs of the Central MA Youth Council (CMYC), helped coordinate the CMYC 2nd annual resources fair "Recovery & Resiliency through the Arts." The Young Adults met with Sue Hannigan, Project Director of Stay Together, to share their personal experiences and knowledge gained from their research study on the support of young adult students with mental health conditions on college campuses.

- MHE & You Advisory Council member Jack Grillo and Transitions RTC's Amanda Costa presented at "The Spot" (a DMH program for Young Adults) in Roxbury along with individuals from the RTC Transitions.

Dissemination/Community Engagement Highlights

- CMHSR has been working with the DMH/WRCH Staff Development Training Specialist to schedule presentations for the WRCH Grand Rounds series. CMHSR coordinated a seminar for Community HealthLink clinicians given by Dr. Mary Ahn on “Young Adults in the Launching Phase: Developmental Considerations.” The seminar focused on developmental issues and treatment challenges that typically arise in emerging adults with comorbid mood and anxiety disorders. DSM V changes pertaining to diagnoses commonly present in childhood and emerge over adolescence to young adulthood were addressed.
- CMHSR faculty and staff educated and informed constituents regarding the dissemination work of our DMH Research Center of Excellence at numerous conferences/meetings in the Commonwealth including the Children’s Mental Health Research and Policy Conference, UMass Center for Clinical & Translational Science 2012 Community Engagement & Research Symposium, and the 2012 NAMI Massachusetts Convention. In total, 1,416 unique individual products from our Psychiatry Information in Brief catalogue were distributed.
- CMHSR and RTC websites received 24,172 visits from over 10,731 visitors. Product downloads from our websites and the *Psychiatry Information in Brief* e-journal totaled over 81,000.
- CMHSR, RTC and MHE &YOU social media sites continue to grow. Our Facebook pages reached 579 “likes”; Twitter pages currently have 268 followers while our listserv reached 1,752 members.
- Karen Albert coordinated with the UMMS Psychiatry Department to plan a best practices research recruitment and retention workshop that included presenters from CHMSR, other faculty from the Psychiatry Department, Community Healthlink, and the UMMS Conquering Diseases Program.
- Carl Fulwiler co-presented with Dr. Marie Hobart, Medical Director of CHL, at the annual UMass Clinical and Translational Science Community Engagement Symposium. The presentation, titled *Dissemination: Successes and Challenges in Working with Communities*, described the work of the MHARN in disseminating information about relevant research to a variety of audiences, and engaging community agencies to help translate research findings into practice. Drs. Fulwiler and Hobart detailed the CMHSR and CHL collaboration to obtain federal funding to integrate primary care and wellness services at CHL to improve the overall health status of its clients with serious mental illness.
- Carl Fulwiler, Len Doerfler and CMHSR research staff collaborated with ServiceNet leadership to examine the efficacy of Dialectical Behavior Therapy (DBT) in community-based service agencies. This research evaluates the efficacy of DBT in reducing rates of psychiatric hospitalization, suicide attempts, and non-suicidal self injurious behavior; explores clients’ implementation of DBT skills over the course of treatment; and evaluates the efficacy of DBT in the domains of trauma and depression symptoms, substance use, quality of life, and general well-being.
- Gina Vincent and Rosalie Torres-Stone worked with leaders at CHL and Assumption College on a study examining relapse and readmission among adolescents discharges from CHL’s Motivating Youth Recovery Program.
- CMHSR faculty collaborated with the Southeast Asian Coalition of Massachusetts on their grant submission examining emerging mental health challenges in Southeast Asian communities. Faculty worked with SEACMA leadership designing research to assess and evaluate the mental health needs of this underserved community.

Collaborations with DMH and Other State Agencies Highlights

- Jonathan Delman began work with DMH (Brooke Doyle) and community collaborators to develop outcome measures for Recovery Learning Communities.
- Carl Fulwiler organized and facilitated a professional training in Mindfulness-Based Cognitive Therapy for Depression. Therapists, psychologists, psychiatrists and psychiatric residents were trained to administer the evidence-based group-based treatment.
- Carl Fulwiler and David Smelson continue to work closely with Dr. Debra Pinals (DMH) 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. Results showing increased social connectedness and decreased PTSD symptoms highlight the effectiveness of a wraparound, trauma-informed jail diversion programs in reducing trauma-related symptoms in veterans.
- Nancy Byatt and Kate Biebel began work with the Massachusetts Behavioral Health Partnership to develop and implement a statewide postpartum depression program modeled on the Massachusetts Child Psychiatry Access Project (MCPAP). Obstetricians/gynecologists, family practice physicians, pediatricians, and primary care providers will have access to real-time consultation from a perinatal psychiatrist and resource information from a care coordinator to support the provision of care to this targeted population.
- Jonathan Delman and David Smelson were invited members of the MA Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS-TACS) Steering Committee along with leaders from the MA DPH, DMH, and Office of Medicaid, provider agencies and the Transformation Center. The Steering Committee proposes to build on the existing infrastructure of Peer Recovery Services and cross-stakeholder partnerships to identify, design and implement strategic policies, financing mechanisms, and/or infrastructure improvements to increase the number and quality of peer services. Care coordination across state agencies and community-based services and supports are emphasized to integrate peer services into existing and developing programs/systems.
- CMHSR faculty contributed to the recently awarded planning grant, Jail Diversion Across the Continuum: Opportunity for Reflection and Planning. This is a joint effort between DMH, DOC, DPH and DYS to develop a new collaborative to enhance jail diversion policies and planning for persons with co-occurring mental health and substance use disorders.
- CMHSR faculty and staff continued to serve on a number of DMH committees including the Central Office Research Review Committee, the Central Area Research Monitoring Committee, the Multicultural Advisory Committee, the Behavioral Health Integration Taskforce, the Youth Development Committee, the Statewide Planning Group on Parents with Mental Illness, the Advisory Committee to Child Behavioral Health Initiative, the Mental Health Planning Council, and the Task Force on Staff and Client Safety.
- Carl Fulwiler worked with Dr. Debra Pinals and representatives from the DPH Bureau of Substance Abuse, the Department of Corrections, and the Department of Youth Services on a recently-awarded grant to adapt the MISSION model to include integrated primary care services and serve both men and women.

- Tom Grisso presented at the Juvenile Detention Alternatives Initiative Conference with the Massachusetts Department of Youth Services on their progress in developing a failure to appear tool.
- Al Grudzinskas conducted trainings on “Recognizing Persons in Crisis,” “Stress Management for Correction Officers,” and “The Human Element of Corrections Work” in partnership with DPH for the Massachusetts Sheriff’s Association and the Middlesex County Sheriff’s Office. Al and Barry Feldman conducted similar trainings for the Suffolk County’s Sheriff’s Office in addition to a training needs assessment of the Massachusetts Correction Departments for the MA DPH.

Fiscal Year 2014 is off to a great start. We have a number of new grants funded and are exploring innovative opportunities to help us diversify our funding portfolio. We have begun the implementation of 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 2013.

