

Annual Report

To the Massachusetts Department of Mental Health

2013-2014



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/sparc/about-our-center/annual-report/

Our Mission: In collaboration with DMH and its academic and community partners, the Systems and Psychosocial Advances Research Center (SPARC), formerly the Center for Mental Health Services Research, provides state-of-the-art and recovery-informed research, training, and systemic interventions to enhance the mental and behavioral health of all citizens in Massachusetts and beyond, and to guide leaders in the development of enlightened public health policies that support the treatment and prevention of mental illness and addiction across the life span. The work of SPARC 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



The Systems & Psychosocial Advances Research Center, UMass Department of Psychiatry
A Massachusetts Department of Mental Health Research Center of Excellence



Executive Summary

We are grateful to the Massachusetts Department of Mental Health for its continued support of the University of Massachusetts Medical School's (UMMS) DMH Research Center of Excellence, the Systems and Psychosocial Advances Research Center (SPARC) (formerly the Center for Mental Health Services Research [CMHSR]). We continue to leverage the DMH investment to support innovative, recovery-oriented, state-of-the-art psychosocial and systems research. Highlights of Fiscal Year 2014 include an increase in research dollars awarded through new grants and contracts, and continuation of our three-year Strategic Plan to guide our growth and trajectory over the coming years.

SPARC Overview

The Systems and Psychosocial Advances Research Center 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. SPARC 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. DMH and SPARC 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.

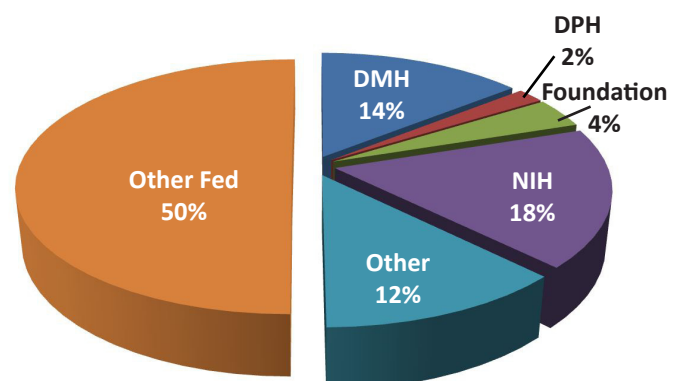
Research Portfolio

Fiscal Year 2014 was a healthy year for the Center.

- The SPARC received \$2,669,431 in new research funding (see Appendix A)
- The SPARC submitted 20 grant applications
- The SPARC was awarded 15 new research grants and contracts
- The SPARC published 35 research articles, briefs, and manuals

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, technical assistance, and service delivery.

SPARC Funding Sources FY 14



SPARC Strategic Plan

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

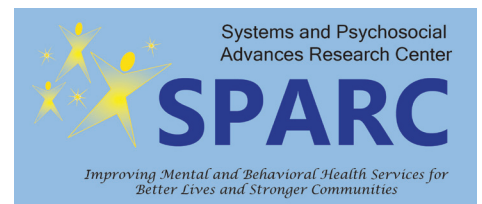
SPARC Strategic Plan Goals

- Goal 1:** Increase national and international recognition of the SPARC.
- Goal 2:** Increase long-term financial stability through diversifying our funding base.
- Goal 3:** Broaden and deepen collaborations with key stakeholders including DMH and other public agencies, within Psychiatry and with other departments at UMMS, Commonwealth Medicine, and other UMass campuses.
- Goal 4:** Assure an organizational structure, resources, and facilities to meet demands going forward toward the other three goals in the strategic plan.

SPARC faculty and staff are working collaboratively on each of the goal areas, with support and resources from a Strategic Planning Leadership Team. We 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 within SPARC. We 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. Highlights from efforts during Fiscal Year 2014 for each of the strategic goals include:

Goal 1: Activities within goal one include creating a positive recognizable identity (e.g., branding, logo, collateral), and increasing awareness of knowledge translation products through technical assistance, training and dissemination activities. Center faculty and staff developed and implemented a new:

- **Name** – The Systems and Psychosocial Advances Research Center (SPARC)
- **Mission Statement** - In collaboration with DMH and its academic and community partners, the SPARC provides state-of-the-art and recovery-informed research, training, and systemic interventions to enhance the mental and behavioral health of all citizens in Massachusetts and beyond, and to guide leaders in the development of enlightened public health policies that support the treatment and prevention of mental illness and addiction across the life span. We strive for the broadest possible dissemination of our research with the goal of informing all stakeholders as to the state of the science.
- **Tagline** – Improving Mental & Behavioral Health Services for Better Lives & Stronger Communities; and,
- **Visual Identity** to better reflect the activities and scope of work conducted within the Systems and Psychosocial Advances Research Center.



Goal 2: Key activities within this goal area include increasing long-term financial stability through diversifying our funding base and increasing our revenue generating capacity through two major initiatives:

- The SPARC Grant Support Team was developed to provide a more formalized and consistent approach

to obtaining timely information about grant announcements and opportunities and assist with grant preparation.

- A SPARC Business Plan was developed to address growth in the areas of training, technical assistance & evaluation.

The SPARC Grant Support Team has created systems and dedicated resources to: 1) identify funding mechanisms that are of interest to SPARC faculty (and the wider UMMS community) and 2) assist with grant preparation including literature reviews, reading and editing draft proposals and providing feedback to the Investigators. To date the team has met with all SPARC faculty members and attended Department of Psychiatry interest group meetings to become more familiar with faculty expertise and interests, as well as to identify potential community partners for grant submissions. The Grant Support Team has changed the way SPARC faculty and staff approach grant development and submissions. The SPARC faculty considers the Grant Support Team to be extremely useful.

One example of the team's efforts was the submission of the SAMHSA "Now Is the Time" Healthy Transitions (HT): Improving Life Trajectories for Youth and Young Adults with, or at Risk for, Serious Mental Health Conditions grant in collaboration with DMH leadership. Kate Biebel and Karen Albert of the SPARC Grant Support Team, Maryann Davis and Amanda Costa from SPARC/Transitions RTC and Alexis Henry of CHPR/SPARC worked with the Northeast-Suburban Area DMH team led by Susan Wing (PI) to develop and submit this 5 Million dollar/5 year grant to provide enhanced and new services and infrastructure development for transition aged youth and young adults in Lawrence, Haverhill, and surrounding communities. The SPARC team contributed significantly to the development and writing of the proposal, which was submitted in June 2014, and awarded in September 2014.

Goal 3: Involves initiating, strengthening and sustaining collaborations within Psychiatry and with other Departments at UMMS, DMH, Commonwealth Medicine, other UMass campuses, and Massachusetts state agencies; and aligning the SPARC strategic plan with the mission and vision of DMH. SPARC has broadened and deepened its collaborations throughout the Commonwealth during Fiscal Year 2014. Some examples of these collaborations are described below.

- The Worcester Recovery Center & Hospital Transition Study. SPARC faculty and staff worked in collaboration with the WRCH Medical Director & COO to design and implement a study examining the transition, for both staff and patients, from the Worcester State Hospital to the new WRCH. Data collection began in October 2012 and concluded in May 2014. SPARC and DMH leadership have reviewed the data, and are discussing strategies to utilize findings for services planning and quality improvement.
- SPARC began working closely with the Commonwealth Medicine (CWM) Marketing Analytics Team to acquaint them with the range of SPARC research, training and technical assistance expertise. As an example, the crisis intervention training offered by Albert Grudzinskas, Barry Feldman, and Jonathan Clayfield is being added to contract proposals for the U.S. Bureau of Prisons. Additionally, the trauma informed training for clinicians being offered in Massachusetts by Jessica Griffin and the Child Trauma Training Center (CTTC) will now be part of clinician training contract offered to the states Commonwealth Medicine serves. The collaborations run in both directions. The linkages developed by Maryann Davis and the Transitions RTC with Research Triangle Institute have allowed Commonwealth Medicine to begin negotiations for a series of new collaborations with this leader in national research.

Goal 4: The main focus of Goal 4 has been to secure permanent space for SPARC. In June 2014, the SPARC

relocated to the Chang Building at 222 Maple Avenue in Shrewsbury, MA. The new space is clean, modern, accessible, and facilitates teamwork and efficiency among SPARC faculty and staff and our collaborators. The new location also provides opportunities for growth and development, and collaboration with the faculty and staff involved with the National Children's Mental Health Study who are also located in the Chang Building.

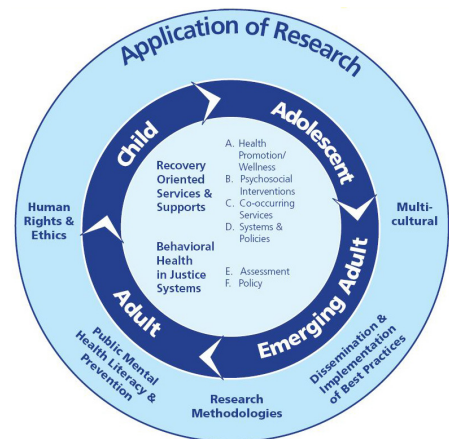
Internally, the SPARC has been re-organized into eight Areas of Research Concentration (ARCs) based on current research activities of the Center and the potential for each of them to relate to external partners. These areas include research on services as well as the application of research across the life span from child to adult.

Research on Services

- Mental Health and Criminal Justice Services
- Adolescent Development and Juvenile Justice Services
- Health Promotion and Psychosocial Interventions
- Mental Health Services for Emerging Adults

Application of Research

- Human Rights and Ethics
- Multicultural Factors in Mental Health Care
- Public Mental Health Literacy and Prevention
- Dissemination and Implementation of Best Practices
- Research Methodologies



New Initiatives/Research Highlights

- Jonathan Delman, Lorna Simon, and Karen Albert examined personal recovery outcomes of participants at the six MA DMH Recovery Learning Communities (RLCs). Two hundred and sixty-three (263) surveys were collected from all six RLCs. The findings demonstrated that a majority of respondents (73%) reported meaningful gains in their overall recovery because of their participation in RLC activities, with more frequent participation significantly related to improved outcomes. Aspects of recovery with the highest rates of meaningful gains because of RLC participation were: 1) feeling better about oneself, 2) having more hope for the future, and 3) learning what recovery means for oneself. Discussions are taking place with DMH Assistant Commissioner Brooke Doyle and Consumer Liaison Rob Walker about potential presentations of results and follow-up studies. The research team is completing an analysis of the psychometric properties of the RLC Outcomes survey.
- Rosalie Torres Stone received \$30,000 from the Worcester Division of Public Health (WDPH) to conduct a mental health assessment study of the local Worcester Community, with a focus on refugee and immigrant populations. The results from this project will allow WDPH to move forward with exploring the behavioral health initiatives identified in the 2012 Greater Worcester Region Community Health Improvement Plan.
- The 2014 DMH Consumer and Family Member Satisfaction Survey had 1,141 adults, 193 family members, and 185 inpatient consumers completing surveys. This year marked the second year that optical mark recognition (OMR) software was used to scan paper survey returns. Additionally, English and Spanish-speaking adult consumers and family members of children/adolescents receiving DMH services had the option of completing the survey on-line via Survey Monkey. In an effort to reach non-English speaking consumers selected for the survey, this year's survey materials were translated into fifteen foreign languages. In addition, our sample of adult consumers included fifteen individuals who are deaf/hard of hearing.

