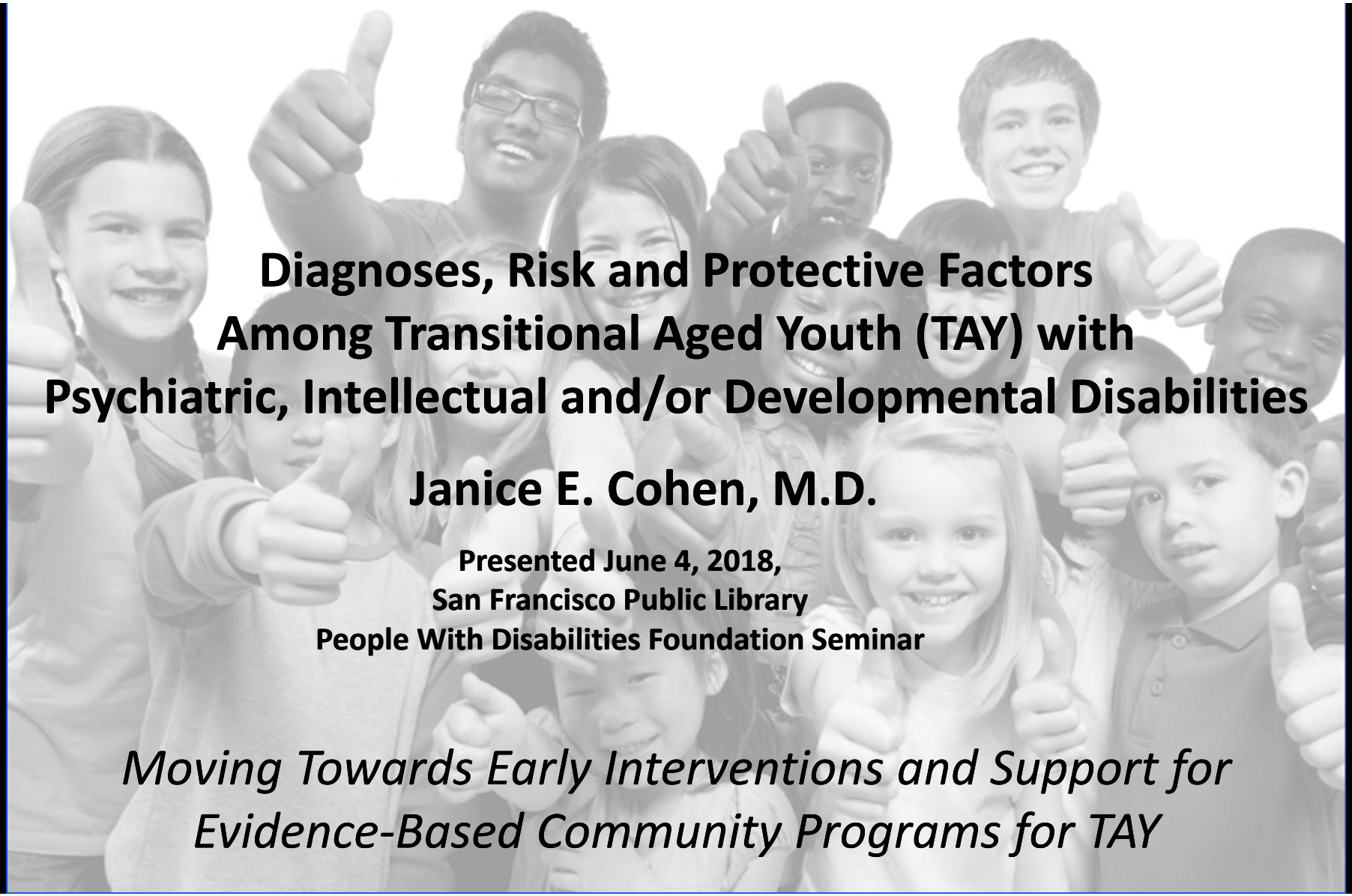


Diagnoses, Risk and Protective Factors Among Transitional Aged Youth (TAY) with Psychiatric, Intellectual and/or Developmental Disabilities

Janice E. Cohen, M.D.

Presented June 4, 2018,
San Francisco Public Library
People With Disabilities Foundation Seminar

Moving Towards Early Interventions and Support for Evidence-Based Community Programs for TAY

What Do We Know About the Causes of Mental Illness?

Most Mental Illnesses are Heritable

Mental Illnesses are also Caused by Environmental Factors

Heritability of Mental Illness

Heritability	Psychiatric Disorders	Other Important Familial Traits
Zero		Language, Religion
20-40%	Anxiety Disorders, Depression, Bulimia	MI, Blood Pressure, Personality
40-60%	Alcohol and Drug Dependence	IQ, plasma Cholesterol, Adult-Onset Diabetes
60-80%	Schizophrenia, Bipolar Illness	Weight
80-100%		Height

Psychiatric Genetics: A Current Perspective, Kenneth S. Kendler, Virginia Institute of Psychiatric and Behavioral Genetics, Departments of Psychiatry and Human Genetics, Virginia Commonwealth University. Stromgrem Award presentation provided to presenter.

What Mental Health Conditions Affect Children, Adolescents and TAY?

- **Anxiety disorders.** Children who have anxiety disorders — obsessive-compulsive disorder, post-traumatic stress disorder, social phobia and generalized anxiety disorder — experience anxiety as a persistent problem that interferes with their daily activities.

- **Mood disorders.** Mood disorders — depression and bipolar disorder — can cause a child to feel persistent feelings of sadness or extreme mood swings much more severe than the normal mood swings common in many people.