Performance Measure	Accomplished in Fiscal Year 2012	Accomplished in Fiscal Year 2013
Number of research projects approved by DMH ¹	50	37
Number of research proposals submitted and approved by an IRB ²	7	7
Number of grants submitted ³	24	22
Number of grants approved ⁴	18	16

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 2013 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 2012	Accomplished in Fiscal Year 2013
External Funding Obtained	\$5,593,093	\$5,888,491

¹The number of ongoing CMHSR research projects during the 2013 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 2013 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 2013 fiscal year or are approved for funding in the upcoming 2014 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 2012	Accomplished in Fiscal Year 2013
Number of papers submitted and accepted for peer review publication	71	80

Summary of Other Dissemination Efforts

CMHSR continued to conduct trainings and give presentations at a wide variety of venues throughout Fiscal Year 2013. 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 2012	Accomplished in Fiscal Year 2013
Number and types of forums used by CMHSR to share information with DMH State and provider clinical workforce, consumers and family members	36	51
Number of state and provider workforce members and consumers and family members with whom research information was shared ⁵	3,625	4,240
Number of individuals with serious mental illness who were affected by the research conducted and/or received treatment	2,432	1,850

⁵This represents the number of individuals attending CMHSR faculty and staff presentations at conferences and trainings in Massachusetts during FY13. 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

A Career Development Manual for TAYYA

PI: Marsha Ellison, Ph.D.
Co-I: Maryann Davis, Ph.D.
Funding: National Institutes of Health
Budget: \$554,374
Time Frame: 10/1/2012 - 9/30/2017

Description: The UMDNJ Department of Psychiatric Rehabilitation and Counseling Professions and UMass Medical School (UMMS) Transitions Research and Training Center (RTC) will be developing an innovative career development intervention, Helping Youth on the Path to Employment (HYPE). HYPE will be delineated and refined into a manual and training program to integrate Supported Education with Supported Employment (SE) and other vocational services in order to adequately support transition age youth and young adults (TAYYA) with psychiatric conditions in achieving self-sufficient lives. Both organizations are uniquely positioned to develop this intervention and the accompanying manual to assist SE services in integrating employment and educational supports. Such an approach will anticipate common barriers and issues these individuals face including the development of adequate supports for all of their vocational goals. The new manualized HYPE intervention will address the specific needs of TAYYA by helping them to positively launch their careers and develop an early employment history. The integration of educational pursuits will be integral because it is relevant to this developmental period, in which it is common for young adults to pursue both employment and education simultaneously. It is also necessary to prepare them for the demands of the workforce requiring advanced vocational, technical and/or post-secondary education.

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

PI: Douglas Ziedonis, M.D., M.P.H.
Co-I: Jonathan Delman, J.D., Ph.D.
Co-PI: Mary Olson, Ph.D.
Funding: Foundation for Excellence in Mental Health Care. Inc.
Budget: \$100,000
Time Frame: 9/15/2012 - 9/14/2014

Description: This project will develop materials around the Finnish Open Dialogue treatment approach for individuals experiencing acute psychiatric crises. The project team will develop two fidelity tools, one for the psychotherapy component (clinical interactions with individuals and families) and another measure for assessing program/organizational implementation of the Open Dialogue model (key components and readiness). This project is important groundwork for future work re: manual/written material development, staff training, and preparing the model for adaptation and implementation in the U.S.

Designing a Failure to Appear Risk Tool

PI: Gina Vincent, Ph.D.
Funding: Massachusetts Department of Youth Services
Budget: \$18,000
Time Frame: 7/1/2012 - 6/30/2013

Description: This study was designed at the request of the Worcester County Juvenile Probation and the MA Department of Youth Services to help improve their decision-making procedures regarding holding

arraigned youth in detention while awaiting trial. The study seeks to identify factors that are related to the likelihood of “failure to appear” in juvenile court and likelihood of reoffending. The procedures involve obtaining de-identified, coded records of consecutive youths arraigned in multiple juvenile courts in Massachusetts and then tracking their court appearances and re-arrest data for a period of four months. The study will result in a screening tool that can be used by Massachusetts juvenile probation to help make decisions about which youth should be remanded to detention while awaiting trial because they are high risk for failure to appear back in court.

HUD VASH Program Exiters: A Mixed Method Analysis

Personnel: David Smelson, Psy.D.

Funding: Veterans Administration

Budget: \$250,000

Time Frame: 1/1/2013 - 1/1/2015

Description: Ending homelessness among Veterans has become a national priority supported by the White House and the United States Interagency Council on Homelessness. Using reliable evidence to improve the effectiveness of programs that seek to end Veteran homelessness is a priority for both the United States Departments of Veterans Affairs (VA) and Housing and Urban Development (HUD). Currently, there is no existing study that has observed veterans that exit Supportive Housing (SH) programs after receiving housing subsidies, but without successfully obtaining housing units. This outcome deserves further study, so that obstacles can be identified that prevent veterans from obtaining permanent housing. The goal of the current project is to study program exits from the HUD-VASH program, through a multi-site study. This non-randomized multisite, observational study will center on individual, structured interviews conducted with Veterans from the Philadelphia, Tampa, San Francisco, and Bedford VA Medical Centers. Further, a subsample of Veterans will be randomly selected to participate in a longer interview with supplemental open-ended questions. The total study population will consist of 533 Veterans from the four VAMCs (135 subjects recruited from Bedford) who have been admitted into the HUD-VASH program and have obtained a Housing Choice Voucher. Three different study groups will be included: 1. Non-Leased Exiters: have been discharged from the HUD-VASH program before obtaining a lease with their voucher; 2. Leased-Up Exiters: have been discharged from the program after obtaining a lease for an apartment with their voucher, but before using the HUD-VASH voucher for 600 days; and Stayers: have obtained a lease and have continued to use the HUD-VASH voucher for 600 days or longer. The results from this study have the potential to inform program practices by identifying: 1) barriers for veterans accessing housing, 2) frequent causes of veterans’ exit from the HUD-VASH program, 3) housing destinations of veterans who exit the program, 4) practices that lead to the long-term housing stabilization and well-being of participants, and 5) patterns of exit that could improve program efforts to prevent future exits.

Improving Outcomes for Homeless Veterans with Peer Support

PI: Marsha Ellison, Ph.D.

Co-I: David Smelson, Psy.D.

Funding: Veterans Administration

Budget: \$1,100,000

Time Frame: 12/1/2012 - 11/1/2016

Description: This project is a multi-site randomized controlled trial of delivering peer support to homeless veterans with co-occurring mental illness and substance abuse. Using a manualized peer support intervention available in the MISSION-Vet Consumer Workbook this project aims to improve housing retention and community functioning by reducing substance use and relapse among 200 veterans in Bedford, MA and Pittsburgh, PA.

Mind and Health: Developing a Neural Marker for Mindfulness, a Pathway to Health

PI: Carl Fulwiler, M.D., Ph.D.

Co-I's: Douglas Ziedonis, M.D., M.P.H., Allison, J., Jean King, Ph.D., Nanyin Zhang, Saki Santorelli

Funding: National Institutes of Health

Budget: \$740,250

Time Frame: 5/1/2013 - 2/29/2016

Description: This research will use fMRI to characterize individual differences in brain changes associated with Mindfulness-Based Stress Reduction (MBSR) and their relationship to changes in depressive symptoms and health behaviors. Investigators will also conduct a pilot randomized controlled trial of MBSR to assess its impact on health behaviors related to maintenance of weight loss.

National Youth Screening & Assessment Project

PI: Thomas Grisso, Ph.D.

Co-PI: Gina Vincent, Ph.D.

