Healthy Transitions
INITIATIVE

IMPACT AT THE LOCAL COMMUNITY LEVEL

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Introduction

Youth and young adults with serious mental health conditions have some of the poorest outcomes among young people with disabilities. Challenges related to having a mental health condition can disrupt a young person's development during this period of life; in addition, the services that are generally available for this population have been developed either for children or older adults and have not been modified to match young people's needs and preferences. In 2009, the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) funded the Healthy Transition Initiative (HTI). Seven states (Georgia, Maine, Maryland, Missouri, Oklahoma, Utah, and Wisconsin) were awarded funds to identify and implement evidence-based models for service delivery to young adults with serious mental health challenges in at least one local implementation community. Other goals of the HTI initiative were to: 1) bring together relevant stakeholders at both community and state levels; 2) identify system level issues and set in place action plans to effect change to state and local policies; and 3) involve young adults and their families in the process. This issue brief describes the impact of the HTI grant funds at the local community level, with special emphasis on practice improvements. The brief highlights and summarizes data collected from each of ten communities (some HTI jurisdictions had more than one local implementation community), followed by a description of examples of practice change or local organizational change.

Community Support for Transition Inventory (CSTI)

The data presented were collected using the Community Support for Transition Inventory (CSTI), a web-based tool developed by the Research and Training Center on Pathways to Positive Futures (Pathways RTC), at Portland State University, and made available for use by the HTI jurisdictions. The CSTI was designed to serve as a guide to help communities understand both what they are aiming for—sustainable capacity to provide effective, comprehensive support for young people with serious mental health conditions—and how much progress they have made in achieving that goal. The CSTI provides scores on eight themes measured by 45 items. Participants respond to each item on a 5-point scale from "fully developed" to "least developed." A higher score indicates a more fully functioning aspect of the system.
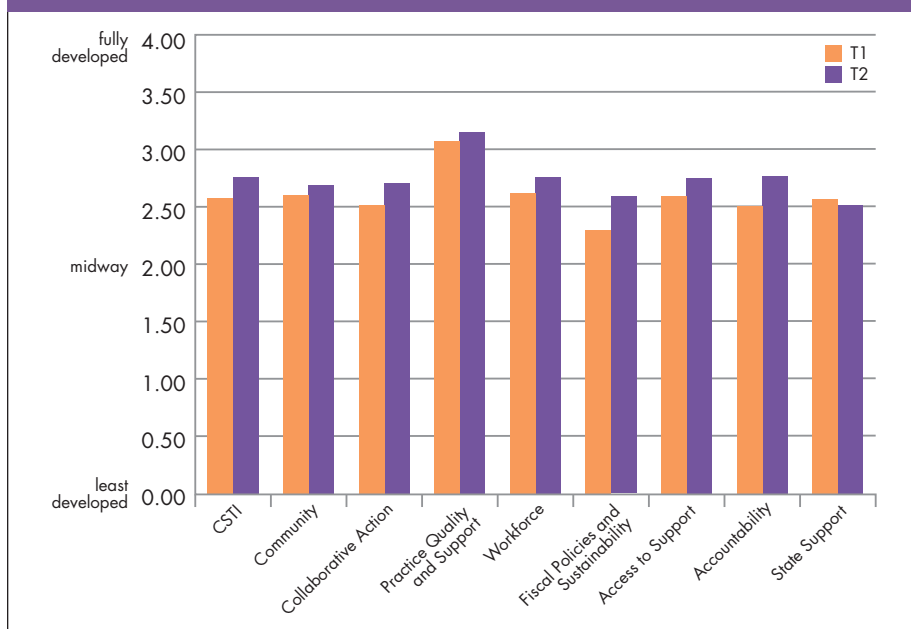
The data from the CSTI were collected from HTI stakeholders at 10 local communities at two points in time. Time 1 (T1) data collection occurred when local implementation was just getting underway and Time 2 (T2) data collection occurred late in the fourth year of the project. Potential respondents to the CSTI were identified locally, and the number varied by the size of the

community and to some extent on how much development had already taken place. On average, the initial lists of respondents for HTI communities were between 15 to 25 individuals. Response rates ranged between 31% and 97% for the CSTI. For more information about the CSTI see Walker, Koroloff & Mehess, (under review).

The first table displays the means for all communities combined and is reported for the overall CSTI score and for the eight themes. On average, respondents rated their community more than midway to being fully developed. The average ratings on each theme moved in a positive direction between T1 and T2 with the exception of scores on state support.

The next table shows where statistically significant changes occurred between T1 and T2 in each community. When all community scores were combined, a trend in a positive direction was found on two themes, *fiscal policy* and *sustainability and accountability*. Individual communities exhibited different patterns of significance. Two communities reported significant positive change on the overall CSTI scores and six or seven of the eight themes (communities B and E1). Four more communities showed significant positive change over time on four or five of the eight themes.

What Made the Most Difference?