- Carl Fulwiler received NIH funding to conduct a study called “Keeping Weight Off: Brain Changes Associated with Healthy Behaviors.” This is a randomized trial comparing Mindfulness-Based Stress Reduction to a health education class for overweight and obese people seeking to maintain weight loss. This study will examine changes in neural markers associated with emotion regulation, health behaviors and maintenance of weight loss with the goal of optimizing outcomes for a broad range of participants including those with depression and anxiety.
- Carl Fulwiler and Stephanie Hartwell received funding from the NIH and from a UMMS Center for Clinical and Translational Science Award for the pilot study, “A Culturally Appropriate Mindfulness Intervention for Survivors of Homicide: A Community-Based Participatory Research Project”. This project will investigate the feasibility of mindfulness for homicide survivors in Boston. The population is largely low-income people of color and the goal of the project is to develop a culturally-adapted version of MBSR as an effective tool to promote coping and healing. Their community partner is Ms. Clementina Chery at the Louis D. Brown Peace Initiative.
- Melissa Anderson, a new SPARC faculty member who is a psychologist and clinical researcher, is studying the development and evaluation of evidence-based psychotherapies for deaf clients. Members of the Deaf community – a sociolinguistic minority group of at least 500,000 Americans whose primary language is American Sign Language-experience trauma, posttraumatic stress disorder, and substance use disorders at rates double to the general population. Yet, there are no evidence-based behavioral health treatments that have been empirically tested for efficacy with deaf people to address these disparities. Melissa is making a critical first step toward reducing deaf people’s behavioral health disparities by developing and evaluating deaf-accessible interventions for trauma and addiction. This is a new area of growth within the SPARC, and addresses an underserved population within the Commonwealth.
- Colleen McKay and the Program for Clubhouse Research are working with the International Brain Injury Clubhouse Alliance to develop a set of performance measures and outcome indicators for clubhouses that serve individuals diagnosed with a brain injury. Currently there are nineteen brain injury clubhouses in the United States, Canada, and Australia.
- Colleen McKay is collaborating with researchers from American University in Washington, DC to examine factors associated with program sustainability within the Clubhouse Model. Initial results suggest that Clubhouse Accreditation is a key factor to sustainability.

Integrated Care

Behavioral health has assumed unprecedented prominence in national and state healthcare reform efforts. SPARC considers behavioral health integration to be a top priority for our research and technical assistance to DMH and providers. SPARC and other Department of Psychiatry faculty members have vital expertise in a wide array of behavioral health topic areas. SPARC Director Carl Fulwiler serves on a cross-system committee for UMass Medical School and UMass Memorial Medical Center that is tasked with developing recommendations for significantly expanding integrated care in clinical services, professional training and research. In addition, because of its priority, SPARC is actively recruiting for a mid-career faculty member with specific research expertise in this area. Other relevant integrated care projects include:

- Carl Fulwiler, Doug Ziedonis, and David Smelson are part of a committee charged advising the Chancellor of UMass Medical School and leadership of the UMass Memorial Health Care system on behavioral health integration. This topic is a top priority for UMass and new initiatives are being planned involving clinical care, education, research and policy.

- The Institute of Medicine (IOM) and the National Research Council released a report to address integrated care in emerging adults (ages 18-26). The report is the result of the work of several experts in this field, including Maryann Davis, Director of the Transitions RTC. Maryann is a member of the IOM Health, Safety and Well-Being of Young Adults Committee, and is the lead author on a chapter in the report regarding integrated care for the transition age youth population (16-25 years) in the Committee's report.
- Utilizing funding from DMH, MCPAP for Moms is a new statewide program to promote maternal and child health by building the capacity of obstetric, pediatric, primary care and psychiatric providers serving pregnant and postpartum women and their children to prevent, identify, and manage depression. SPARC faculty and staff are developing and overseeing this program – Nancy Byatt as Medical Director, and Kate Biebel as Program Director. MCPAP for Moms is an expansion of the existing successful Massachusetts Child Psychiatry Access Project (MCPAP). MCPAP for Moms officially launched on July 1, 2014.
- Doug Ziedonis and colleagues developed Addressing Tobacco through Organizational Change (ATTOC) which is an intervention to assist an organization with tobacco cessation. Addressing Tobacco or Wellness Through Organizational Change (AWTOC), was adapted from the ATTOC model and its purpose is to strengthen an organization's capacity to address a broader spectrum of wellness issues. Both of these employ implementation science and organizational change approaches utilized to transform the culture in behavioral health settings to include wellness topics and prevention of medical diseases. Our Department has numerous faculty focused on agency level change to help the integration of medical and wellness interventions.
- Nancy Byatt received a NIH/National Center for Advancing Translational Sciences K12 award for her Rapid Access to Psychiatric Care in Perinatal Depression Programs (RAPPID). Nancy will use the funding to develop and evaluate programs to improve delivery of depression care in obstetric settings.
- Much of the work is focused on the integration of mental health and substance abuse treatment with linkage to behavioral health in David Smelson's Maintaining Independence and Sobriety through Systems Integration, Outreach and Networking (MISSION) Treatment Model. A large number of projects are presently underway with DMH and the Department of Public Health to integrate the MISSION treatment model in Massachusetts. In addition, there is also a large hybrid implementation and effectiveness study underway with the MISSION model in a number of regions in the VA Health Care System. Treatment manuals have been developed for the clinical staff and workbooks were developed for the program participants to reinforce skills learned in treatment. More recently, MISSION has been adapted for the criminal justice population and Spanish versions of the MISSION manuals are now available. More information about MISSION can be found at MISSIONmodel.org.

UMass Five Campus Consortium on Criminal Justice and Health

Across the criminal justice and juvenile justice systems, the physical and mental health needs of persons with chronic disorders present a complex array of system challenges. Addressing these issues requires continuous development of a knowledge base that can serve as a platform for building effective service systems and interventions. To date, most research in this area has resided in silos within a diverse array of disciplines such as law, psychology, sociology, public policy, and criminal justice. The UMass system, with a tremendous depth of expertise across these and other disciplines, has significant potential to transcend those siloes and establish the UMass brand as a formidable presence in this field. By supporting the development of collaborative research initiatives that leverage the substantial UMass cross-disciplinary expertise residing in the UMass system, the consortium will lay the groundwork for the growth of a substantial research enterprise in a critical area of public health and public policy.

SPARC Director Carl Fulwiler is co-leading this initiative along with leadership from Commonwealth Medicine, with participation of SPARC faculty Gina Vincent and Al Grudzinskas, and with faculty from each of the UMass campuses. The primary goals are to develop collaborative research funding proposals that address the physical and mental health needs of persons in the criminal justice system; to engage strategic partners from local, state and federal agencies; and to support cross-disciplinary training across the campuses. Plans are currently underway for a statewide forum that will focus on behavioral and physical comorbidities of prisoners being released to the community, the research on evidence-based health care for this population, and policy strategies for effectively meeting their health care needs and reducing recidivism.

Consumer Voice Highlights

Consumer voice is critical to all the ongoing work at SPARC. In addition to working side-by-side with individuals with lived experience of mental health concerns, SPARC relies on the direction and guidance of two consumer advisory bodies - the SPARC consumer advisory council – Mental Health Experienced & Years of Understanding (MHE & YOU), and the Transitions Research and Training Center’s Youth Voice. At the Transitions RTC, transition age youth with serious mental conditions work on efforts to improve mental health services. Within SPARC individuals with lived experience are actively involved in all phases of research, from defining the problem to disseminating the results. The voice of individuals with lived experience is infused into all SPARC research, training, and dissemination activities. Highlights include:



- The MHE & YOU Advisory Council, in collaboration with the Mental Health Area Research Network (MHARN) and the SPARC, successfully completed the 2014 May is Mental Health Awareness Month campaign. Thirty-two video statements were produced, focusing on the theme Peers & Allies, and featuring individuals from SPARC, the UMMS Department of Psychiatry, and local community mental health agencies and organizations (e.g., Genesis Club and the Central MA RLC). As of the end June 2014, the videos statements had received 5049 views. The 2014 video statements can be viewed at: <http://www.umassmed.edu/sparc/publications-and-products/multimedia/rehabilitation-recovery/peer-statements/>
- The MHE & YOU Advisory Council created DVD’s consisting of all the Stigma Fighting and Wellness Statements for the May is Mental Health Awareness Month campaigns. To date, six Massachusetts local access TV stations have requested DVD’s. MHE & You is also working with the DMH WRCH to showcase “May is Mental Health Month” videos on WRCH TV.
- The MHE & YOU Advisory Council produced a video presentation, explaining the 2012 Stigma Fighting Campaign, for the 17th International Seminar on the Clubhouse Model held in October 2013. The video was included in a workshop titled “How Clubhouses Can Erode Stigma in their Communities.” MHE & YOU sent out 27 DVDs (including all Stigma Fighting Video Statements) along with contact information and a list of SPARC websites.
- The MHE & YOU Advisory Council led the planning of the DMH’s Research Centers of Excellence conference – What is Integrated Care & Why is it Important. There were over 100 attendees consisting of doctors, nurses, researchers, licensed mental health clinicians, social workers, and persons with lived experience. MHE & YOU leaders worked in partnership with Gillian Simons, a young adult project

assistant from the Transitions RTC, in designing all workshops and presentations. Amanda Costa and Tania Duperoy presented a workshop on “A Consumer Perspective on Whole Health Management.” In this workshop, Tania and Amanda presented on the Whole Health Action Management Model, and led a group discussion on infusing collaborative mental and physical health care into all treatment.

- Amanda Costa, a Research Technician in the Transitions RTC, is co-chair of the DMH Statewide Young Adult Council, and is facilitating an upcoming meeting to provide feedback to a group working with DMH on creating a young adult website with resources and information on applying for and utilizing SSI and SSDI benefits. Recently, Amanda and Tania Duperoy participated in a sub-committee that beta tested the website and provided structured feedback on content and design. The website officially launched July 1st, 2014.