Funding: John D. & Catherine T. MacArthur Foundation

Budget: \$465,000

Time Frame: 7/1/2012 - 6/30/2014

Description: The National Youth Screening & Assessment Project (NYSAP) is a technical assistance and research center dedicated to helping juvenile justice programs identify youths' needs for behavioral health intervention and risk management. NYSAP provides technical assistance, training and consultation to juvenile justice systems and programs on mental health and substance use screening and assessment, assessment of risk of re-offending and youths' placement and program needs, and policy and practice regarding juveniles' competence to stand trial.

Remote Brief Intervention and Referral to Treatment for Alcohol Misuse (R-BIRT)

Co-I: Douglas Ziedonis, M.D., M.P.H.

Funding: National Institute on Alcohol Abuse and Alcoholism

Budget: \$239,219

Time Frame: 9/25/2012 - 2/28/2014

Description: The Remote Brief Intervention and Referral to Treatment service for alcohol (R-BIRT) will create a tele-health delivered model for alcohol brief intervention and referral to treatment.

Risk Assessment Guidelines for Juvenile Justice Project

PI: Gina Vincent, Ph.D.

Funding: Massachusetts Department of Youth Services

Budget: \$54,722

Time Frame: 7/1/2012 - 6/30/2013

Description: This project is designed to produce model Risk Assessment Guidelines for Juvenile Justice for the selection and implementation of risk/needs tools for delinquent re-offending at various points in the juvenile justice system. The investigators will organize a series of meetings with key national experts in risk assessment. Important components of this "model" will include: (a) the design of a protocol for the definition of an "evidence-based" risk/needs assessment tool; (b) the design of a brief protocol for state juvenile justice agencies operating at various decision points or points of contact to select a tool that will meet their needs; (c) the design of guidelines for implementation at different decision points; (d) dissemination and training for judges and attorneys; and (e) an agenda for future research. The final product from this effort will be a manual containing a set of Guidelines for use of Risk Assessments in Juvenile Justice. The Guidelines will include a step-by-step "how-to" guide for implementing risk assessment at each decision point.

The University of Massachusetts Child Trauma Training Center

PI: Jessica Ludy Griffin, Psy.D.

Co-I's: Lisa Fortuna, M.D., M.P.H., Melodie Wenz Gross, Ph.D., Thomas Grisso, Ph.D.

Funding: Substance Abuse and Mental Health Services Administration

Budget: \$1,597,310

Time Frame: 9/30/2012 - 9/29/2016

Description: The University of Massachusetts Medical School Child Trauma Training Center (UMMS CTTC) is working to improve the identification of trauma, increase trauma sensitive care and access to evidence-based trauma-focused treatments to front-line, child-serving professionals within pediatrics and primary care, public schools, law enforcement, and the court system, in Central and Western Massachusetts. The CTTC is working with youth ages 6-18 that have experienced trauma, including underserved populations in Worcester and Hampden counties, court-involved youth and youth in military families. The CTTC widely disseminates trauma-informed, trauma-sensitive trainings for professionals (e.g., pediatricians, courts, law enforcement, & schools) to assist in identification, screening, and/or assessment of trauma and trauma-related symptoms. The CTTC has established a Centralized Referral System that includes a network of mental health agencies and practitioners who have been trained in evidence-based trauma treatments, with a toll-free number 1-855-LINK-KID. Lastly, in order to improve the quality of mental health treatment that children experiencing trauma receive, the CTTC is providing training in Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT), with special applications of TF-CBT for court-involved youth and youth of military families.

Therapy House Calls

PI: Jessica Ludy Griffin, Psy.D.

Co-I's: Lisa Fortuna, M.D., M.P.H., Thomas Grisso, Ph.D., Heather Forkey, Melodie Wenz-Gross

Funding: Substance Abuse and Mental Health Services Administration

Budget: \$152,814

Time Frame: 9/30/2012 - 9/29/2015

Description: Therapy House Calls: Effective Treatment in the Home for Families Experiencing Trauma and Loss (House Calls) will improve access and quality of mental health care for children and families who are experiencing symptoms stemming from trauma or loss. The project will develop an application of Trauma Focused Cognitive Behavioral Therapy (TF-CBT) for use in the setting of In-Home Therapy, a model of community-based mental health treatment in which patients receive intensive psychotherapy in their own homes. In addition to improving access, this application will offer significant advantages for selected patients over the usual outpatient form of TF-CBT by addressing the impact of trauma on the entire family unit. The treatment will then be disseminated through trainings and on-going consultation.

UMass Juvenile Competence to Stand Trial Legislation

PI: Kimberly Larson, J.D., Ph.D.

Funding: Policy Research Associates

Budget: \$225,252

Time Frame: 1/1/2013 - 12/31/2014

Description: This project includes a guide for policymakers who are considering creating juvenile competence to stand trial legislation. The guide outlines the 16 most important points lawmakers must consider in the creation of such legislation. Statutory language examples are provided throughout the guide on each of the sixteen key issues. This guide provides a comprehensive look at juveniles' competence to stand trial. It will be of use not only to those considering drafting legislation in this area or currently creating juvenile competence to stand trial laws in their state, but also to judges who are addressing the issue of competence within their courts. Attorneys and mental health professionals can also use it to learn more about the application of competence to juveniles.

Understanding Predictors of Maternal and Child Health in Rural Western India

PI: Jeroan J Allison, Ph.D.
Co-I: Nancy Byatt, D.O., M.B.A.
Funding: University of Massachusetts Medical School
Budget: \$50,000
Time Frame: 1/1/2013 - 1/1/2015

Description: India bears the greatest burden worldwide of poor nutrition (52 million children), maternal and child health (68,000 deaths/year of mothers during pregnancy and 1.8 million/year deaths of children under the age of 5 years). Current efforts being made by the Indian government to improve health outcomes lack the support of evidence-based research. The underlying causes of poor maternal and child health and under-nutrition may be multi-factorial in nature. To date, the interplay of various factors in perinatal health and its longitudinal impact on maternal and child health has not been studied in India. A prospective longitudinal examination of factors associated with perinatal health can provide valuable insight into the burden of some of the risk factors for adverse outcomes in the Anand district of India. It can allow for the identification of areas of greatest need that, if addressed, can result in the greatest impact. Such an approach is necessary and crucial, especially in a high demand and low resource setting. The proposed research study seeks to investigate the impact of nutrition, mental health, and social factors on women and infants during the perinatal period. Results will have immediate impact locally by guiding the development of sustainable, specific interventions and informing policy change on a regional, state, and national stage in India and in other low-income countries. The study will build on the previous work conducted by India Research and Outreach Initiative and serve as a launch pad for the development of a comprehensive program of research addressing rural health in India through the collaborative effort of UMMS, Des Moines University, local Indian healthcare facilities, and Indian government departments. Furthermore, findings from this study and subsequent interventions will also have relevance for immigrant populations in Massachusetts and across the United States.

Waiver of Counsel in Juvenile Courts

PI: Kimberly Larson, J.D., Ph.D.
Co-I: Thomas Grisso, Ph.D.
Funding: National Institutes of Health
Budget: \$228,271
Time Frame: 1/1/2013 - 6/30/2015

Description: In collaboration with Georgetown University, UMass will be examining how youth and their parents understand juveniles' right to counsel, and how they make decisions regarding whether or not to waive that right.

