Improving Life Trajectories: Outcomes from the Rhode Island Healthy Transitions Project

The transition from adolescence to adulthood is a challenging developmental period for many individuals and is significantly more so for those with serious emotional disturbance. Youth and young adults with serious emotional disturbance often struggle with adult roles and responsibilities (e.g., educational attainment, employment, housing).[1] With the continuity of care across child and adult institutions often lacking, many of these individuals lose access to important services and supports once they age out of the child mental health system and legally enter adulthood.[1] As a result, treatment and support services that effectively meet the unique needs of this population are critically necessary.

In 2015, the state of Rhode Island implemented the Healthy Transitions Project (RI HT) with support from the Substance Abuse and Mental Health Services Administration (SAMHSA) to address the needs of youth and young adults ages 16–25 with serious emotional disturbance, severe mental illness, and/or co-occurring substance use disorders. Utilizing a multidisciplinary and community-based approach, RI HT seeks to improve the behavioral health of transition-aged youth, including youth on the cusp of aging out of the child behavioral health system, to help them lead healthy and productive lives as adults.

RI HT was modeled after an evidence-based Coordinated Specialty Care (CSC) model developed and used throughout New York for transition-aged youth with first episode psychosis (FEP; see https://www.ontrackny.org, accessed 03-26-19). This CSC model uses a multidisciplinary team approach including health professionals, specialty care providers, youth and their family members working together to reach a youth's recovery goals. Each team consists of 6–8 behavioral health providers who fill the following roles: Team Leader, Clinician/Psychotherapist, Psychiatrist, Nurse, Supported Employment and Education Specialist, Case Manager, and Recovery Coach. Treatment decision making is shared among team members, and an individualized treatment plan is developed to reflect the youth's own goals and preferences. The CSC model emphasizes outreach and engagement, and interventions typically last for two years. Wraparound services including individual and group therapy, medication management, employment and education services, intensive case management, recovery skills, suicide prevention, peer support, and family education and support are available to all participants. RI HT expanded this model to include: youth and young adults with FEP as well as other serious mental and emotional disorders, and a systematic method of tracking model fidelity across 28 indicators (e.g., maintaining staffing levels, family involvement) using electronic health records.

The state of Rhode Island partnered with two community mental health centers (CMHCs) to pilot the RI HT project. Transition-aged youth were screened in the community at a variety of locations/agencies with

connections to the participating CMHCs, such as physicians' offices and schools. Youth who screened positive were then referred to one of the CMHCs for an RI HT assessment. Those found to meet diagnostic criteria (e.g., major depression, bipolar disorder, FEP), disability criteria, and traumatic experiences criteria were offered RI HT clinical services. Preliminary outcomes were evaluated using Center for Substance Abuse Treatment (CSAT) Government Performance and Results Act (GPRA) Client Outcomes Measure for Discretionary Programs[2] data collected from 102 participants. Interviews were conducted at intake into the program and again six months later. The average age of participants was 20.8 years old. Most participants identified as White (81.4%), non-Hispanic (83.5%), and heterosexual (66.7%). Almost half of participants (49.0%) identified as male. Regarding participants' clinical presentation at intake, 29.6% reported feeling depressed most or all of the time, 74.3% reported feeling nervous all or most of the time, and 52.1% reported feeling hopeless and worthless most or all of the time. Furthermore, 51.0% reported having attempted suicide in their lifetime and 77.4% endorsed a history of trauma. Substance use was common among participants. At intake, 45.5% of participants reported alcohol use in the past 30 days, of whom 51.2% reported binge drinking at least once in the past 30 days; 40.4% reported marijuana use in the past 30 days, of whom 42.9% reported using marijuana daily; and 22.0% reported illicit drug use in the past 30 days (not including marijuana). Model fidelity was met on 68% of criteria.

Compared to intake, at 6-month follow-up assessment, youth reported significantly better functioning in social situations, feeling significantly less bothered by their symptoms, being significantly more in control of their lives, and significantly better functioning in school and/or work. Additionally, as compared to intake, at the 6-month follow-up assessment significantly fewer youth reported having spent a night in the hospital for mental health care in the past 30 days (9.3% vs 27.6% at intake); and significantly fewer participants reported having gone to an emergency room for a psychiatric or emotional problem in the past 30 days (7.1% vs. 24.6% at intake).

No differences were found from intake to 6-month follow-up assessment for participants in their reported social connectedness, substance use, or relationships with family members. This may result, in part, from the shared decision making that occurs as part of the CSC model. For example, the treatment team may not initially focus on substance use until more buy-in is obtained from the youth. In addition, it may take longer to effect change in some outcomes. For example, although youth reported improved social functioning, it may take longer to feel more connection to others. Unexpectedly, participants reported feeling depressed significantly more often at 6-month follow-up assessment compared to intake. It may be that engaging in treatment is a difficult process, and that feeling some dysphoria is to be expected, at least initially.[3]

Overall, participants reported having positive perceptions of the care they received. A large majority of participants agreed or strongly agreed that: staff believed participants can grow, change, and recover (80%); staff encouraged participants to take responsibility for how they live their lives (79.8%); staff respected participants' wishes about who is and who is not given information about their treatment (84.2%); staff were sensitive to participants' cultural background (77.9%); staff helped participants obtain information needed to take charge

of managing their illness (76.8%); and participants, not staff, decided on treatment goals (79.8%).

Preliminary results of the program evaluation are promising and suggest RI HT has demonstrated some success in improving the mental health and well-being of transition-aged youth with serious mental health concerns. Furthermore, youth reported feeling respected and empowered by the treatment model. These findings are consistent with recent research[4] and provide additional support for the effectiveness of using a CSC model to address serious mental health concerns, including FEP among transition-aged youth. More research is needed to determine program outcomes for participants over longer follow-up periods (e.g. 12 months, 18 months) and to identify participants for which RI HT may be most effective.

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