Bridging the Transition Cliff: Building Effective Services for Transition-Age Youth Diagnosed with Serious Mental Health Conditions
WHO ARE WE?

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Youth & Young Adult Services

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Program Director
Emerge and MindStrong programs
WHO ARE YOU?

Settings?

Role?

Working with TAY?
OUR GOALS FOR TODAY

• Identify developmentally-specific needs of Transition Age Youth (TAY)

• Describe two best-practice approaches:
  • TIP (Transition to Independence Process) for mental health treatment for Transition Age Youth
  • CSC (Coordinated Specialty Care) for recent onset of psychosis

• Introduce Thresholds Emerge and MindStrong models, which integrate & adapt these approaches

• Examine the lessons learned through implementation thus far
“Transition Age Youth”
“Emerging Adulthood”

Adolescence

Early Adulthood

16-24ish Transition Age Youth

18-29ish Emerging Adulthood

www.jeffreyarnett.com
THRESHOLDS EMERGING ADULT PROGRAMS SERVE:

**Emerge:** 17-26 y/o with SMHC

**MindStrong:** 14-40 y/o, within 18 months of first episode of psychosis

*So far: 14-28 y/o*

*Mean Age = 20-21 y/o*
"GRADUAL" TRANSITION

Social Support

Social Demands

Independence

Dependence

Pre-frontal cortex not fully functioning until mid-20s!

Official “Adulthood”
1. Take responsibility for self
2. Make independent decisions
3. Become financially independent

Arnett, 2000
of serious mental health conditions develop in people before age 24.

Including: Schizophrenia, Bipolar Disorder, & Major Depressive Disorder
18-25 Year Olds...

(Compared to middle-aged & older adults)

...have the **HIGHEST** rates of serious mental health conditions

...& the **LOWEST** rates of mental health service use
WHY? SOME REASONS...

- **IDENTITY**: What does all this mean about me?
- **STIGMA**: Worry about impact on social status, peer relationships
- **EXECUTIVE FX**: Not yet good at planning, in combination with....
- **LESS SOCIAL SUPPORT**: No one “makes you”
- **Mental Health Condition itself** (Paranoia? Mania? Depression? Anxiety?) → confusion about who to trust, less ability to follow through; not yet developed coping or compensation skills
WHY TAY-SPECIFIC TRANSITION SERVICES ARE NEEDED:

Child Systems  
(0 to 18 years)  
Depending on state & system: 0-16, 0-21, 0-24

Adult Systems  
(18+ years)  
Depending on state & system: 16+, 21+, 24+
WHY TAY-SPECIFIC TRANSITION SERVICES ARE NEEDED:

**Child Services**
- Appealing to kids
- Family-oriented
- Less voluntary
- "doing for"
- Communication between systems
- More sources of $

**Adult Services**
- Appealing to adults
- Individual-oriented
- Voluntary
- "cheering on"
- Communication between systems
- Fewer sources of $
WHAT TRANSITION CAN **REALLY** BE LIKE:

Child Systems

Adult Systems
ADULT SERVICES

Adult

- Recovery-oriented
- Person-centered
- Community-based
- Multi-disciplinary teams
- Integrated (physical & mental health)
- Supported housing
- Supported employment
- Peer-provided services
TAY VS. ADULT
COMMUNITY-BASED SERVICES

TAY
- Discovery-oriented
- Individualized and...
- Partner with young people & their self-identified family
- Multidisciplinary teams trained in TIP
- Integration of supported employment & education & non-traditional therapies
- Transitional housing?
- Developing peer support and connections
- Youth-friendly engagement techniques

Adult
- Recovery-oriented
- Person-centered
- Multi-disciplinary teams
- Integrated (physical & mental health)
- Supported employment
- Supported housing
- Peer-provided services
WHAT IS THE TRANSITION INTO INDEPENDENCE PROCESS (TIP)?

- Engagement/Strength Discovery
- Tailor services
- Develop personal choice and responsibility with young people.
- Experiential learning “In Vivo”
- Futures Planning
- Involve young people, parents, and other community partners

www.TIPStars.org
**KEY EMERGE (TAY) PRACTICES**

- Lengthy engagement phase & creative engagement strategies
- Flexibility: home, community & clinic-based
- Using technology: texting & social media
- Individualized approach toward goal development and service delivery with coaching around self-determination
- Including TAY-chosen family (e.g. romantic partners, & friends)
- Assigned primary team (vs total team approach)
- Social activities
- Youth-friendly Employment and Education Specialists linking with developmentally appropriate experiences (modified IPS)
- Therapist embedded in team, therapy in home or community
EMERGE MODEL
TRANSITION COACHES

- Peer Support Services (CRSS)
- Supported Employment & Education
- Psychiatry (youth & young adult specialty)
- Therapy (art & trauma)
- Peer Ambassador (soon)
- Community Support or transition facilitators

Transition Age Youth

Thresholds
HOME | HEALTH | HOPE
TRANSITION AGE ONSET OF SCHIZOPHRENIA-SPECTRUM PSYCHOSIS

Schizophrenia: 75% onset between 16-25
    average (median) = 23
Males: 16 – 25 y/o,
    average age = 18
Females: later and more after 30
    average age = 25
Treatment is often delayed after onset

The average delay between a psychotic first break & treatment.¹

74 Wks.

The average delay between symptom onset & treatment across all diagnoses.²

10 yrs.