Appendix B

CMHSR Dissemination Products



Psychiatry Information in Brief

Psychiatry Issue Brief

- Mindfulness-Based Cognitive Therapies for Behavioral Health Disorders
- Intermediaries Promote the Use of Research Evidence in Children's Behavioral Health Systems Change

Research in the Works

- Overcoming Barriers to Addressing Perinatal Depression: Perspectives of Women
- Treatment Retention Strategies in Transition Age Youth
- Preparing the Open Dialogue Approach for Implementation in the United States
- A Jail Diversion Program for Veterans with Co-occurring Disorders: MISSION – DIRECT VET
- The University of Massachusetts Medical School Child Trauma Training Center (UMMS-CTTC)

Transitions Research & Training Center

- Do I Tell My Boss?: Disclosing My Mental Health Condition at Work

Mindfulness-Based Cognitive Therapies for Behavioral Health Disorders

Jeremiah Slutsky, Jay Byron, Carl Fulwiler

Mindfulness is the act of moment to moment awareness of what is happening in the here and now. The practice of mindfulness is to bring awareness to one's present experience in a non-judgmental, non-reactive manner. Mindfulness practice has been in existence for over 2,500 years, however, it has gained increasing attention by Westerners since the 1970's.

This issue brief provides a brief history of Mindfulness-Based Stress Reduction (MBSR) followed by a focus on Mindfulness-Based Cognitive Therapy (MBCT). An overview and literature review of MBCT describes the emergence of MBCT as an intervention addressing depression. This issue brief concludes with recent findings that call for further MBCT research in the areas of anxiety and addiction relapse.

Mindfulness and Mindfulness-Based Stress Reduction

In 1979, Jon Kabat-Zinn at the University of Massachusetts Medical Center developed the Mindfulness-Based Stress Reduction (MBSR) Program to alleviate the suffering of patients with chronic conditions. The MBSR Program is an 8 week class focused on experiential learning of mindfulness practices and yoga, involving teacher-guided inquiry and psychoeducation. Over time participants develop their own personal practice of mindfulness. They learn new ways of relating to themselves and their experience through training to focus attention on kindness and compassion rather than judgment or avoidance. As evidence began to accumulate for the efficacy of MBSR, a number of related interventions were developed to address mental health problems such as depression, anxiety, and addiction.



Mindfulness-Based Cognitive Therapy

Mindfulness-Based Cognitive Therapy (MBCT) was created to prevent recurrence of depression in people recovered from previous depressive episodes (Segal, 2012). Major Depression (MD) is a common and serious health problem and the chances of a recurrence increase with each episode. In response to relatively small normal changes in mood, people who have suffered an episode of depression are much more likely to experience a return to negative thinking and sadness. MBCT integrates elements of Cognitive Therapy with the basic framework of MBSR. Cognitive Therapy focuses on psychoeducation about depression and mindfulness preventative depressive relapse skills. In MBCT these are substituted for MBSR's focus on stress reduction. With MBCT participants learn to become more aware of negative thoughts and sad feelings, and to adopt an attitude of curiosity, acceptance, and non-judgment. In contrast to traditional therapeutic approaches, the point of MBCT is neither to explain the origin of unpleasant thoughts or feelings, nor to replace them with different ones. Rather, MBCT helps patients

sustain an alert and flexible awareness, which over time diminishes the impact of negative thoughts and low moods.

Current Research: MBCT for Major Depression

Recent research has supported the efficacy of MBCT for reducing the chances of a further depressive episodes for patients with major depression. This research on MBCT is based on the 8-week class format in a series of randomized clinical trials with patients who had experienced 3 or more episodes of depression and are currently in remission. There have been six randomized controlled trials of MBCT in people with a history of depression that, in aggregate, demonstrate that it reduces the chances of another episode of depression by almost half (Williams & Kuyken, 2012). Two studies compared the efficacy of MBCT and gradual discontinuation of maintenance anti-depressants (ADs) vs. continuation of ADs alone (Segal, 2010; Kuyken et al., 2008). The data show no significant difference in the number of relapses between the two treatment options. The study by Kuyken et al. (2008) was notable for being conducted in primary care settings and for demonstrating that MBCT was superior for improving quality of life and comparable in cost. As a result of these studies MBCT is now considered an evidence-based practice for the prevention of depressive relapse (National Registry of Evidence-based Programs and Practices (NREPP), 2012). All of this current research suggests that for patients with 3 or more episodes of depression, MBCT is equal in efficacy to remaining on antidepressants indefinitely for preventing future episodes.

Research has also explored MBCT for the reduction of residual depressive symptoms in patients with MD. Studies have shown that MBCT added to treatment as usual was significantly better than treatment as usual for the reduction of residual depressive symptoms (Kingston et al., 2007; Barnhofer et al., 2009; Crane et al., 2008). One study also shows that MBCT and gradual discontinuation of maintenance ADs provides significantly greater reduction of symptoms than the continuation of ADs alone (Kuyken et al., 2008).

Further Research: MBCT for Anxiety and Addiction

MBCT has also been adapted as an intervention for other disorders but only a few studies have been published to

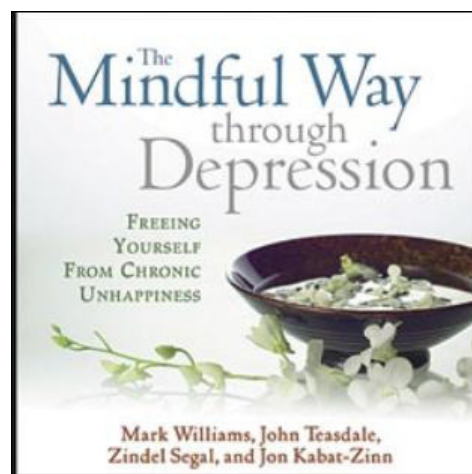
date and therefore the evidence is limited. For anxiety disorders, MBCT has been studied specific to Generalized Anxiety Disorder, Panic Disorder (Kim et. al., 2009), and Social Phobia (Piet, Hougaard, Hecksher, & Rosenberg, 2010). These studies have demonstrated significant improvement in anxiety symptoms with MBCT compared to control interventions such as psychoeducation groups or group-based cognitive therapy, but the sample sizes have been small and additional studies will be needed to confirm the results.

MBCT has also been adapted for the prevention of addiction relapse. Mindfulness-Based Relapse Prevention (MBRP) follows the same 8-week group-based format incorporating cognitive behavioral treatment for relapse prevention. Like MBCT, patients are introduced to body scans, sitting meditation, and yoga. Over the course of MBRP, patients are instructed to be mindfully aware of their cravings for drugs and alcohol, identify triggers, and prepare for the possibility of a relapse. A pilot study of MBRP found reductions in days of use and cravings at the end of treatment compared to controls who received treatment as usual (Bowen et al., 2009). Post-hoc analysis data from this study suggested that MBRP might be most helpful in the presence of depressive symptoms, which may predispose to relapse (Witkiewitz & Bowen, 2010).

For more information about MBCT for depression see

www.mbct.com

or the book *“The Mindful Way Through Depression: Freeing yourself from Chronic Unhappiness,”* that includes a CD with guided practices.