Dissemination/Community Engagement Highlights

- SPARC faculty and staff educated and informed constituents regarding the dissemination work of our DMH Research Center of Excellence at numerous conferences/meetings including the 27th Children’s Mental Health Research and Policy Conference, UMass Center for Clinical & Translational Science’ 2013 Community Engagement & Research Symposium, the 17th International Seminar on the Clubhouse Model, and the 2013 NAMI Massachusetts Convention.
- SPARC and Transitions RTC websites received 17,474 visits from over 11,128 visitors. Product downloads from our websites and our Psychiatry Information In-Brief e-journal totaled over 50,000. Our Facebook pages reached 657 “likes”; Twitter pages currently have 373 followers while our listserv reached 2,190 members.
- In September 2013 Gina Vincent was invited to speak at the annual conference of the National Council of State Legislatures in Boston, MA. Her talk was entitled “Maximizing the Impact of Interventions for Youth: Importance of Risk/Needs Assessment”. In May 2014 Gina was invited talk at the annual conference of the Committee for Public Counsel Services in Worcester, MA to give the same presentation.
- SPARC faculty and staff continue to work with Corey Gabowitz (DMH/WRCH Staff Development Training Specialist) to schedule speakers for the WRCH Grand Rounds. On October 15, 2013, Kate Biebel and Nancy Byatt presented on “Optimizing Maternal Mental Health”.
- Jonathan Delman was appointed to two national committees at the Institute Of Medicine (IOM):
 - Committee on Developing Evidence Based Standards for Psychosocial Interventions for Mental Disorders, and;
 - The Department of Health and Human Services and National Quality Forum, Advisory Board for Developing Home and Community-Based Waiver Quality Measures
- The Transitions RTC successfully conducted a state of the science conference, “Tools for System Transformation for Young Adults with Psychiatric Disabilities.” The conference was held at Georgetown University National Technical Assistance Center for Children’s Mental Health on September 24-25th, 2013. The conference proceedings can be found at: http://labs.umassmed.edu/transitionsRTC/Resources/SOS_ConferenceProceedings.html



Additional dissemination products from the RTC include:

- Promise For The Future: How Federal Programs Can Improve Career Outcomes For Youth & Young

Adults With Serious Mental Health Conditions. This report examines various federal programs that can provide assistance in meeting the educational, vocational and basic supports needs of youth and young adults with serious mental health conditions (SMHCs). The full report text is at: <http://labs.umassmed.edu/transitionsRTC/Resources/publications/promiseforthefuture.pdf>

- **Promise for the Future: A Compendium of Fact Sheets on Federal Programs for Transition-Age Youth with Serious Mental Health Conditions.** This compendium of fact sheets describes 34 programs administered by the federal government that could help young people (14-30 year-olds) gain a firm footing on the path to a career and independent living. The compendium is available at: http://labs.umassmed.edu/transitionsrtc/Resources/publications/PromiseForTheFuture_FactSheets.pdf
- **A View into Young Adults with Psychiatric Disabilities: The Mission & Work of the Transitions RTC** a video montage, created by a Transitions RTC young adult with lived experience, is to provide an engaging overview of the challenges faced by young adults with psychiatric disabilities, and the critical issues surrounding their movement into adult roles as student and worker.
- **A Community of Practice on Young Adults with Serious Mental Health Conditions in Northeast Massachusetts**, which is an infographic that describes the process of creating a community practice (CoP) to support young adults with serious mental health conditions. Included is the definition of a CoP, systems and stakeholders involved, formation of the group, communications, goals and results of this CoP. <http://labs.umassmed.edu/transitionsRTC/Resources/publications/infographic.pdf>

Collaborations with DMH and Other State Agencies Highlights

- Carl Fulwiler is Co-Investigator on a new grant awarded to DMH (Debra Pinals, PI) for the MISSION-IRAPS program. Funded by the Bureau of Justice Assistance's Second Chance Act Reentry Program for Adult Offenders with Co-Occurring Substance Abuse and Mental Health Disorders, the program is a collaboration between the Department of Mental Health, Executive Office of Public Safety and Security, UMass Medical School and UMass Boston, and community-based agencies focused on addressing the complex needs of men and women with co-occurring disorders being released from incarceration.
- Kate Biebel is working with Larry Seidman and Cindy Liu of the Harvard Commonwealth Research Center on research collaboration opportunities specific to parents with mental illness. Kate Biebel is also working with Debbie Sapor, a WRCH Senior Clinician and Treatment Planning Facilitator, to discuss strategies for infusing issues of family and parenting into ongoing administrative and clinical work. This includes providing feedback on Pre-Admission forms, the patients' Recovery Journals, and the WRCH Treatment Planning forms. This group is meeting on a monthly basis.
- Kimberly Larson and colleagues are working with Debra Pinals, M.D. and Ivy Sohn, M.D., J.D. on a National Survey of Juvenile Competence to Stand Trial Evaluation Procedures and Services. This is a 50 state survey of the state mental health service directors through their national organization.
- DMH held its' 3rd Annual Peer Leadership Recognition Event on July 17th, 2013 to recognize young adult peer leaders across the state for their work in the mental health field. At the ceremony, young adults witnessed the unveiling of the DMH Youth Orientation video, a presentation on the Young Adult Peer Mentor Training, and received certificates for their accomplishments. Amanda Costa, Tania Duperoy, Jennifer Whitney, Gillian Simons, and Greg Romanowicz from the Transitions RTC were among 100 young adults honored.

- Maryann Davis, Marsha Ellison and Kathryn Sabella met with Ann Capoccia and Suzanne Hannigan from DMH to discuss their SAMHSA Systems of Care grant that is aiming to better serve transition age youth and young adults within the CSA's. They provided technical assistance around education issues and engaging colleges. They also provided a training component for the newly re-funded DMH STAY Together Grant, discussed ongoing research and possible future research collaborations, and planned future technical assistance activities.
- Gillian Simons is on the DMH Northeast Area Site Board, which is comprised of two consumers, one family member, and DMH staff, including Susan Wing, Area Director. The board makes financial, housing, hospital bed, and community decisions within the DMH system.

Honors and Awards

Maryann Davis:

- Member of the National Academy of Science, Institute of Medicine, Committee on Improving the Health, Safety, and Well-Being of Young Adults.
- Organized National Conference: State of the Science on Career Development in Young Adults with Serious Mental Health Conditions in Washington DC.



Maryann Davis, PhD



Jonathan Delman:

- Received the 2014 Karl Ackerman "Ox" Award from The (Massachusetts) Transformation Center, for systems transformation advocacy achievements. Jon has conducted some of the early research that led to the development of the peer specialist role and the important role of young adults in policy development and service provision. Jon has expanded greatly the research on peer-led Recovery Learning Communities, with a focus on recovery outcomes and participant social network development.

Jonathan Delman, PhD, JD, MPH

Tom Grisso:

- On September 19, 2013 Tom Grisso was awarded the University of Massachusetts Medical School Chancellor (UMMS) Chancellor's Medal for Distinguished Scholarship. At the award presentation, it was noted by UMMS Chancellor, Michael F. Collins, that Dr. Grisso has made seminal contributions to the field of forensic psychiatry and psychology. Chancellor Collins commented "Your research has had substantial, sustained and demonstrable impact on clinical practice, juvenile justice policies and the law. Your work has stimulated thought and empirical designs used by every major researcher in these areas." Dr. Grisso gave the keynote address at the 2013 UMMS Research Retreat.
- December 5, 2013, Dr. Grisso received the Citizens for Juvenile Justice (CfJJ) Leadership Award for his lifetime of work on improving forensic evaluations and informing policy and law for youths in the juvenile justice system.



Thomas Grisso, PhD

Kim Larson:

- Appointed to Federal Advisory Committee on Juvenile Justice (FACJJ). The FACJJ's role is to advise the President and Congress on matters related to juvenile justice, assist in evaluating the progress and accomplishments of juvenile justice activities and projects, and advise the Administrator of the Office of Juvenile Justice and Delinquency Prevention.
- Appointed Legislative Liaison to the Juvenile Justice and Child Welfare Section of the Massachusetts Bar Association. The legislative liaison tracks juvenile legislation in the state of Massachusetts and serves as member of the Section Council to facilitate communication between the Section Council and the Office of General Counsel.



Kim Larson, PhD



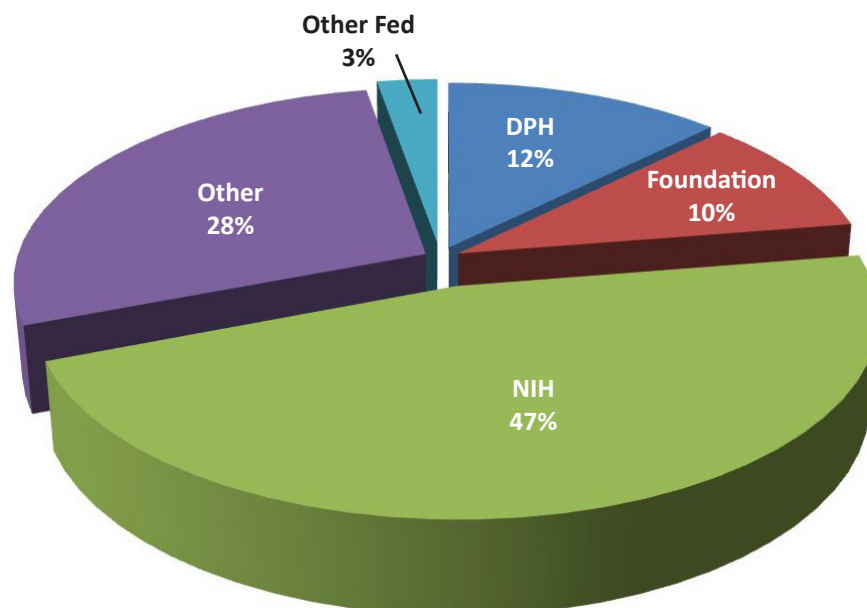
Gina Vincent, PhD

Gina Vincent:

- In August 2013 Gina was appointed the Chair of the American Psychology-Law Society (APLS) Professional Development of Women Committee by the president of APLS.

Fiscal Year 2015 is off to a great start. We have a number of new grants funded and are continuing to explore innovative opportunities to help us diversify our funding portfolio. We entered our final year of our Strategic Plan, with a clear focus on priorities and action items that support the shared DMH and SPARC 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.

Funding Sources for New Grants Awarded



Fulfillment of DMH Contract

Research Activity

These numbers represent both ongoing and new SPARC research during Fiscal Year 2014.

Performance Measure	Accomplished in Fiscal Year 2012	Accomplished in Fiscal Year 2013	Accomplished in Fiscal Year 2014
Number of research projects approved by DMH ¹	50	37	38
Number of research proposals submitted and approved by an IRB ²	7	7	10
Number of grants submitted ³	24	22	20
Number of grants approved ⁴	18	16	17

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

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

³The total number of grant applications that SPARC submitted during the 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 fiscal year or are approved for funding in the upcoming fiscal year.

Summary of New Grant Funding

The ongoing financial support provided by DMH confers SPARC 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 2014 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 SPARC, the UMass Department of Psychiatry, and the University of Massachusetts Medical School).