The **longer** an individual & their family go without treatment after the onset of psychosis, the **worse** the prognosis.

**Early Intervention works.**

- Early detection
- Aggressive treatment in critical period

= Improved Outcomes
WHAT IS COORDINATED SPECIALTY CARE?
CSC Across the World

- 1988: EPPIC
- Late 90s/Early 2000s: OPUS, TIPS
- 2000: PIER
- 2001: NAPLS
- 2004: IRIS
- 2005: OASIS
- 2007: FIRST
- 2007: CA Prop 63 Passes; PREP
- 2007: RAISE: NAVIGATE & Connections (OnTrackNY)
- 2007: FIRST
- 2004: IRIS
- 2001: EAST; 2007: EASA
- 2005: OASIS
- Late 90s/Early 2000s: OPUS, TIPS

1988
- EPPIC
- 2006
- Orygen

1990s
- NAPLS

2000s
- PIER
- IRIS
- OASIS

2010
- RAISE: NAVIGATE & Connections (OnTrackNY)
CSC TREATMENT COMPONENTS

Multidisciplinary Team Approach:

• Community education and outreach
• Specialized clinical intervention (Individual Resiliency Training, CBT-P, other)
• Specialized psychopharmacology
• Family psychoeducation and support (individual families, multi-family groups)
• Supported Employment & Education
CSC TREATMENT COMPONENTS

Possible additional components:

• Peer support
• Occupational Therapy
• Case Management
• Cognitive Remediation
• Other....
WHAT IS FIRST.IL?

A comprehensive, team-based treatment program aimed at improving the mental health and quality of life for individuals who have experienced a first episode of a psychotic illness

- promotes early identification
- provides best treatment practices as soon as possible

A partnership of

- community mental health agencies
- IDHS Division of Mental Health
- Northern Illinois University
- Best Practices in Schizophrenia Treatment (BeST) Center at Northeast Ohio Medical University (NEOMED)
MINDSTRONG MISSION

Our mission is to change the life course of young people experiencing first-episode psychosis through multi-disciplinary evidence-based treatment.

MINDSTRONG ELIGIBILITY

- Target age of 14 to 40 years old
- Experiencing psychosis for first time within the last 18 months
- Most commercial insurances, Medicaid & private pay accepted

www.thresholds.org/mindstrong/
MINDSTRONG
MODEL

Total Team Approach

- Psychiatry & Medication Management
- Individual Resiliency Training
- Care Coordination
- Family Education & Support
- Supported Employment & Education
- Community Education
- Peer support (soon)
- Multi-family Groups
EVALUATION & QUALITY IMPROVEMENT

- **Partnerships & Alliance with Experts (Community-based & University-based):**
  - Align evaluation design with others & share knowledge widely
  - Alliances contribute to staff training, new service element integration & referrals

- **Program Evaluation: Define, Measure, & Summarize “Outcomes”**
  - Program evaluation design & benchmarks defined through literature review & stakeholder input
  - Includes both Process Outcomes (e.g., cost, fidelity, service use, satisfaction) & Client Outcomes (e.g., health, hospitalizations, vocational attainment) collected through both self and clinician report
EVALUATION & QUALITY IMPROVEMENT

- Dashboard Developed with data summaries in diagram form in order to review outcomes in real time

- **Continuous Quality Improvement:** Measurement is one part of process
  - Multidisciplinary team approach (i.e., quality, research, evaluation, & training) to engage teams in CQI process
  - Team uses Plan, Do, Study, Act (PDSA) Process to identify areas of improvement, coach around team-based practice and system-changes, & measure & summarize changes.
ENGAGEMENT

- 61% always or usually kept scheduled appointments in FY17.
- 70% were always or usually engaged during appointments in FY17.
- Engagement increases based on time enrolled*:

<table>
<thead>
<tr>
<th>Time Enrolled</th>
<th>Always or Usually Engaged</th>
<th>Always or Usually Keeps Appointments</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 mon or less (n=12)</td>
<td>36%</td>
<td>21%</td>
</tr>
<tr>
<td>13-24 mon (n=9)</td>
<td>89%</td>
<td>78%</td>
</tr>
<tr>
<td>25+ mon (n=19)</td>
<td>89%</td>
<td>79%</td>
</tr>
</tbody>
</table>