Intermediaries Promote the Use of Research Evidence in Children's Behavioral Health Systems Change

Kathleen Biebel, Susan Maciolek, Joanne Nicholson, Gifty Debordes-Jackson, & Laurel Leslie

The use of research to inform policy and practice has received enormous attention in behavioral health over the last decade. Federal agencies and service purchasers are increasingly demanding that interventions and the dollars that fund them be attached to a body of evidence demonstrating effectiveness with regard to desired outcomes. In this Issue Brief, we provide background on the use of research to inform policy and practice, describe the use of evidence in the context of Massachusetts-wide systems change in children's behavioral health services, and discuss the key role of intermediaries in facilitating knowledge exchange. Research or research evidence is defined as empirical findings derived from systematic analysis of information, guided by purposeful research questions and methods (Asen et al., 2011).

An intermediary facilitates knowledge exchange and brokers information among stakeholders, providing value-added contributions to decision-making.

Use of Research by Policymakers and Practitioners

There is a small but growing body of literature focused on how policymakers and practitioners interact with researchers around the use of research findings. Earlier, more traditional models of research use suggest a linear, uni-directional approach where a producer, often in an academic setting, conducts and delivers research to a user, usually a policymaker or practitioner (Lavis et al., 2003). More recent models highlight the complexities surrounding the use of research evidence including the bi-directionality of the exchange of research knowledge (Tseng, 2012). Appropriate linkages between research and the users of research are necessary to properly facilitate the use of research in policy and practice. Researchers themselves may not be the best translators of their own work and may lack the

communication and leadership skills required to bridge the research to policy and practice gap (Gold, 2009).

The Context: The Massachusetts Children's Behavioral Health System

Changes in the Massachusetts children's behavioral health system over the last decade presented a unique opportunity to examine how research is brought to bear when developing and implementing policy and program change. In 2006, Massachusetts was found in violation

of the Federal Early Periodic Screening Diagnosis and Treatment (EPSDT) provisions of the Medicaid Act (*Rosie D. v. Romney*). A remedy plan was developed to enable eligible children with behavioral health issues to receive appropriate treatment and care in their homes and local communities.

Key to the remedy was the incorporation of Wraparound, a family-driven, intensive care coordination process for children involved with public child- and family-serving systems (Burchard et al., 2002; Rossman, 2002). The body of research evidence for Wraparound is growing, with a significant literature base, evaluation data, fidelity measures, and implementation in numerous settings.

Investigators examined the use of research evidence (i.e., Wraparound in this case example) as state-level stakeholders prepared for and implemented court-mandated changes in children's behavioral health services in partnership with community agencies across the state. Investigators conducted a mixed methods study including an extensive review of public documents, an agency survey, and one-on-one and group interviews with key informants.

The Role of Intermediaries

Intermediaries were critical to translating both the Wraparound model and the Medicaid program context for both state and local stakeholders charged with designing and implementing the *Rosie D.* remedy. Two distinct types of intermediaries were identified, *external intermediaries* and *internal intermediaries*, who completed different types of work, under different conditions, at different stages in the remedy design and implementation.

The *external intermediary* was a policy expert who assisted policymakers in translating the remedy provisions into state Medicaid managed care program standards. This intermediary was based in a local consulting firm, was highly regarded nationally, and had deep experience designing and implementing Medicaid reforms in numerous states. The intermediary was skilled in facilitating the exchange of information among a small number of stakeholders representing plaintiffs and defendants working together intensively, over a concentrated period of time. This group produced complex documents (i.e., Medicaid program standards aligned across seven remedy components) that served as the foundation for the systems change initiative. As someone external to the state system, the intermediary brought knowledge and experience from other states' reforms as well as the skills to support the group in exchanging and using knowledge from a range of sources.

The *internal intermediaries* advised practitioners at community agencies using Wraparound in their work with children and families. These intermediaries were staff of the Medicaid Program's Managed Care Entities (MCEs), which hold and manage contracts with the community agencies. They provided real-time consultation at agency site visits and statewide meetings about how to adhere to Wraparound best practice within the Medicaid program. These intermediaries brought their internal knowledge of Massachusetts Medicaid and, over time, developed proficiency in Wraparound best practice. This work has been ongoing for over three years.

Using Intermediaries

The decision to engage an external intermediary or develop internal intermediary capacity should be informed by the nature of the work and the conditions

under which it must be accomplished. In this study, the work of intensive, time-limited policy-making and long-term system-wide practice change required different types of intermediaries.

- The *external intermediary* brought knowledge and skills not available within the stakeholder organizations. The one-time nature of the work and aggressive timeline made developing these assets internally impractical.
- *Internal intermediaries* were developed over time in order to build the organizational capacity needed to sustain the practice change. MCE-based intermediaries received training in Wraparound to complement their pre-existing expertise in Medicaid requirements.

Characteristics of Intermediaries

Stakeholders identified certain personal qualities and characteristics of intermediaries as important to building their relationships and facilitating the work.

- *Trust.* Trust was based on the intermediary's reputation, existing relationships or networks, and the reliability of the information they shared.
- *Neutrality and transparency.* The external intermediary was valued for the ability to remain impartial – not representing any one position (e.g., plaintiff or defendant). Although the internal intermediaries were not neutral regarding their MCE role, they were transparent about how they were translating the research evidence in the context of the Medicaid program.
- *Collegiality and enthusiasm.* Ease of working together, enthusiasm for the work and commitment to the collaborative knowledge exchange process facilitated evidence-informed decision-making. This was particularly important given time and resource parameters established in the remedy plan.

Preliminary findings from this study highlight the important role of intermediaries along with characteristics and strategies that may be related to the promotion of research evidence use in policy and practice decision-making. Further model development and testing will allow for more specific, evidence-based recommendations in the future.

Investigators: Joanne Nicholson, PhD (Dartmouth); Laurel K. Leslie, MD, MPH (Tufts); Susan Maciolek, MPP (Policy & Management Consultant); Kathleen Biebel, PhD (UMMS); & Gifty Debordes-Jackson, MA (UMMS)

Funder: The William T Grant Foundation **Time Period:** July 2010 to June 2013 **Contact:** Joanne.Nicholson@Dartmouth.edu

Overcoming Barriers to Addressing Perinatal Depression: Perspectives of Women



Major Depressive Disorder is the leading cause of disability among women of reproductive age.¹ Up to 18% suffer from depression during pregnancy, and as many as 19% of new mothers develop postpartum depression.² Perinatal depression, described as depression that occur either during pregnancy or within the first year after delivery,² has deleterious effects on infant attachment, behavior and development.^{3,4} Although 90% of women and OB/Gyns will participate in depression screening, it does not improve treatment entry or outcome.^{6,7} Despite the availability of effective evidence-based treatments⁸ and frequent contact with OB/Gyn providers, perinatal depression remains under-diagnosed and under-treated.^{5,9-11} Understanding the perceptions of women who have experienced perinatal depression may inform needed changes in screening, assessment, treatment, and prevention.

Research Goals

1. Identify barriers women with perinatal depression encounter in accessing and following through with depression treatment.
2. Elicit ways in which barriers to the treatment of perinatal depression can be overcome in obstetric settings to facilitate the participation of perinatal women in treatment.