Performance Measure	Accomplished in Fiscal Year 2012	Accomplished in Fiscal Year 2013	Accomplished in Fiscal Year 2014
External Funding Obtained	\$5,593,093	\$5,888,491	\$4,558,847

Summary of Publications

SPARC faculty and staff publish in a variety of different venues. Although the majority of publications appear in peer-reviewed journals, SPARC 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	Accomplished in Fiscal Year 2014
Number of papers submitted and accepted for peer review publication	71	80	64

Summary of Other Dissemination Efforts

SPARC continued to conduct trainings and give presentations at a wide variety of venues throughout Fiscal Year 2014. The following numbers represent the efforts of SPARC 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	Accomplished in Fiscal Year 2014
Number and types of forums used by SPARC to share information with DMH State and provider clinical workforce, consumers and family members	36	51	36
Number of state and provider workforce members and consumers and family members with whom research information was shared ⁵	3,625	4,240	4,893

⁵This represents the number of individuals attending SPARC faculty and staff presentations at conferences and trainings in Massachusetts during FY14. This does not include Massachusetts individuals accessing research information through other SPARC mechanisms (i.e., website, listservs, social media).

Appendix A

New SPARC Funded Research

Adapting Alcohol Behavioral Couples Therapy for Service Members in Post-Deployment

PI: Smelson, David A.
Funding: National Institute on Alcohol Abuse and Alcoholism
Total Budget: \$386,423.00
Direct Budget: \$230,783.00
Indirect Budget: \$155,640.00
Funds per FY: \$55,253.00
Time Frame: 5/15/2014 - 4/30/2017

Description: This project seeks to adapt and test a well-established civilian Alcohol Behavioral Couple Therapy (ABCT) approach to meet the unique needs and challenges facing returning service members from Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND). ABCT-Military will deliver existing core sets of (a) abstinence-based, alcohol-related interventions, and (b) couple interventions, but with adaptations to make the treatment palatable and relevant to post-deployment service members. Four new optional modules will be developed to address issues exacerbated by and aggravating problem drinking among soldiers and their families following return from theater; the modules are designed to help couples cope with symptoms of: 1. Intimate Partner Violence; 2. Depression; 3. PTSD, and 4.TBI.

Adolescent Domestic Battery Typologies Validation Study

PI: Vincent, Gina
Funding: John D. And Catherine T. MacArthur Foundation
Total Budget: \$195,000.00
Direct Budget: \$169,565.00
Indirect Budget: \$25,435.00
Time Frame: 7/1/2013 - 6/30/2015

Description: A two-year research project to cross-validate an assessment tool for subtyping and intervention planning for youth charged with a domestic battery towards a parent in five juvenile courts around the U.S.

Improving Implementation in Risk/Needs Assessment in Juvenile Probation Project

PI: Vincent, Gina
Funding: John D. and Catherine T. MacArthur Foundation
Total Budget: \$250,000.00
Direct Budget: \$217,391.00
Indirect Budget: \$32,609.00
Funds per FY: \$130,435.00
Time Frame: 5/1/2014 - 4/30/2016

Description: A two-year quasi-experimental research study of the impact of implementing risk assessment and risk-needs responsivity in juvenile probation offices in two states.

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

PI's: Fulwiler, Carl
Funding: NIH R34 At006963-01A1

Total Budget: \$740,250
Direct Budget: \$450,000
Indirect Budget: \$290,250
Funds per FY: \$282,634
Time Frame: 5/1/2013 - 2/29/2016

Description: The goal of this study is to characterize the impact of Mindfulness-Based Stress Reduction on emotion regulation circuitry using fMRI and examine the association of these changes with depressive symptoms, health behaviors and maintenance of weight loss in subjects who have intentionally lost 5-10% of their weight.

Mindful Physician Leadership Program

PI: Ziedonis, Douglas M.
Funding: The Physician's Foundation
Total Budget: \$75,000.00
Direct Budget: \$65,217.00
Indirect Budget: \$9,783.00
Funds per FY 14: \$56,588.00
Time Frame: 5/1/2014 - 8/31/2015

Description: The Mindfulness-Based Stress Reduction model, developed at UMass, will be reviewed, to the ends of promoting personal mindfulness practice and creating a more mindful health care workplace for physicians, staff, and patients.

MISSION FORWARD (Maintaining Independence and Sobriety through Systems Integration)

PI: Smelson, David A.
Funding: Massachusetts Department of Public Health, Bureau of Substance Abuse Services
Total Budget: \$419,264.00
Direct Budget: \$334,473.00
Indirect Budget: \$84,791.00
Funds per FY 14: \$100,207.00
Time Frame: 9/11/2013 - 6/30/2016

Description: *MISSION-FORWARD* will serve 180 clients (120 clients in the Quincy Adult Drug Court and 60 clients in the Dedham Veterans Treatment Court) who will receive MISSION services for up to one year. The project focuses on two types of specialty courts and will embed peer and case manager teams who will use an evidence-based wraparound model previously developed with SAMHSA funding to specifically improve coordination between the courts, clients, and community-based treatment providers.

Mississippi Statewide SAVRY Implementation

PI: Vincent, Gina
Funding: Council of Juvenile Correctional Administration
Total Budget: \$25,000.00
Direct Budget: \$21,739.00
Indirect Budget: \$3,261.00
Funds per FY 14: \$21,739.00
Time Frame: 3/1/2014 - 12/31/2014

Description: A technical assistance and training project for advising key personnel in Mississippi on the steps to preparing to implement the SAVRY in several juvenile probation offices. Trainings on juvenile risk assessment and the SAVRY will be designed and delivered to key stakeholders (attorneys and

judges), and technical assistance will be provided to refine documentation developed by key personnel in Mississippi, and with the revision of policies, SAVRY interviews, and service plan protocol.

MST-EA DC Evaluation

PI: Davis, Maryann

Funding Evidence-Based Associates

Total Budget: \$19,867.00

Direct Budget: \$14,608.00

Indirect Budget: \$5,259.00

Funds per FY 14: \$14,608.00

Time Frame: 10/1/2013 - 9/30/2014

Description: Ongoing evaluation and consultation to a Multi-systemic Therapy team for Emerging Adults funded by NAFI and implemented in Washington, DC.

Rapid Access to Psychiatric Care in Perinatal Depression Programs (RAPPID)

PI: Byatt, Nancy

Funding: National Institutes of Health

Total Budget: \$775,359

Time Frame: 7/1/2013 - 6/30/2018

Description: Development and evaluation of program to improve delivery of depression care in obstetric settings.

Setting the Research Agenda: Supporting the Transition to Education and Employment

PI: Davis, Maryann

Funding Annie E. Casey Foundation

Total Budget: \$5,000.00

Direct Budget: \$5,000.00

Funds per FY: \$5,000.00

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

Description: Grant funds were used to support costs associated with the Transitions RTC State of the Science Conference: "Tools for System Transformation for Young Adults with Psychiatric Disabilities", a conference with over 50 attendees (federal policy makers, parents, young adults, and researchers) held in Washington DC in September 2013.

Using Evidence to Improve Medicaid Mental Health Services for New Hampshire Children and Youth - Part II

Co-PI's: Biebel, Kate and Nicholson, Joanne

Funding: W. T. Grant Foundation

Total Budget: \$68,518

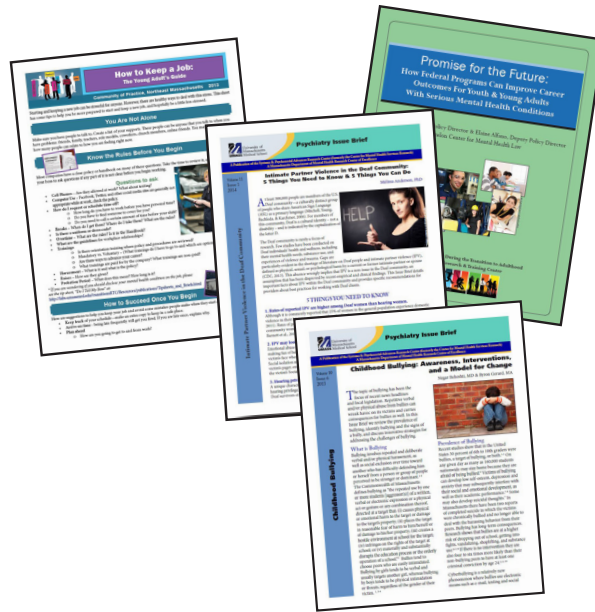
Funds per FY 14: \$68,518

Time Frame: 7/1/2013 - 11/1/2013

Description: Examining the use of research evidence in regional systems of care planning meetings.

Appendix B

SPARC Dissemination Products



Psychiatry Information in Brief

Psychiatry Issue Brief

- Childhood Bullying: Awareness, Interventions, and a Model for Change
- Getting Acquainted with Stigma: A Brief Introduction
- Intimate Partner Violence in the Deaf Community: 5 Things You Need to Know & 5 Things You Can Do
- Navigating the Complexity of Using Research in Policy and Practice Decisions

Research You Can Use

- Listening to Mothers: What's Helpful for Mothers Experiencing Perinatal Depression

Transitions Research & Training Center

- How to Keep a Job: The Young Adults Guide
- How to Speak up & Be Heard: Self Advocacy
- Making it Work: Vocational Peer Mentors for Emerging Adults with Serious Mental Health Conditions
- Telling Your Money What to Do: The Young Adult's Guide

Childhood Bullying: Awareness, Interventions, and a Model for Change

Negar Beheshti, MD & Byron Gerard, MA

The topic of bullying has been the focus of recent news headlines and local legislation. Repetitive verbal and/or physical abuse from bullies can wreak havoc on its victims and carries consequences for bullies as well. In this Issue Brief we review the prevalence of bullying, identify bullying and the signs of a bully, and discuss innovative strategies for addressing the challenges of bullying.

What is Bullying

Bullying involves repeated and deliberate verbal and/or physical harassment, as well as social exclusion over time toward another who has difficulty defending him or herself from a person or group of people perceived to be stronger or dominant.¹⁻⁴ The Commonwealth of Massachusetts defines bullying as “the repeated use by one or more students [aggressor(s)] of a written, verbal or electronic expression or a physical act or gesture or any combination thereof, directed at a target that: (i) causes physical or emotional harm to the target or damage to the target’s property; (ii) places the target in reasonable fear of harm to him/herself or of damage to his/her property; (iii) creates a hostile environment at school for the target; (iv) infringes on the rights of the target at school; or (v) materially and substantially disrupts the education process or the orderly operation of a school.”⁵ Bullies tend to choose peers who are easily intimidated. Bullying by girls tends to be verbal and usually targets another girl, whereas bullying by boys tends to be physical intimidation or threats, regardless of the gender of their victim.^{1, 3-4}



Prevalence of Bullying

Recent studies show that in the United States 30 percent of 6th to 10th graders were bullies, a target of bullying, or both.¹⁻² On any given day as many as 160,000 students nationwide may stay home because they are afraid of being bullied.⁶ Victims of bullying can develop low self-esteem, depression and anxiety that may subsequently interfere with their social and emotional development, as well as their academic performance.⁷⁻⁸ Some may also develop suicidal thoughts.⁷ In Massachusetts there have been two reports of completed suicide in which the victims were chronically bullied and no longer able to deal with the harassing behavior from their peers. Bullying has long-term consequences. Research shows that bullies are at a higher risk of dropping out of school, getting into fights, vandalizing, shoplifting, and substance use.^{6-7, 9} If there is no intervention they are also four to six times more likely than their non-bullying peers to have at least one criminal conviction by age 24.^{2, 6, 10}

Cyberbullying is a relatively new phenomenon where bullies use electronic means such as e-mail, texting and social

networking sites to send mean or threatening messages or images to or about someone. Oftentimes disparaging information is sent anonymously, or bullies pretend to be someone else.^{1, 6, 11} What makes cyberbullying especially dangerous is the speed at which the information is propagated with a few simple clicks of a mouse. In some ways cyberbullying can be more damaging because embarrassing or disparaging information can be sent well beyond the victim's school, town, or even state, to virtually anyone around the globe.