The leaders from state and local HTI jurisdictions were asked to identify one or two activities over the past five years that had the greatest impact on local services or practice.

Increased visibility and awareness of needs and preference of young adults. These factors emerged as the most important impacts. The existence of the HTI project brought attention to the unique needs of young adults, especially to the need for supports around education and employment. Respondents reported more community awareness, greater recognition, and greater commitment to working on identified issues. Social marketing was key, even though it wasn't a requirement of the grant.

Clear practice model. Most communities reported that adopting a specific practice model helped to focus and improve their services. The Transition to Independence (TIP) model was most frequently mentioned; both Maine and Missouri have certified TIP trainers. Other practice models including Project

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TABLE 1: CSTI MEAN AND THEME MEANS: ALL COMMUNITIES COMBINED

TABLE 2: COMMUNITY-LEVEL (CSTI) CHANGE FROM T1 TO T2

Site	All	A	B	C1	C2	D	E1	E2	F1	F2	G
CSTI			++++	++	+		++++	+			+++
Community Partnership			+++				+++				
Collaborative Action			++++		++		++++	+	+		++
Practice Quality and Support				+			++		-		
Workforce			++++	+			++++	++	----		+++
Fiscal Policies and Sustainability	+		++++	++	++		++++	++	--	+	++++
Access to Supports and Services			++++	+	+		+++	+			+++
Accountability	+	++	+++	+++	++	+	++++	+		++	+++
State Support						-	----				

'+' indicates that the T1 to T2 change was positive.
"–" indicates that the change was negative.
$p < .1$ + or - (trend level); $p < .05$ ++ or --; $p < .01$ +++ or ---; $p < .001$ ++++ or ----

RECONNECT and Wraparound were also noted. Wisconsin has created a unique practice model, based on the values and beliefs of Wraparound. Their practice model has been expanded to better fit the needs of young adults. Young people get to choose the services they need, and the model includes an explicit phase for engagement. Oklahoma mentioned changes to smaller team size for wraparound and the introduction of more flexibility into the model. Several communities reported changes to include more emphasis on promoting young people's choice and voice within services and assisting them in developing life skills and future plans.

Other actions at the practice level that adapted the service system included an increase in peer-to-peer supports, increased attention to and support of youth leadership, and an increased collaboration between child and adult mental health agencies, as well as between mental health and other agencies, particularly employment, education, and vocational rehabilitation.

Examples of Changes in Practice

The following are some specific examples of action that have changed the shape of practice and the ways agencies work with older adolescents and young adults in the HTI communities.

- Both Utah and Maryland have developed ongoing positions for supported employment specialists on local teams. Utah has added a supported education specialist in one community. Both have established a position for a young person with lived mental health experiences to coordinate youth development activities at the state level.

- Maine worked with an interagency committee to develop Standard Operating Procedures for services to youth and young adults with serious mental health concerns. In that state, tracking young people who are referred and ensuring that the referral process is completed is the responsibility of the HTI project's Operations Coordinator. Oklahoma instituted best practice standards of care and developed a related outcome instrument. Both are used statewide.

- Missouri developed procedures that allow 16 and 17 year olds to consent to their own treatment and to joint meetings with their caseworker/team leader and vocational rehabilitation (VR) counselor. This arrangement has reduced the time it takes to open a case with VR. Missouri has also developed common practice guidelines with other agencies and changed agency intake and assessment procedures to better fit the special needs of young people.

- Both Georgia and Maryland developed a written policy that would allow staff to use their smart phones to text with young adults where previously this had been forbidden. This local policy change allows for more communication and better engagement between young adults and providers.

- Wisconsin has expanded the utilization of peer supports in their programs. They created three different positions for peer support, located at Owen's Place, a clubhouse-like facility that serves as the front end to engagement in HTI.

- Utah and Georgia worked out modified guidelines for using flexible funds. In Georgia, flexible funds were utilized to meet educational needs of participants and help them prepare for employment. In Oklahoma, a transition housing subsidy was developed and is available to participants in the HTI program and in System of Care sites. Young people continue to have access to housing after they graduate from the HTI program.

- Maryland has blended youth and young adult voice into its programs by establishing a separate organization to support leadership development. Young adults lead their own meetings every two weeks and choose the activities they want to pursue as a group. As a result they are more active in directing their own plans and teams. Integral to this practice change is that staff are trained to solicit and use youth input.

- Georgia has expanded its use of apprenticeships and volunteering as a gateway to employment opportunities for youth and young adults. For example, a young adult worked as an apprentice in a barbershop before obtaining employment with the company.

For more information about each of these policy or structural changes, go to the HTI Tool Kit at http://www.pathwaysrtc.pdx.edu/ HTItoolkit.

Reference

Walker, J.S., Koroloff, N. and Mehess, S.J. (under review) *Community and state systems change associated with the Healthy Transitions Initiative*. Submitted to *Journal of Behavioral Health Services & Research*.