Study Design

This study is a collaborative effort between University of Massachusetts Medical School researchers and the leadership of MotherWoman, a community-based organization in Amherst, Massachusetts that supports and empowers mothers and provides Postpartum Depression trainings for healthcare professionals.* Researchers are conducting four, two-hour focus groups with women who self-identify as having experienced depression and/or anxiety during pregnancy and/or the postpartum period. Participants are recruited from MotherWoman networks across Western Massachusetts.

Anticipated Contribution to Postpartum Treatment for Perinatal Women:

Findings from this study will:

- Contribute to the understanding of barriers that perinatal women experience when accessing depression care.
- Provide preliminary data for the development of strategies to improve the delivery of depression care in obstetric settings.

Research Team: Nancy Byatt, DO, MBA (Principal Investigator); Kathleen Biebel, PhD; Liz Friedman, MA.; Gifty Debordes-Jackson, MA.

Funder: UMMS Faculty Scholar Award; **Time Frame:** 2011 – 2012; **Contact:** Nancy.Byatt@umassmemorial.org

*For more information on MotherWoman, visit: <http://www.motherwoman.org/>



Treatment Retention Strategies in Transition Age Youth

The transition from adolescence to adulthood is a critical window for the development of the adult roles that society relies on: productive worker, nurturing parent, and law-abiding citizen. As they move into adulthood, Transition Age Youth (TAY; ages 17-25) with serious mental health conditions often have poor functioning and high rates of homelessness (30%), arrests (60%), school dropout (42%), and unemployment.¹ Among outpatient mental health clients, research shows that TAY are consistently the most likely to drop out of treatment¹ and complete the fewest number of sessions compared to other age groups.² These problems present a unique challenge for keeping TAY in mental health treatment long enough to improve their transition into adult roles.

Improving Treatment Retention for TAY

Currently there are no clinical trials underway or published treatment retention interventions for TAY. However, there are broad arrays of existing and developing psychotherapies available to the 760,000 TAY who use outpatient psychotherapy each year.³ The current research study tests Motivational Interviewing* (MI) as a treatment retention intervention in TAY to determine whether sufficient evidence can be found to justify a full scale clinical trial.

Study Methodology:

- **Study Population** – Study population includes TAY recommended for individual psychotherapy after clinical assessment who have no involvement or recommendation for other formal outpatient psychotherapies (e.g. group or family therapy). The study is being conducted at a community mental health center in Central Massachusetts.
- **Study Analysis** – The primary outcomes are recruitment and retention rates of TAY, as determined by assessing the moderating factors and instrumental goals of the intervention at baseline and at treatment termination or 4 months, whichever occurs first.

Treatment Retention Intervention	Moderating Factors	Instrumental Goals
<i>Motivational Interviewing</i>	<ul style="list-style-type: none"> • <i>Baseline Motivation to change</i> • <i>Abstract thinking skills</i> 	<ul style="list-style-type: none"> • <i>Increased motivation to change</i> • <i>Increased self-efficacy</i> • <i>Strong therapeutic alliance</i>

Anticipated Contribution to Mental Health Services for TAY:



Progress toward retaining TAY in mental health treatments by developing an age-appropriate treatment retention protocol



Developing a manual for training therapists in the Motivational Interviewing-based strategy for treatment retention in TAY and a supervision protocol to ensure treatment fidelity

*Motivational Interviewing is a widely used intervention to enhance motivation & reduce ambivalence about change, which has been shown to increase treatment adherence in older & younger age groups.

Research Team: Maryann Davis, PhD (Principal Investigator); Charles Lidz, PhD; Lisa Fortuna, MD, MPH; William Fisher, PhD; Lisa Mistler, MD; David Haddad, EdD; Cindy Christiansen, PhD; Ashli Sheidow, PhD. **Funder:** NIH # RC1MH088542-01; **Time Frame:** 2010–2011; **Contact:** Maryann.Davis@Umassmed.edu

Preparing the Open Dialogue Approach for Implementation in the United States

- 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.
- Effective recovery-oriented psychosocial treatments exist and continue to be developed, and there is a great need to disseminate and implement these approaches into clinical practice.
- 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. Drs. Jaakko Seikkula, Birgitta Alakare, and Jukka Aaltonen developed the approach at Keropudas Hospital / University of Jyväskylä in Tornio, Finland, and it is now being used in many places in Europe.
- 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 (Aaltonen, Seikkula, & Lehtinen, 2011; Seikkula, Aaltonen, Alakare, Haarakangas, & Lehtinen, 2006; Seikkula, Alakare & Aaltonen, 2011).
- As enthusiasm for the approach increases, there is a realization that there is a need for therapy / program implementation manuals and fidelity tools to help clinicians and leaders. There is a need for lessons learned in adapting to new cultures.

Present UMass Global Partnership Project

Drs. Douglas Ziedonis and Mary Olson are 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. Dr. Jaakko Seikkula and his team at the University of Jyväskylä in Finland are working closely with the UMass project leadership team which also includes Drs. Jon Delman, Daniel Fisher, Lisa Mistler, and others. 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.

Guiding Principles of the Open Dialogue Approach:

1. IMMEDIATE HELP
2. FAMILY / SOCIAL NETWORK PERSPECTIVE
3. FLEXIBILITY AND MOBILITY
4. RESPONSIBILITY
5. PSYCHOLOGICAL CONTINUITY
6. TOLERANCE OF UNCERTAINTY
7. DIALOGUE (& POLYPHONY)

The Open Dialogue approach is distinguished by the integration of two key elements, the therapeutic “**dialogic process**” of clinical practice and the **organizational change** adaptations of the treatment system.

The products created in this project are an important step for future research and program implementation. The project will create:

- Psychotherapy-focused manual & fidelity tool for clinical interactions with individuals and families
- System-focused manual & fidelity tool for assessing program/organizational implementation of the Open Dialogue model

Value of this work:

This project is a crucial step for clinicians, program leaders, and researchers in the United States and throughout the world to further investigate the Open Dialogue approach. These written materials will provide important groundwork for future endeavors in staff training and implementation activities needed to apply and further evaluate this recovery-oriented model in new settings.

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Project Team Leaders: Douglas Ziedonis, MD, MPH (Principal Investigator); Mary Olson, PhD (Co-Investigator)

Funder: Foundation for Excellence in Mental Health Care

Contact Person: Makenzie.Tonelli@umassmed.edu

A Jail Diversion Program for Veterans with Co-occurring Disorders: MISSION – DIRECT VET

An estimated 18.5% of Iraq and Afghanistan veterans have an active mental health condition¹ and over half have two or more mental health diagnoses.² Growing concern over criminal justice system involvement is stemming from evidence that approximately three of every four Vietnam veterans experience co-occurring disorders³ and that individuals with co-occurring mental illness/substance use disorders are disproportionately represented in jails and prisons.⁴

Addressing these concerns is MISSION DIRECT VET, (Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking Diversion & Recovery for Traumatized Veterans, “MDV”) a study funded by a grant from SAMHSA to the Massachusetts Department of Mental Health (DMH) being conducted by the UMass Medical School, UMass Boston, Veterans Administration, DMH, and other state agencies. This court-based diversion program serves Massachusetts veterans with trauma-related mental health and substance use problems. MDV seeks to:

- reduce criminal justice involvement
- treat mental health, substance abuse and other trauma related symptoms
- use a systematic wrap-around model
- provide care coordination, and peer support and trauma informed services
- develop interagency partnerships

STUDY GOALS

- Identify veteran criminal defendants with Axis I Disorders and/or trauma history and substance use disorders prior to sentencing
- Propose services and treatment options as alternatives to incarceration
- Coordinate services between treatment providers and the courts, attorneys, jails, probation officers, and houses of correction

INTERVENTION DESIGN

MDV is court-based, diverting veterans post-adjudication. Inclusion criteria are:

- >18 years old
- Veteran status
- Trauma history or other Axis I psychiatric disorder
- Substance abuse or dependence
- Criminal charge(s)

Once eligibility has been determined, MDV personnel conduct a clinical assessment and present a treatment plan to defense counsel, who may present the MDV option to the court in lieu of incarceration. Criminal justice personnel and public defenders receive training on the mental health needs of returning veterans and on the MDV program. MDV clinical teams, consisting of Case Managers and Peer Support Specialists, receive training in veteran-focused trauma-informed care.