Identifying Bullying

It is important to recognize signs that a youth may be the victim of bullying. Some common signs are withdrawal and apprehension about going to school, riding the school bus, or taking part in organized activities with peers.^{6, 12} Youth may also develop physical symptoms such as headaches, abdominal pain, poor appetite, sleep disturbance, and cold-like symptoms.^{7-8, 12}

Parents, teachers, and physicians should also look for signs that a youth might be a bully. If the youth gets into frequent fights or destroys, steals, or vandalizes property, these might be the signs of a bully.⁴

What Can be Done

Teachers, parents, and the community at large can teach youth what they should do if they witness a peer being bullied.⁴ Youth should be taught that it is not okay to be a bystander or an instigator and not to encourage the bully in any way. Witnesses should be taught to report the bully to a supervising adult. In cases of cyberbullying youth should be instructed not to respond to any posted messages and to report the incident to their parents or teachers.

It is important to let victims of bullying know that it is not their fault. Victims can be empowered by teaching them to take an assertive stance to bullies, such as ignoring them and walking away and seeking help from a teacher or staff member at their school. Explain to them that the true goal of the bully is to get a response and it is best that the bully get a consequential response from an authoritative figure at the school rather than the satisfaction of seeing his/her victims continue to suffer and feel helpless. If it is

clear a youth is bullying others, a referral to a mental health professional for a comprehensive evaluation may help to explain what is causing the bullying and to develop a plan to address the destructive behavior. Often bullies are not even aware of the extent to which they are inflicting physical and emotional trauma.¹³

Bullying Prevention

The response to bullying behavior can be seen in both the development of novel interventions and legislative agendas to impede bullying. One model intervention, the Olweus Bullying Prevention Program (BPP) from Norway, reduced bullying incidents by nearly 50 percent.¹⁴ The program, which aims to change the social norms that promote passive acceptance of bullying behavior, has been adapted and implemented in a number of countries.¹⁵ Pilot studies of the Olweus BPP implemented in the United States have demonstrated effectiveness, showing a decrease in bullying incidents by 20 - 45 percent.^{3, 16-17} The most robust decreases were noted in the presence of strong parent/family and community involvement, similar to findings from the Norway BPP.

In 2010 Massachusetts passed one of the country's strictest anti-bullying laws, An Act Relative to Bullying in Schools. The law required all school districts to implement bullying prevention programs within one year.¹⁸

Bullying Prevention Resources

To learn more about bullying and bullying prevention:

<http://www.stopbullying.gov/index.html>¹⁹

For school districts interested in developing their own Bullying Prevention and Intervention Plans:

<http://www.doe.mass.edu/bullying/>²⁰ & <http://www.cfchildren.org/steps-to-respect.aspx>²¹

For researchers: The CDC has compiled a compendium of measures for assessing bullying experiences:

<http://www.cdc.gov/violenceprevention/pdf/bullycompendium-a.pdf>²²

Getting Acquainted With Stigma: A Brief Introduction

Stephanie Rodrigues, PhD

When people have a personal understanding of the facts, they will be less likely to stigmatize mental illnesses and more likely to seek help for mental health problems. The actions of reducing stigma, increasing awareness, and encouraging treatment will create a positive cycle that leads to a healthier population.

The President's New Freedom Commission on
Mental Health, 2003

Stop for a moment and think about how much information you process daily to successfully navigate the world. The amount is enormous, right? So, how do we manage all of it? Stereotyping is one way. Stereotyping, a social cognitive structure, can help us categorize the constant stream of information we are tasked with processing in order to simplify our lives (Corrigan, 2004). When used for good, stereotyping can help us carry out daily activities quickly and efficiently, bypass awkward moments like walking into the wrong rest room, and help us identify professionals with specialized skills (e.g., firemen, doctors, lawyers) who can help manage problems that may benefit from additional support. However, stereotyping can also lead to the application of negative beliefs toward a group of people, including those with a mental illness, resulting in stigma and derailments in care (Corrigan, 2004).

In this Issue Brief we define stigma, describe its negative consequences, and offer ways to address stigma and promote engagement in care.



Conceptualizing Stigma

Link & Phelan (2001) conceptualize stigma as resulting from five interrelated factors:

1. labeling of individual differences (e.g., individuals diagnosed with schizophrenia vs. individuals without diagnoses of schizophrenia)
2. association of labeled persons (e.g., individuals with schizophrenia) with negative stereotypes (e.g., incompetence, violence)
3. assignment of labeled persons to distinct groups (e.g., "psycho"), creating "in" versus "out" group members
4. loss of status and discrimination experienced by labeled persons, resulting in disadvantages related to education and employment, as well as basic necessities, such as housing and health care
5. perpetuation of widespread acceptance of labeling, stereotyping, separation and discrimination via social, economic or political power.

Now that you are familiar with the conceptualization of stigma, let us

deconstruct stigma further by looking at types of stigma and its consequences.

Public vs. Self-stigma and its Consequences

Public and self-stigma act together, build upon each other, and impede recovery (Corrigan, 2004).

Public stigma is a negative societal reaction that results in prejudice toward a group of people with a negatively viewed trait such as mental illness (Corrigan, 2004). Public stigma reinforces a greater desire for social distance from people with mental illnesses, leading to lost employment and housing opportunities, as well as decreased social support from family and friends (Pescosolido et al., 2010).

Self-stigma is an internalized negative reaction that results in shame due to membership in a stigmatized group (Corrigan, 2004; Rüsch et al., 2006). Shame is an involuntary emotional reaction that develops as a result of perceived defects (e.g., mental illness) acknowledged by self and/or others. Shame is both distressing and debilitating (Rüsch et al., 2009). People who experience shame experience decreased self-esteem and self-efficacy (Baldwin, Baldwin, & Ewald, 2006; Rüsch et al., 2006), both of which are associated with self-stigma (Corrigan, Watson, & Barr, 2006; Rodrigues et al., 2013). These negative consequences may engender a poor self-concept that inhibits engagement in care and other recovery-oriented activities, best explained by the “why try” effect (Corrigan, Larson, & Rüsch, 2009).

Label Avoidance. People who engage in label avoidance refrain from associating with individuals and/or institutions that may connect them to a stigmatized group (e.g. mental health consumers, providers, and treatment facilities). People engage in label avoidance to escape the negative consequences of public and self-stigma, even when it means foregoing available services that have been shown to have a lasting impact on recovery (Corrigan & Wassel, 2008; Rodrigues et al., in press).

Thus, fear of stigmatization, a well-established and persistent barrier to care, creates a community of people who often suffer in silence until emergency intervention is necessary and recovery becomes a much more challenging and lengthy endeavor.

Addressing Stigma to Promote Engagement in Care

Mental illness may often be hidden, and fear of disclosure can complicate outreach efforts as well as engagement and retention in care. Providers should be vigilant about these effects of stigma and adhere to the following recommendations to encourage disclosure and engagement in mental health services:

Primary care providers

- Incorporate routine mental health screening into primary care visits.
- Make treatment referrals and engage in “warm hand offs” to mental health providers/services whenever possible.

Mental health providers:

- Ask about stigma concerns and address them in treatment planning and psychoeducation for persons with mental health conditions and their families.
- Encourage engagement in peer-run supportive networks that challenge stigma and shame and provide hope for mental health and recovery.

In conclusion, professionals and the general public alike should avoid describing people by their diagnoses (e.g., “he/she is schizophrenic”). Use of person-first language (e.g., person with schizophrenia) connotes respect by emphasizing the person, not the disorder.

Additional Resources

- Resource on Person-First Language: http://www.asha.org/publications/journals/submissions/person_first/
- Resource Center to Address Discrimination and Stigma: http://www.nami.org/Content/ContentGroups/Home4/Home_Page_Spotlights/Spotlight_1/ADS_Center_Spotlights_Anti-Stigma_Programs.htm
- NAMI StigmaBusters: http://www.nami.org/template.cfm?section=fight_stigma
- Mental Health Experienced & Years of Understanding (MHE & YOU) Advisory Council's Stigma Fighting Campaign videos to observe Mental Health Awareness Month: <http://www.umassmed.edu/cmhsr/stigmafightingstatements.aspx>

Intimate Partner Violence in the Deaf Community: 5 Things You Need to Know & 5 Things You Can Do

Melissa Anderson, PhD

At least 500,000 people are members of the U.S. Deaf community—a culturally distinct group of people who share American Sign Language (ASL) as a primary language (Mitchell, Young, Bachleda, & Karchmer, 2006). For members of this community, Deaf is a cultural identity – not a disability – and is indicated by the capitalization of the letter D.

The Deaf community is rarely a focus of research. Few studies have been conducted on Deaf individuals' health and wellness, including their mental health needs, substance use, and experiences of violence and trauma. Gaps are particularly evident in the shortage of literature on Deaf people and intimate partner violence (IPV), defined as physical, sexual, or psychological harm by a current or former intimate partner or spouse (CDC, 2013). This absence wrongly implies that IPV is a non-issue in the Deaf community, an assumption that has been disproved by recent empirical and clinical findings. This Issue Brief details important facts about IPV within the Deaf community and provides specific recommendations for providers about best practices for working with Deaf clients.



5 THINGS YOU NEED TO KNOW

1. Rates of reported IPV are higher among Deaf women than hearing women.

Although it is commonly reported that 25% of women in the general population experience domestic violence in their lifetime, estimates within the Deaf community are closer to 50% (Anderson & Leigh, 2011). Rates of psychological, physical, and sexual victimization among Deaf college students and community women are significantly higher compared to their hearing peers (Anderson & Leigh, 2011; Barnett et al., 2011).

2. IPV may look different in the Deaf community.

Emotional abuse may include the perpetrator insulting the Deaf victim by calling her “hearing” or making fun of her ASL skills. Intimidation may manifest as the perpetrator signing very close to the victim's face when angry, or overuse of floor stomping and pounding to get the victim's attention. Social isolation may be imposed through fear of the perpetrator's checking behavior - checking the victim's pager, email, or videophone logs. Economic abuse can be seen in the perpetrator's control of the victim's Social Security Disability Income checks (DeafHope, 2006).