FINANCIAL STABILITY

Financial stability & goal progress increases with time enrolled.*

<table>
<thead>
<tr>
<th>Time Enrolled</th>
<th>Made Individualized Goal Progress</th>
<th>Achieved Financial Stability</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 mon or less (n=12)</td>
<td>57%</td>
<td>50%</td>
</tr>
<tr>
<td>13-24 mon (n=9)</td>
<td>89%</td>
<td>78%</td>
</tr>
<tr>
<td>25+ mon (n=19)</td>
<td>89%</td>
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* Based on FY17Q3

82% maintained or increased housing stability.
- 48% lived with family; 31% in own apartment; 8% with friends or romantic partners; 8% in group or nursing home.
- 5% experienced homelessness (streets/shelters) during FY17 (all within 6 months of Emerge enrollment or less).

67% made vocational progress through:
- Educational Program Enrollment
- Securing Competitive Employment
- Completing an internship through new CORE program
- Engagement in IPS Supported Employment &/or Education

77% avoided psychiatric hospitalization.
- Majority who experienced hospitalization were enrolled less than 6 months.
- Only three experienced more than 1 psychiatric hospitalization during FY17; subsequent stays were for shorter durations.
EMERGE LESSONS LEARNED: IMPLEMENTATION CHALLENGES

**Challenge:** Fee-for-service billing; TAY require longer engagement period; TAY disappear and reappear

**Adaptations:** Productivity offsets ($ not enough)
- Smaller catchment area than initially
- Managing/mapping catchments

**Challenge:** Housing instability and transience

**Adaptations:** Some flexibility in catchment esp. if TAY will travel
- Relationships with SROs, informal key players
- Roommate pairings

**Challenge:** TAY often don’t have Medicaid yet (required for CST)

**Adaptations:** Medicaid-eligibility only required for enrollment; team assists with Medicaid application
**EMERGE LESSONS LEARNED:**

**IMPLEMENTATION CHALLENGES**

**Challenges:** TAY don’t engage in traditional practices (group, individual), and lack social skills; CST requires 2X/week

**Adaptations:** Large social activities prescheduled through year

- Smaller targeted activities for 2-5 TAY work well
- Volunteering in community with group works well
- Brief check ins (phone) with staff are effective

“Skill share group” currently beginning

**Challenge:** Transportation is a challenge for all services

**Adaptations:** Budgeted $ for transportation, staff need to account for travel time to get TAY to group activities

**Challenge:** TAY often don’t have Medicaid yet (required for CST)

**Adaptations:** Medicaid-eligibility only required for enrollment; team assists with Medicaid application
EMERGE LESSONS LEARNED: IMPLEMENTATION CHALLENGES

Challenges: High crisis, and potential for aggression → safety concerns

Adaptations: Trained staff in portions of Therapeutic Crisis Intervention (TCI)

Create solid crisis plan during intake process

Created mechanism for immediate consult with team

Challenge: Eligibility in relation to Level of Care

Adaptations: “Sweet spot”: take those eligible for CSI or ACT unless very low need, or very high (e.g. need nursing availability)

Challenge: Eligibility in relation to age range

Adaptations: Case-by-case decisions regarding when TAY should “age out” to adult services, based on individual needs

Differences between Medicaid-based CST team and new team (Medicaid or commercial insurance)
EMERGE ADDITIONAL ONGOING CHALLENGES

- Success in program (seems to) correlate with pathway to involvement; those with “system” involvement/history of placement struggle more.
  → to collect data, design differential interventions
- Parents need help to be engaged effectively
  → borrow “family education” lessons from MindStrong work
- Integration with substance use treatment needed

- Ongoing challenges with funding sources and requirements, affect eligible age range and other aspects of model
- Ongoing challenges with limitations of psychiatry, therapist, Employment/Education Specialist time
- Ongoing challenges with housing options
- Risk Tolerance!!
MINDSTRONG
LESSONS LEARNED SO FAR

- **Safety needs to be addressed early on**
  - creating a crisis management plan from the beginning

- **Families need a LOT!**
  - Multi Family Groups help to provide psychoeducation efficiently, and also creates opportunity for mutual support

- **Most TAY do not identify with having “psychosis”; many don’t want “therapy”; many additional therapeutic needs not addressed by model**
  - We are needing to borrow from different models, change language used in IRT, psychoeducation
MINDSTRONG CURRENT CHALLENGES

- MFGs/psycheducation is beginning, not end, of family needs → need a robust array of service options, clarification of boundaries of this service, possible external referrals

- Peer model: Who is an appropriate peer? (Age? Lived experience of psychosis?) How can peers be best utilized? Stay tuned!!

- Substance use is an issue for the vast majority of youth - → need more robust services targeting this aspect

- Financial viability? Stay tuned on this too!!
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