MDV participants receive 12 months of:

- Critical Time Intervention case management (time intensive intervention promoting community services engagement and supports)
- Dual Recovery Therapy (counseling for co-occurring mental health and substance abuse disorders involving the teaching and reinforcement of self-management skills)
- Peer support role modeling of recovery behaviors reinforcing treatment engagement
- Manualized MISSION approach:
 1. Care coordination and wraparound model
 2. Integrated Dual Recovery Therapy, Critical Time Intervention, and Peer Support
 3. Treatment manual and consumer workbook^{5,6}
 4. Trauma-informed care

Additional wraparound services include referrals and linkages to services as needed.



Research Team: Paul P. Christopher, MD; William H. Fisher, PhD; Mary Ellen Foti, MD; Carl Fulwiler, MD, PhD; Albert J. Grudzinskas, Jr, JD; Stephanie Hartwell, PhD; David A. Smelson, PsyD; Debra A. Pinals, MD.; **Funder:** SAMHSA Grant #E635000000Z1628; **Time Frame:** 2008-2013; **Contact Person:** Carl.Fulwiler@umassmed.edu

The University of Massachusetts Medical School Child Trauma Training Center (UMMS-CTTC)

BACKGROUND: Research indicates that childhood trauma is a pervasive, global, healthcare crisis with a majority (68%) of children having experienced exposure to traumatic events.¹ Youth who have multiple exposures to violence or victimization are at higher risk for mental health problems, behavioral problems, substance abuse, and delinquent behaviors, often resulting in their involvement with the court system.^{2,3,4,5} The majority of children who experience traumatic events are seen first by their pediatricians, schools, or courts and law enforcement before being referred for trauma assessment/treatment. By training professionals in these groups, the University of Massachusetts Medical School Child Trauma Training Center (UMMS-CTTC) aims to identify and improve access for children who would benefit from evidence-based trauma-focused treatment, specifically, Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT).⁶

MISSION: The UMMS Child Trauma Training Center mission is to improve the identification of trauma and increase trauma-sensitive care and access to evidence-based trauma-focused treatment for at-risk and underserved populations in Central and Western Massachusetts, including court-involved youth and military families, ages 6 to 18 years.

Population Focus:	<ul style="list-style-type: none"> Children and adolescents ages 6-18 who have experienced trauma and reside in Central and Western Massachusetts (Worcester and Hampden counties)
Specific Trainings CTTC will provide:	<ul style="list-style-type: none"> Trauma-informed, trauma-sensitive training for professionals (pediatricians, court personnel, law enforcement, attorneys, schools) to assist in the identification, screening, and/or assessment of trauma and trauma-related symptoms Training in Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT), and adaptations to TF-CBT for court-involved youth and youth of military families Disaster response training Training on cultural competence and the treatment of trauma (e.g. trauma & Latino families) Training on family engagement strategies with youth and families who have experienced trauma
Goals:	<ul style="list-style-type: none"> Provide training in trauma-sensitive care to 1800 professionals Create a centralized referral system inclusive of a network of mental health agencies and practitioners trained in evidence-based trauma treatments, toll-free number 1-855-LINK-KID Provide training in TF-CBT to increase number of clinicians trained in an evidence-based trauma treatment Provide trauma-focused treatment to 900 youth and their families in 60 cities and towns in Central MA and 23 cities and towns in Western MA

RESEARCH TEAM: Jessica L. Griffin, PsyD (**Principal Investigator**); Melodie Wenz-Gross, PhD (**Co-PI**); Toni Irsfeld (**Project Director**); Heather Forkey, MD (**Co-I**); Thomas Grisso, PhD (**Co-I**); Laurel Post (**Centralized Referral Coordinator**) **FUNDER:** SAMHSA Grant# S6111000021849; **TIME FRAME:** 2012-2016; **CONTACT PERSON:** Jessica.griffin@umassmed.edu

The Child Trauma Training Center, a program within the Department of Psychiatry, UMass Medical School/UMass Memorial Health Care, and the Center for Mental Health Services Research, is funded by a 4-year Substance Abuse Mental Health Services Administration (SAMHSA), National Child Traumatic Stress Network (NCTSN) Category III grant.

For more information: <http://www.umassmed.edu/CTTC.aspx>



Do I Tell My Boss?: Disclosing My Mental Health Condition at Work

The Word on Work, Tip Sheet 7

TRANSITIONS RTC

2012

What Should I Say About My Mental Health Condition at Work?

Every young adult with a mental health condition will face the decision of whether or not to tell others about, or “disclose” their condition at work. Typically the reason for disclosure is to ask for an accommodation in order to perform better at your present job. An accommodation is modifying a job, the job site, or the way things are done in order to enable a qualified individual with a disability to have an equal opportunity for employment.¹ The following information can provide some guidance in helping you make an informed decision.



Some Reasons to Disclose Having a Mental Health Condition on the Job:	Some Reasons Not to Disclose Having a Mental Health Condition on the Job:
<ul style="list-style-type: none"> • To obtain protection under the Americans with Disabilities Act (ADA)¹ • Required in order to request job accommodations² • To serve as a role model and educate others • Reduces stigma • Relieves the stress some may feel about “hiding” a disability • Makes employers better able to respond to sudden symptoms or hospitalizations • Disclosure to a supervisor is kept confidential by law 	<ul style="list-style-type: none"> • There is no need for accommodations • Hiring or promotion chances may be negatively affected due to stigma • To protect your privacy • Fear of: <ul style="list-style-type: none"> - Negative employer or coworker reactions to you or your work - People not respecting your privacy and confidentiality (others in community/ workplace will be told) - Being held to a different standard, i.e., less will be expected of you

If I Want to Disclose, How Should I Do It?

- Let your employer know you have a medical disability. Steer clear of medical terms and a specific diagnosis. Instead provide examples of how your disability affects you i.e., “I have a medical condition that affects my concentration.”
- You will need to provide information about the existence and extent of your disability or diagnosis, how your condition may limit your functioning in the job, and the accommodations that address these barriers. YOU DO NOT need to disclose your entire medical record, progress notes or tests, etc.
- Focus on your abilities, not disabilities.
- Prepare and practice what you will say ahead of time.
- List your strengths and qualifications related to this job. You can also give examples of how your experiences with a disability will positively affect your work performance.
- Share what issues you may face in the workplace due to your diagnosis and try to word it in a positive way. For example, “My disability requires me to take frequent breaks in order for me to stay productive.”