3. Hearing privilege can be used against Deaf victims/survivors of IPV.

A unique characteristic of hearing-Deaf relationships is the potential for the hearing partner to abuse hearing privilege, the system of advantage based on hearing ability. From her experience working with Deaf survivors of IPV, Julie Rems-Smario (2007) has compiled an extensive list of examples of this

abuse of hearing privilege: A hearing perpetrator does not inform the Deaf victim when people try to call; excludes the victim from important conversations and financial decisions; leaves the victim out of social situations with other hearing people; talks negatively about the Deaf community or disallows access to Deaf culture; criticizes the victim's speech and English skills; and manipulates police officers when they are called to the house.

4. Deaf survivors may not label their experiences of IPV as “abuse”

Many Deaf people lack information on what constitutes IPV and whether such violence is acceptable, due to a number of factors: limited family communication, reductions in incidental learning, lack of health education programs provided in ASL, etc. A recent study on IPV among Deaf female college students found that more than 50% of Deaf survivors did not label their experiences of psychological aggression and physical assault as abuse, even when these experiences included severe harm (e.g., death threats, choking). An overwhelming majority of these survivors did not label partner-perpetrated sexual coercion as an abusive act (Anderson & Kobek Pezzarossi, 2012). Similarly, Deaf rape survivors often struggle to define their experience at all, or label these experiences as miscommunication or bad sex (Elliott, 2012).

5. Deaf survivors experience significant barriers to seeking help.

Many agencies for hearing survivors of IPV do not provide communication accessibility for Deaf survivors (i.e., ASL interpreters, accessible hotlines, videophones). Survivors may avoid treatment due to valid concerns about confidentiality – reduced anonymity within the close-knit Deaf community, fears about confidentiality among sign language interpreters, and unease about Deaf providers/ASL interpreters who belong to the same social circles as their clients (Barber, Wills, & Smith, 2010). An additional barrier is Deaf people's substantial distrust of healthcare systems run largely by and for hearing people (Steinberg, Sullivan, & Loew, 1998). A history of paternalism, bans on sign language, and eugenics is not easily forgotten.

5 RECOMMENDATIONS FOR PROVIDERS

1. Tap Deaf clients' expertise on the unique communication needs of the deaf community.

Build an effective alliance by meeting Deaf clients' unique language and communication needs, valuing Deaf culture, and respecting the client's survivorhood and Deafhood. Although providers' ASL fluency is typically the first priority of Deaf clients, a close second is working with a provider who has the “right attitude.” For hearing providers who are not versed in Deaf culture or ASL, this means keeping an open mind, deferring to deaf clients' expertise in these areas, acknowledging the benefits one receives from a system of hearing privilege, and being willing to learn and adapt one's practice accordingly.

2. Screen all clients for IPV – whether Deaf or hearing!

Given the high rates of IPV within the Deaf community, IPV screening with Deaf clients is essential. Yet, Deaf individuals are frequently not screened for behavioral health problems. Screening for trauma may be even less likely, due to common misconceptions about romance and sexuality among Deaf individuals. For example, service providers often pay less attention to the sexual histories and sexual trauma experienced by women with disabilities, due to the incorrect belief that individuals with disabilities are not sexual beings (McRuer & Mollow, 2012; Olkin, 1999).

3. Use objective, behavior-driven language.

When screening for IPV, use language that is objective and does not require the client's cognitive appraisal of their experiences. For example, say slap, punch, kick, curse, threaten, force and avoid using more clinical terms such as abuse, intimate partner violence, domestic violence, or coercion. These labels can be applied after sufficient psychoeducation has been provided.

4. Address information gaps about IPV and health relationships.

Investigate clients' knowledge of IPV and, if needed, provide education and resources. Additionally, direct clients to Deaf-friendly resources such as DeafHope's Lavender Revolution or ASL videos created by SafePlace and Vera House.

5. If needed, provide referrals to behavioral health treatment, preferably with a Deaf or ASL-fluent clinician.

If you feel that additional treatment for victims of IPV or trauma is needed, contact your state's commission for the Deaf and hard-of-hearing to obtain information about clinicians that provide specialized behavioral health services for Deaf clients.

*The image used in this brief depicts a model and not an actual victim or perpetrator of violence.

Navigating the Complexity of Using Research in Policy and Practice Decisions

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

Calls to bridge the gap between “what is known” and “what is done” have led to a small but growing body of literature on how research is used in policy and practice decision-making. Early models of research use focused on the autonomous production and passive transfer of research, describing linear, rational processes whereby research is conducted by a research “producer” and then “pushed” to a ready and waiting research “user” (Lavis, Robertson, Woodside, Mcleod, & Abelson, 2003). More recently, knowledge translation and exchange models have been promoted as potentially useful for examining the interactions among researchers, policymakers, and practitioners.

There are several themes common among a variety of knowledge translation and exchange models. First, researcher, practitioner, and policymaker communities all have knowledge and expertise that is needed by the other. Second, the knowledge being exchanged does not consist only of the available research about an evidence-based practice but also includes experiential knowledge about the context within which a policy or practice might be embedded (Graham et al., 2006). Third, relationships and trust among researchers, policymakers, and practitioners are critical (Gagnon, 2011; Ko, Kirsch, & King, 2005). Last, knowledge translation and exchange models acknowledge the complexities of the sociopolitical context in which practice and policy decision-making occurs (Gibbons, 2008).

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

knowledge exchange in a real-world setting. 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.

Investigators examined the use of research evidence 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. The study used mixed methods including an extensive review of public documents, an agency survey, and one-on-one and group interviews with key informants.ⁱ

Multiple Levels and Episodes of Decision-Making

The overarching goal of improving behavioral health services for Massachusetts children covered by Medicaid falls under the purview of Federal, state, and community-based entities. Decisions and actions at the Federal, state, and community levels are all necessary; no one level is sufficient by itself to change publicly funded behavioral health services for children. Decisions across these levels occurred over several years in three distinct episodes. Each episode had a different purpose, requiring the exchange of different types of knowledge and involving multiple and shifting participants representing research as well as policy, program, and practice.

- **Episode 1:** The Federal Court determined that the state had failed to comply with Federal EPSDT requirements and ordered a remedial plan with several components. To do so, the judge heard testimony from a range of

researchers, clinicians, program administrators, family members, and fiscal experts.

- **Episode 2:** State administrators determined how to translate the remedy plan into state Medicaid program standards. They supplemented research knowledge provided by national experts with their own professional experience, the experience of administrators in other states that had made similar changes, and parents' experiences as conveyed by advocates.
- **Episode 3:** Community Service Agencies (CSAs) made daily practice decisions about how to implement Wraparound using the resources available in their communities and within Medicaid rules and rates. They relied on their own expertise and experience in delivering services as well as knowledge provided by a Wraparound purveyor and technical assistance teams from Medicaid's managed care entities.

Decision-Making Parameters Narrow and Participants Broaden over Time

Over the course of the three episodes, decisions made in one episode established parameters within which decisions in subsequent episodes had to be made. The Judge's ruling regarding EPSDT compliance and the resulting remedy plan became the parameter within which numerous decisions were made about revisions to state Medicaid program standards. The state Medicaid standards shaped and bounded the daily practice decisions by CSAs. Each of these decision episodes limited the range of choices available in subsequent episodes.

At the same time that the parameters narrowed in scope, the numbers of participants with different organizational affiliations increased. In the first episode, the Judge was the sole arbiter of the evidence and decision maker. Following his rulings, decision-making shifted to a small group of state administrators, with the input of plaintiff's attorneys and the court monitor. Once their decisions were translated into Medicaid program standards,

decision-making shifted to the CSAs whose staff made practice decisions on a daily basis.

Thus, the nature of the complexity shifted from a broad policy question in the hands of one person to detailed program standards being interpreted by hundreds of practitioners. Researchers engaging in knowledge exchange must be aware of and prepared to navigate this shift to help maintain the integrity of research evidence as it is translated across inter-connected decision-making episodes.

Public Documents

Most participants were not consistently engaged across all three decision-making episodes, requiring some other vehicle for transmitting information. Public documents were essential to maintaining coherence from one set of decisions to the next. Both episodes two and three were guided by written documents resulting from decisions made during previous episodes. These documents established a public record readily available on web sites that allowed participants to learn about and track the basis of decisions from policy to program to practice.

Intermediaries

As the number of participants in the episodes broadened, so did the contextual factors informing or influencing their decision-making. Intermediaries were critical in translating both the complex context (e.g., regulatory, fiscal, and local community environment) and the research evidence (e.g., Wraparound). To be effective, intermediaries had to be knowledgeable about the research being embedded as well the state and local contexts. For more on the role of intermediaries in this case study, see [Psychiatry Information in Brief, volume 10, issue 4](#).

Preliminary findings from this study call for heightened attention to the shifting and multi-dimensional complexity of decision-making that occurs in public service systems. Attention to this complexity will allow for the use of research evidence in coherent, relevant and effective ways.

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

ⁱMore detail about this study can be found at Leslie, L, Maciolek, S., Biebel, K., Debordes-Jackson, G. & Nicholson, J. (in press). Exploring research use at the research-policy-practice interface in children's behavioral health services. *Administration and Policy in Mental Health and Mental Health Services Research* (2014).

Listening to Mothers: What's Helpful for Mothers Experiencing Perinatal Depression

Approximately 1 in 8 women experience *perinatal depression*, a depressive episode that occurs during pregnancy or within the first year after delivery or adoption. The perinatal period is an ideal time to screen, diagnose, and treat depression as women have frequent and regular contact with health care providers (Smith et al., 2009; Weissman et al., 2006). Current screening efforts may improve detection of perinatal depression (Birndorf, Madden, Portera, & Leon, 2001) but they do not improve treatment entry or outcomes (Gilbody, Sheldon, & House, 2008; Kozhimannil, Adams, Soumerai, Busch, & Huskamp, 2011; Smith et al., 2009). Understanding the experiences of women who have experienced perinatal depression may help inform needed changes in how health care professionals and organizations screen, diagnose, and treat perinatal depression.

The following recommendations come from 27 mothers who shared their own experiences of perinatal depression. See *Overcoming Barriers to Addressing Perinatal Depression: Perspectives of Women* for study details.



What Providers Can Do to Help

- Have open lines of communication between providers (e.g., primary care, OB/Gyn and psychiatric providers) to better coordinate and facilitate mental health care for mothers.
- Be knowledgeable about treatment options including medication and non-medication treatments.
- Prepare women for the emotional spectrum of pregnancy and the postpartum period by providing psychoeducation about the symptoms of perinatal depression and challenges that may occur.
- Provide opportunities for mothers to process the birth experience.
- Create a conversation about perinatal depression – have literature available on perinatal depression and discuss it with mothers.
- Ask mothers specific questions to learn about their mental health – e.g., How are you sleeping? How are you eating? Are you crying during the day – if yes, how often? How are you coping with having a new baby?