- You should engage in an “informal interactive process” with your employer and provide a specific list or a written statement that summarizes the disability and accommodations that would help you at this job.²
- Inform your employer of an action plan that works best for your safety if you become unwell at work.
- Some employers may have policies and processes in place for disclosure, which may be helpful to look over and potentially use.

If I Want to Disclose, When Should I Do It?

There is no exact point in time that is best to disclose, however, each has its advantages and disadvantages. You have the right to disclose at any time during your employment. You also have the right not to disclose. The Americans with Disabilities Act(ADA)¹ states that employers cannot ask questions that will likely reveal the existence of a disability before making a job offer.

SOME TIMES YOU CAN DISCLOSE	PROS OF DISCLOSURE AT THAT POINT IN TIME	CONS OF DISCLOSURE AT THAT POINT IN TIME
In a cover letter/ resume/ job application	Shows honesty, gives the opportunity to prepare a written statement including your abilities	Employer may have pre-conceived opinions on disabilities and may not offer you an interview
Before an Interview	You can discuss the accommodations that you may need during an interview ²	May affect the interview process and how you are viewed due to stigma
During the interview	Opportunity to discuss strengths and how disability will positively affect employment Can interact with people and flexibly respond to questions/concerns	May affect the interview process and how you are viewed due to stigma
Once hired	Avoids possibility of discrimination during the hiring process. Secure accommodations and coverage under the ADA ¹	May affect how your job duties and assignments are handled due to stigma
During Employment	You may find that you will need accommodations once you’ve been at the job for a while You may want to wait until you form a relationship with your boss, prove your abilities and feel confident with your job. Disclosing enables you to have a conversation with your boss. Hopefully you are perceived as a valued worker and they will be motivated to make adjustments in order to keep you.	May affect co-workers responses to you May affect how your performance is evaluated by the employer May affect promotional opportunities
After Performance Difficulties Arise	If you become sick or hospitalized you may need to request time off, so you will need to inform your workplace.	Your employer may feel betrayed, wonder why you waited so long, and look at it as an excuse for bad performance.

Footnotes

1. Americans with Disabilities Act of 1990, Pub. L. No. 101-336, § 2, 104 Stat. 328 (1991); ADA Amendments Act of 2008, PUB. L. No. 110-325 (2008) found at: <http://www.eeoc.gov/laws/statutes/adaaa.cfm>

2. Job Accommodation Network Accommodation and Compliance Series: <http://askjan.org/media/downloads/accommodationrequestletter.pdf>

What Employers Can & Cannot Ask During a Job Interview About Your Mental Health Condition:

In the table below, we have posed some questions that are allowed and not allowed during a job interview, including ways to answer appropriately and in a professional manner.

EMPLOYERS CANNOT ASK	EMPLOYERS CAN ASK	SUGGESTED EXAMPLES OF ANSWERS
Do you have any physical or mental impairment that would keep you from performing the job you seek? What physical or mental impairments do you have that would affect your job performance?	Are you able to perform the essential function of the job you are seeking, with or without accommodations?	If you are able to perform the essential functions with accommodations, you can simply answer “Yes”. You are not required to give details about what specific accommodations you would need or why you may need them until after you are hired.
How many days were you sick during your last job?	Can you meet our attendance requirements? How many days were you absent from your last job?	Indicate that you are able to meet the attendance requirements of the job. If you are disclosing, you can speak about accommodations that may be needed for hospital or therapy visits.
What medications are you currently taking?	Are you currently using illegal drugs?	Reply no illegal drug use and that your medications are private information.
Questions to a third party (service providers/friends/state agency) that they could not directly ask the applicant.	Questions to a third party (service providers/friends/state agency) that they are legally allowed to ask the applicant directly.	Tell them you can supply medical information if you are disclosing; if not, that is private information.
The employer is prohibited from asking disability-related questions or requiring a medical examination before making the individual an offer.	After the employer extends an offer for the position, he may ask the individual disability-related questions or require a medical examination as long as he does so for all entering employees in the same job category	A question about your disability that is asked before a job offer is illegal and you can reply that it is private information and you are not comfortable answering that question.

References:

The U.S. Equal Employment Opportunity Commission: <http://www.eeoc.gov/policy/docs/preemp.html>

National Collaborative on Workforce and Disability for Youth. *The 411 on Disability Disclosure: A Workbook for Youth with Disabilities:* <http://www.ncwd-youth.info/411-on-disability-disclosure>

National Collaborative on Workforce and Disability for Youth. *Cyber Disclosure For Youth with Disabilities:* <http://www.ncwd-youth.info/cyber-disclosure>

Ellison, M.L., Russinova, Z., MacDonald-Wilson, K.L., & Lyass, A. (2003). Patterns and correlates of workplace disclosure among professionals and managers with psychiatric conditions. *Journal of Vocational Rehabilitation*, 18(1), 3-13.

MacDonald-Wilson, K.L., Russinova, Z., Rogers, E.S., Lin, C.H., Ferguson, T., Dong, S., & MacDonald, M. K. (2011). Disclosure of mental health disabilities in the workplace. In I. Z. Schulz & E. S. Rogers (Eds.) *Work accommodation and retention in mental health*. New York, NY: Springer Publishing.

Luecking, R. G. (2009). *The way to work: How to facilitate work experiences for youth in transition*. Brookes Publishing Company.

To Whom Do I Disclose?

You are only required to share disability information with the person/s in the workplace who is involved with approving or providing accommodations. You can choose whether or not to tell other people at the workplace. An employment specialist or counselor may be able to help you determine who that might be. Some examples of types of disclosure include:

- **Full Disclosure:** Being open with everyone at work (bosses and coworkers) about your mental health condition, including details and your diagnosis. Note: not all coworkers will understand, and some may resent accommodations.
- **Targeted Disclosure:** Telling specific people such as:
 - Your immediate boss /supervisor if they will be the one providing accommodations and support.
 - A higher level manager such as your immediate supervisor/boss's manager.
 - The human resources manager who can help you with legal rights, health insurance, medical leave, etc.
 - A job coach or transition youth advocate who may represent you if you are uncomfortable/unable to disclose yourself.
 - Your co-workers who may be able to provide informal supports. Note: The ADA requires your employer to keep all information about your disability confidential. Keep in mind when disclosing disability-related information to co-workers, that they are not held to the same standard.
- **Inadvertent Disclosure:** Others find out about your condition without you telling anybody.

Think About “Cyber Disclosure” When Using Social Media Sites!

With sites like Facebook and Twitter becoming increasingly popular, you may find yourself sharing a lot of information about yourself, and disclosing your mental health condition online without realizing it. Here are some tips to avoid inadvertent cyber disclosure:

- Know what information about you is available for all to see online. Do a check by entering your name every few months into search engines (Google) to see what information comes up.
- Check the privacy settings on any site you may be a part of i.e., Facebook. You can make your profile private so only the friends you choose can see your page, photos, and specific information. Double check that you have made each part of your profile private.
- Realize that others, including employers, may see information you post that could relate to you having a mental health condition i.e., awards you received from mental health organizations or memberships in self advocacy groups, etc.
- During employment, review your rights and privacy laws when it comes to using work computers. You should assume that any work equipment is the employer's, not yours, and you have no privacy on that equipment. For example, some organizations have public e-mail that can be looked at by request of your employer.

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