Community Resources that Help

- Supportive, sympathetic and helpful family members and providers, (e.g., supportive partner and/or parent, lactation consultant).
- A safe environment to discuss the struggles and challenges of motherhood (e.g., community programs designed specifically to support new mothers).
- Concrete strategies to help alleviate stress and anxiety associated with motherhood (e.g., finding someone to watch the baby so mothers can have some alone time, taking an exercise class).

Take Home Message: Mothers who have experienced perinatal depression are quite clear about what supports and resources are most helpful to them. Providers and community members should listen to their wisdom.

"...I did find support through the hospital. They have a new mother's group and that was extremely helpful, just talking to other mothers and meeting with other people and... That was definitely the most, the most support I got."



How to Keep a Job: The Young Adult's Guide

Community of Practice, Northeast Massachusetts 2013

Starting and keeping a new job can be stressful for anyone. However, there are healthy ways to deal with this stress. This sheet has some tips to help you be more prepared to start and keep a new job, and hopefully be a little less stressed.

You Are Not Alone

Make sure you have people to talk to. Create a list of your supports. These people can be anyone that you talk to when you have problems: friends, family, teachers, role models, coworkers, church members, online friends. You may be surprised how many people can relate to how you are feeling right now.



Know the Rules Before You Begin

Most companies have a clear policy or handbook on many of these questions. Take the time to review it, and sit down with your boss to ask questions if any part of it is not clear before you begin working.

Questions to ask

- **Cell Phones** – Are they allowed at work? What about texting?
- **Computer Use** – Facebook, Twitter, and other social media sites are generally not appropriate while at work, check the policy.
- **How do I request or schedule time off?**
 - How long do you have to work before you have personal time?
 - Do you have to find someone to cover for you?
 - Do you need to call a certain amount of time before your shift?
- **Breaks** – When do I get them? Where do I take them? What are the rules?
- **Is there a uniform or dress code?**
- **Overtime** – What are the rules? Is it in the Handbook?
- **What are the guidelines** for workplace relationships?
- **Trainings**
 - Is there orientation training where policy and procedures are reviewed?
 - Mandatory vs. Voluntary – (What trainings do I have to go to and which are optional?)
 - Are there ways to advance your career?
 - What trainings are paid for by the company? What trainings are non-paid?
- **Harassment** – What is it and what is the policy?
- **Raises** – How are they given?
- **Probation Period** – What does this mean? How long is it?

** If you are wondering if you should disclose your mental health condition on the job, please see the tip sheet, "Do I Tell My Boss" at:*

http://labs.umassmed.edu/transitionsRTC/Resources/publications/Tipsheets_and_Briefs.html



How to Succeed Once You Begin



Here are suggestions to help you keep your job and avoid some mistakes people make when they start a new job.

- **Keep track** of your schedule—make an extra copy to keep in a safe place.
- **Arrive on time** - being late frequently will get you fired. If you are late once, explain why.
- **Plan ahead**
 - How are you going to get to and from work?

- What's a backup plan to get to work?
- What should you do in an emergency?
- **Know your job description**
 - Just like an employee handbook, most jobs have a job description.
 - Review your job description carefully and ask your supervisor any questions.
 - Let your supervisor know if there are tasks that you aren't able to complete.

Use Your Supervision Time Well

Having supervision does not mean you are in trouble. Some bosses schedule time to meet with employees. Use this time to ask questions, build skills and be curious.

- Your boss does not expect you to know everything; it is ok to ask questions. There are no dumb questions.
- If your boss does not regularly schedule supervision, ask him or her if he or she could give you a few minutes each week to discuss how you are doing.
- Ask them what you are doing well, what they would like to see you change, and make an effort to apply this information to your work.
- It's ok to ask your boss for help with difficult situations (such as with customers, co-workers, etc.).

Take Care of Yourself

You can't be a good employee if you do not take care of yourself.

- Live a healthy lifestyle.
- Get enough sleep.
- Take care of any health issues you may have.
- Just as important is taking care of your emotional health.
 - Schedule time to do the things that you enjoy
 - Spend time with the people you love
 - Don't stop doing the activities you love, work them into your schedule responsibly
 - Reach out to people who care about you: friends, family, mentors, church members, counselors, etc.



Reasons That Could Cause You to Lose Your Job

- Being late
- Being rude
- Breaking the company rules
- Lying
- Using drugs or alcohol on the job
- Not being flexible
- Not showing up
- Stealing
- Being unprofessional (language, dress/hygiene, or sharing too much)
- Badmouthing the company (to other coworkers/on social media)

Leaving a Job on a Good Note

- Generally, you want to give your job advanced warning if you plan to quit, so you can leave on good terms.
- Most employers expect at least a two-week notice, but more can be helpful.
- Be honest and polite when telling your boss why you're leaving.
- Be careful about speaking negatively about former employers or coworkers when you leave a job.
- Doing the above can help you get a good reference from a past employer for future jobs.

For useful tips on how to get a job, download our free "How to Get a Job" tip sheet:

http://labs.umassmed.edu/TransitionsRTC/Resources/publications/Tipsheets_and_Briefs.html



Recommended citation: Northeast Massachusetts Community of Practice (2013) How to Keep a Job: The Young Adults Guide. Worcester, MA: University of Massachusetts Medical School, Department of Psychiatry, Systems and Psychosocial Advances Research Center.

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



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.

The Transitions RTC is part of the Systems & Psychosocial Advances Research Center (SPARC), formerly known as the Center for Mental Health Services Research, A Massachusetts Department of Mental Health Research Center of Excellence



How To Speak Up and Be Heard: Self Advocacy

Community of Practice, Northeast Massachusetts 2014

SELF ADVOCACY IS THE ABILITY TO SPEAK UP FOR YOURSELF AND FOR THE THINGS THAT ARE IMPORTANT TO YOU. AS YOU BECOME OLDER AND TAKE ON MORE RESPONSIBILITIES IN YOUR LIFE,

SELF ADVOCACY HELPS YOU:

- ▶ Get what you need
- ▶ Make your own choices
- ▶ Learn how to say no
- ▶ Express your feelings respectfully

Places to Use Self Advocacy

Putting it Into Words

AT WORK OR SCHOOL

- Adjusting your schedule
- Participating in meetings
- Asking for accommodations
- Requesting tutoring
- During a job interview
- Asking for a raise

• **AT SCHOOL:** E-mail to professor: “I am asking for a week extension for this assignment. I haven’t been feeling well and I fell behind.”

• **AT WORK:** “I can’t work on Sunday, I have a family commitment. Can I work a different shift instead?”

AT HOME

- Managing finances (bills/ roommates)
- Requesting personal space/time
- Renting an apartment
- Sharing food costs
- In a relationship

• **WITH ROOMMATES:** “I have class at 8 A.M. Can you stop playing your music by 10 P.M.?”

• **ARGUMENT WITH A SIGNIFICANT OTHER:** “I need to remove myself from this conversation, could we talk about this later when we are both feeling less angry?”

IN THE COMMUNITY

- Arranging transportation
- Presenting in court
- Making a complaint
- Paying a check

• **AT THE BANK:** “I don’t understand this statement, can you explain the fees to me?”

• **SPLITTING A CHECK:** “I’d love to go out to dinner. Can we split the check?”

AT THE DOCTORS OFFICE

- Making an appointment
- Reviewing a treatment or recovery plan
- Requesting a second opinion
- Asking for clarification

• **AT THE DOCTOR:** “Before we make a final decision, I would like to get a second opinion.”

• **MEDICAL APPOINTMENT:** “The side effects of this medication are bothering me. Can we discuss other options or choices?”

10 Ways to be Heard

1. Ask questions.
2. Listen! Be interested in what the other person is saying.
3. Think before you speak. People listen when you choose your words carefully.
4. Write down your thoughts and/or rehearse what you will say with a friend or in a mirror.
5. Speak to others in the way you want to be spoken to.
6. Know to whom you are talking. For example, friend, grandparent, or boss and use language and tone that they would find respectful.
7. Know when to stop talking and how to exit a conversation politely.
8. Be willing to compromise and be flexible.
9. Using words like “please” and “thank you” go a long way.
10. Do your research. Find out if what you’re asking for is reasonable.

Questions to Ask Yourself

If you are getting ready to advocate for something you need, think about the questions below. You can review your answers with someone you trust. Role-playing the scenario can also help you to figure out exactly what you want to say and how.

1. What am I advocating for? What do I want?

2. Why is it important?

3. How should I make my request?

4. Who do I need to talk to?

5. Who else will this affect?

6. Is there a compromise or another option?

7. What should I do if my request is denied?

For additional information on self advocacy visit these websites:

<http://www.ncwd-youth.info/tip-sheet/becoming-a-self-advocate>,

<http://www.selfadvocacyonline.org/learning/>

SAMHSA Guide on self advocacy: <http://store.samhsa.gov/shin/content/SMA-3719/SMA-3719.pdf>



Download at: http://labs.umassmed.edu/transitionsRTC/Resources/publications/Tipsheets_and_Briefs.html

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Making it Work: Vocational Peer Mentors for Emerging Adults with Serious Mental Health Conditions

Tip Sheet 8

Transitions RTC

April 2014

The Transitions RTC and Thresholds Young Adult Program (YAP) developed a supported employment/education model based on the Individual Placement and Support¹ model (IPS) and added a vocational peer mentor for emerging adults with serious mental health conditions (SMHC). This model is still being developed, but preliminary research has identified several guidelines that could be helpful for others thinking about implementing peer mentors into their vocational services for emerging adults with SMHC.

Tips for Implementing Vocational Peer Mentors for Emerging Adults

Fully Integrate Peer Mentors into Service Team

- Leadership should promote the value of peer mentors in order for the rest of the team to understand and meaningfully integrate the peer mentors into the delivery of vocational services.
- Clearly define the role of the peer mentors in relation to other members of the team.
- Set up mechanisms (e.g. group team meetings) to ensure that the peer mentor is working in collaboration with the team.

Develop Peer Mentors

- Adopt or develop training for peer mentors. We developed a 40-hour training on the IPS model, how the mentor can support vocational goals within IPS, group and individual engagement techniques, and how to tell one's story in an empowering way.
- Provide training and supervision on how to build and maintain strong relational boundaries with mentees, including how to maintain confidentiality.
- Define the role of the peer mentors in relation to the mentees. Partner with organizational leaders to develop clear peer mentor policies and practices.

Support Mentee-Mentor Interactions

- Support in-person community meetings (for example, supply gift cards to coffee shops).
- Provide peer mentors with cell-phone (or reimbursement) & email account.
- Support peer mentor travel costs to meet mentees closer to their work, school, or home.
- Support "off-hours" connections between peer mentors & mentees if necessary.

Support Peer Mentors

- Provide weekly group supervision meetings to manage relational boundaries.
- Help mentors identify when their own mental health issues arise and connect them with supports.
- Continue training based on arising topics (e.g., conflict resolution; self-care; mental health symptoms and treatment).
- Check-in with peer mentors about their own vocational development, struggles, and successes.
- Empower mentors to develop advocacy skills to be used in team meetings, both for themselves and for mentees.

The Model We Developed

WHAT DID WE DO? The Transitions RTC and Thresholds Young Adult Program (YAP) collaborated to adapt the evidence-based Individual Placement and Support (IPS)¹ model of supported employment for 16-21 year olds with serious mental health conditions. This adaptation included the addition of Supported Education services and the addition of near-age vocational peer mentors with similar life experiences (e.g., mental health diagnosis, treatment, and system involvement).

WHO WERE THE PEER MENTORS? Vocational peer mentors were ages 20 to 30 and were either employed, in an education program, or both. “Peer” was defined as having similar life experiences such as mental health diagnoses, treatment experience, and system involvement. The role of the vocational peer mentors was to engage the mentees in vocational services, provide encouragement in vocational pursuits, and coach and model professionalism.

HOW DID THEY “MENTOR?” After being matched with 4-6 mentees, peer mentors met individually with mentees in the community each week. They also participated in vocational groups, a vocational staff team meeting, and clinical supervision. Mentors provided emotional and informational support to the mentee as they pursued their vocational goals. They supported the exploration of jobs, careers, and schools, coached professionalism, and promoted engagement with the education and employment specialists.

WHAT WERE THE CHALLENGES TO ADDING PEER MENTORS TO IPS? Peer mentor turnover was high until older peer mentors (over age 25) were recruited who were further along in their own vocational attainment and who did not maintain the same peer groups as their mentees. Finding mutually available times for peer mentors and mentees to connect proved challenging due to the many school, work, and mental health treatment commitments that both peer mentors and mentees have. Finally, there were some initial struggles to define the peer mentor role and relationship to others on the IPS team.

Perceptions of Peer Mentoring

What did mentees think about peer mentoring as part of IPS?

A survey found that most mentees benefitted from peer mentoring. Mentees valued experiences of trust, feeling understood, and forming a meaningful relationship through talking one-on-one. Valued mentor characteristics included authenticity, flexibility, and being a YAP graduate.

The Value of Vocational Peer Mentors

“[My peer mentor and I] talked about my job and how important it was that I keep it...but it was also a bond.”

“[My peer mentor] understands where I am coming from and I understand where she is coming from.”

“[My peer mentor] didn’t look at me differently...she didn’t put on a phony act.”

¹Bond, G. R. (2004). Supported employment: Evidence for an evidence-based practice. *Psychiatric Rehabilitation Journal*, 27(4): 345-359.



THRESHOLDS

For more information, contact: Marc Fagan (Marc.Fagan@thresholds.org) or Marsha Ellison (Marsha.Ellison@Umassmed.edu)

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Telling Your Money What to Do: The Young Adult's Guide

Community of Practice, Northeast Massachusetts 2013

Has it ever felt like your money, or the lack of it, is telling you what you can or can not do? If you take control of your money and spending, you can find ways to do more with what you have. This sheet provides tips on how this can be done.

Top Money Tips

Tell your money what to do by following these tips.

- ✓ **Track your money** for one or two weeks to see where your money is going – then develop a basic budget to set goals on spending. You can use the one on this tip sheet.
- ✓ **Monitor your checking account** and make sure you understand your bank's policy on overdrafts. Fines for overdrafts can be costly. You may need a savings account to prevent overdraft fees. You can also ask the bank to deny charges that overdraws your account.
- ✓ **Fees and interest on credit cards** can add up. To avoid this, pay as much of your bills as you can each month.
- ✓ **Emergency funds** can save you if you have a car breakdown, unexpected medical expenses, a traffic ticket, etc.
- ✓ **Start Saving**, 5 to 10% per paycheck is a great start.
- ✓ **Eating out**, though convenient, is VERY expensive – cooking at home can save you a lot of money.
- ✓ **Smoking, drinking and drugs** add up and are expensive. Make sure to include them in your budget.
- ✓ **Borrowing money** from friends or family can add stress to your relationships. If you have to borrow money you may want to put yourself on a payment plan to pay it back.
- ✓ **Lending money** can also add stress to your relationships. Family and friends have financial stress too, so they may not be able to pay it back.

It All Adds Up

One meal out may not seem like much, but if you look at costs over time you see how much it takes from your wallet.

SPENDING

	Average Cost per Item	Average Cost per Week	Average Cost per Month
Energy drinks	\$2.50	$7 \times \$2.50 = \17.50	\$75
Daily Coffee	\$2.00	$7 \times \$2.00 = \14	\$60
Cigarettes	\$6.25	$4 \times \$6.25 = \25	\$100+
Eating Out	\$7.00	$2 \times \$7.00 = \14	\$60
Taxi Rides	\$10	$1 \times \$10 = \$10/\text{week}$	\$40
Cat	---	---	\$60
Dog	---	---	\$100

A little bit of savings also adds up over time.

SAVINGS

Average Savings per Week	Average Savings per Month	Average Savings per Year
\$5.00	\$20.00	\$260.00
\$10.00	\$40.00	\$520.00
\$25.00	\$100.00	\$1,300.00

Starting a Budget

The **First Things** to put in your budget are necessities, the costs you can't do without:

- Housing (rent, etc.)
- Utilities (gas, electric)
- Transportation (car payment, gas, repairs, tolls, bus/train fare or pass)
- Groceries/food
- Medical bills/ prescriptions and doctors
- Education and/or work expenses (books, uniforms, tuition)
- Communications (phone, internet, cable)
- Other debts or installment payments (student loans, credit card)

Do You Want to Cut Down on Your Spending?

Here are some smart strategies:

- If you are paid every week and you make \$100/wk and put 10% into savings with every paycheck you will have \$520 at the end of the year!
- Shop for clothes and furniture at consignment and second-hand stores. If you like designer clothes you can still find the brand name and styles you like.
- If you rely on Social Security and Medicaid you may be entitled to discounts for phone, cable and heat.
- If you have a disability, check your local transit to see if you can get discounted rates for public transportation. For example: in Massachusetts on the MBTA you can save \$4 on an \$8 fare.
- When shopping for groceries look for deals and if possible stock up and buy less the following week.
- Get a free checking and/or savings account. With many banks if you have a check direct deposited at least monthly the account is free. Many check cashing places charge a high fee which is money that could be yours.
- Use coupons – look online and in the newspaper for food, clothes, music, etc.
- Go to yard sales - Craigslist has listings for your local community.

Managing Money Resources

Here are some resources or strategies to help manage your money:

Apps: Mint – helps to organize spending and bills; ShopSavvy and RedLaser – Compare prices scanning bar codes; GasBuddy – find the cheapest gas in the area; RetailMeNot – coupon finder.

Websites: www.mint.com – organize bills and accounts www.bankrate.com - calculators www.coupons.com - coupons

Calculators: Use both the one on your phone and consider using calculators available on www.bankrate.com.

The Envelope System: Each time you get paid, divide your money into areas of spending: food, gas, clothing, entertainment, etc. Then create an envelope for each category. No need to be fancy; a plain, white envelope with the category written on the front will do. Try the Easy Envelope Budget Aid App.



Download at: http://labs.umassmed.edu/transitionsRTC/Resources/publications/Tipsheets_and_Briefs.html

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To Tell Your Money What to Do: Track Your Income & Spending!

Track daily expenses using an app on your phone or a daily log and then enter totals on this monthly budget sheet. This will give you a picture of how you are spending your money on a monthly basis. Does your income match your expenses? Where are places you can cut down?

MONTHLY INCOME

Monthly Income:

Social Security: _____
TAFDC (welfare): _____

Weekly Income:

Paycheck 1st Week: _____
Paycheck 2nd Week: _____
Paycheck 3rd Week: _____
Paycheck 4th Week: _____
Paycheck 5th Week: _____
(some months have 1 extra pay period)

Additional Income:

Add all lines for

TOTAL MONTHLY INCOME:

ACTUAL MONTHLY SPENDING

Transportation:

Car Payment _____
Gas _____
Insurance _____
Repairs _____
Car Fees _____
Bus Pass/Fees _____
Train Pass/Fees _____
Taxi Fares _____

Child Expenses:

Baby-sitting _____
Child Support _____
Diapers/Formula _____
Clothing _____
Medical Expenses _____

Housing & Utilities:

Rent _____
Gas _____
Electric _____
Phone _____
Cable _____
Internet _____
Cleaning Supplies _____
Household Goods _____

Medical:

Prescriptions _____
Co-payments _____
Over the counter medications _____

Food (don't forget energy drinks):

Groceries _____
Eating Meals Out _____
Coffee/Drinks Out _____

Recreation:

Sports _____
Video Games _____
Computer Games _____
Gaming Fees _____
Drinks/Alcohol _____
Cigarettes _____
Movies _____
Lottery _____

Personal Care:

Work clothing _____
Laundry _____
Haircuts _____
Personal Products _____
Clothing _____
Manicures _____

Gifts:

Birthdays _____
Holidays _____

Debt:

Loan _____
Credit Card _____
Credit Card _____
Other _____

Savings:

Giving/Donations:

Faith Community _____
Other _____

Miscellaneous:

TOTAL MONTHLY SPENDING:



Set Goals for Your Spending!

Set goals for how to adjust spending habits.

Do Income and Spending Match?

Compare your monthly income to actual expenditures. Are you spending more than you take in? Are there places you can cut down so you can better meet expenses? Set your new spending goals in the chart below.

TOTAL MONTHLY INCOME:

ACTUAL MONTHLY SPENDING:

MONTHLY SPENDING GOALS

Transportation:

Car Payment _____
 Gas _____
 Insurance _____
 Repairs _____
 Car Fees _____
 Bus Pass/Fees _____
 Train Pass/Fees _____
 Taxi Fares _____

Child Expenses:

Baby-sitting _____
 Child Support _____
 Diapers/Formula _____
 Clothing _____
 Medical Expenses _____

Housing & Utilities:

Rent _____
 Gas _____
 Electric _____
 Phone _____
 Cable _____
 Internet _____
 Cleaning Supplies _____
 Household Goods _____

Medical:

Prescriptions _____
 Co-payments _____
 Over the counter medications _____

Food (don't forget energy drinks):

Groceries _____
 Eating Meals Out _____
 Coffee/Drinks Out _____

Recreation:

Sports _____
 Video Games _____
 Computer Games _____
 Gaming Fees _____
 Drinks/Alcohol _____
 Cigarettes _____
 Movies _____
 Lottery _____

Personal Care:

Work clothing _____
 Laundry _____
 Haircuts _____
 Personal Products _____
 Clothing _____
 Manicures _____

Gifts:

Birthdays _____
 Holidays _____

Debt:

Loan _____
 Credit Card _____
 Credit Card _____
 Other _____

Savings:

Giving/Donations:

Faith Community _____
 Other _____

Miscellaneous:

MONTHLY SPENDING GOALS:

Appendix C

New SPARC Publications

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