- **Attention-deficit/hyperactivity disorder (ADHD).** Typically includes symptoms in difficulty paying attention, hyperactivity and impulsive behavior. Some children with ADHD have symptoms in all of these categories, others may have only one.

https://www.mayoclinic.org/healthy-lifestyle/childrens-health/in-depth/mental-illness-in-children/art-20046577

What Mental Health Conditions Affect Children, Adolescents and TAY?

- **Schizophrenia.** This chronic mental illness causes a child to lose touch with reality (psychosis). Schizophrenia most often appears in the late teens through the 20s.

- **Autism spectrum disorder (ASD).** Autism spectrum disorder is a serious developmental disorder that often appears in early childhood — usually before age 3. Symptoms and severity varies enormously, ASD always involves deficits in social communication and social interaction and secondly restrictive or repetitive patterns of behavior, interest or activities.

- **Asperger's Syndrome**, no longer included in the current DSM-5, refers to individuals who are on the high-functioning end of the Autism Spectrum. Typically these individuals are misdiagnosed during childhood. Many are diagnosed and treated in adulthood.

https://www.mayoclinic.org/healthy-lifestyle/childrens-health/in-depth/mental-illness-in-children/art-20046577

What Mental Health Conditions Affect Children, Adolescents and TAY?

- **Substance Use Disorders** – Alcohol (most common), Cannabis, MDMA/Ecstasy, Cocaine, Heroin, Methamphetamine and Prescription Stimulants, Opioids and other pharmaceuticals

- **Dual and Multiple Diagnoses** – typically a substance abuse disorder plus one or more additional psychiatric, intellectual or developmental disorders

- **Eating disorders.** Eating disorders — such as anorexia nervosa, bulimia nervosa and binge-eating disorder — are serious, even life-threatening, conditions. Youth can become so preoccupied with food and weight that they focus on little else.

https://www.mayoclinic.org/healthy-lifestyle/childrens-health/in-depth/mental-illness-in-children/art-20046577

Additions made by Janice E. Cohen, M.D

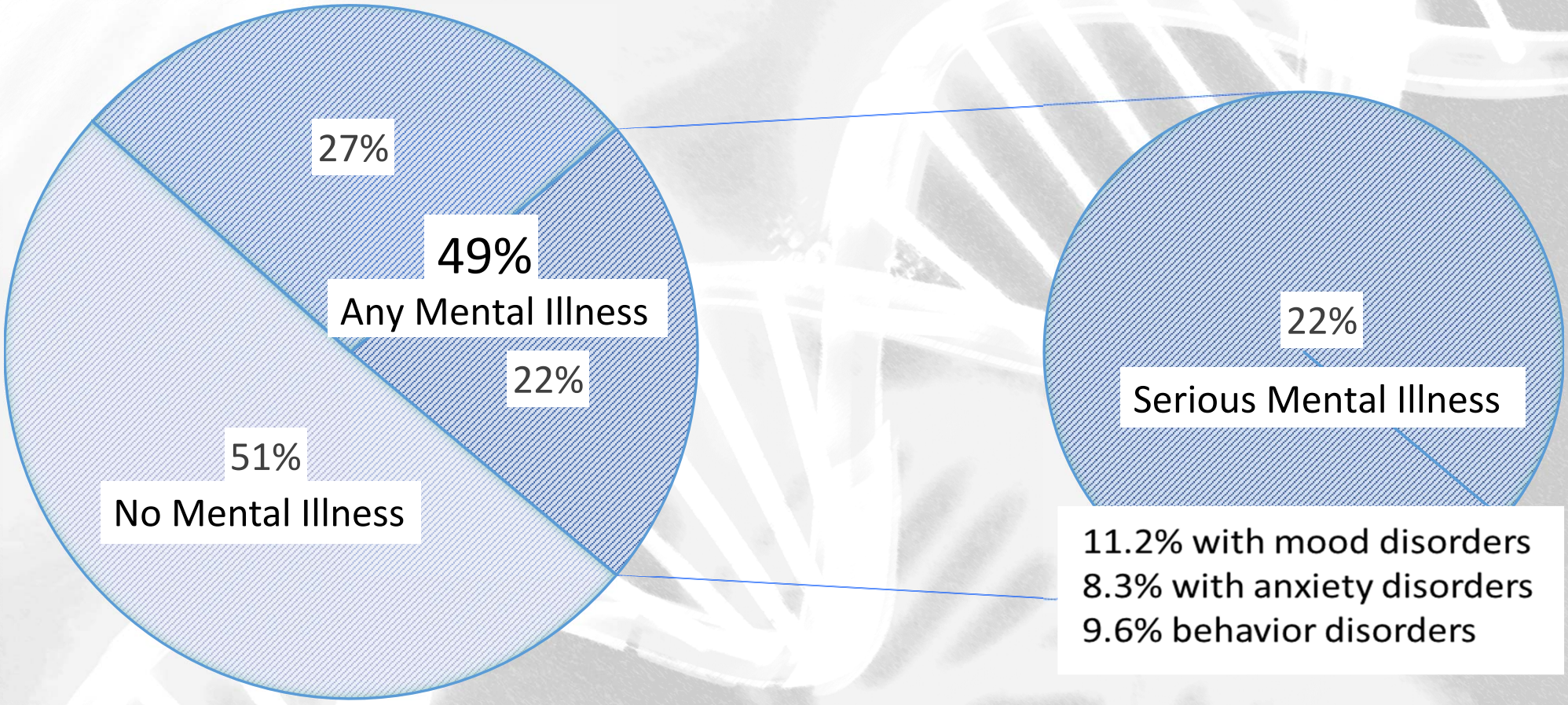
The National Comorbidity Survey-Adolescent Supplement (NCS-A)

The NCS-A estimated the lifetime prevalence of ***DSM-IV*** mental disorders with and without severe impairment, their comorbidity across broad classes of disorders and their sociodemographic correlates.

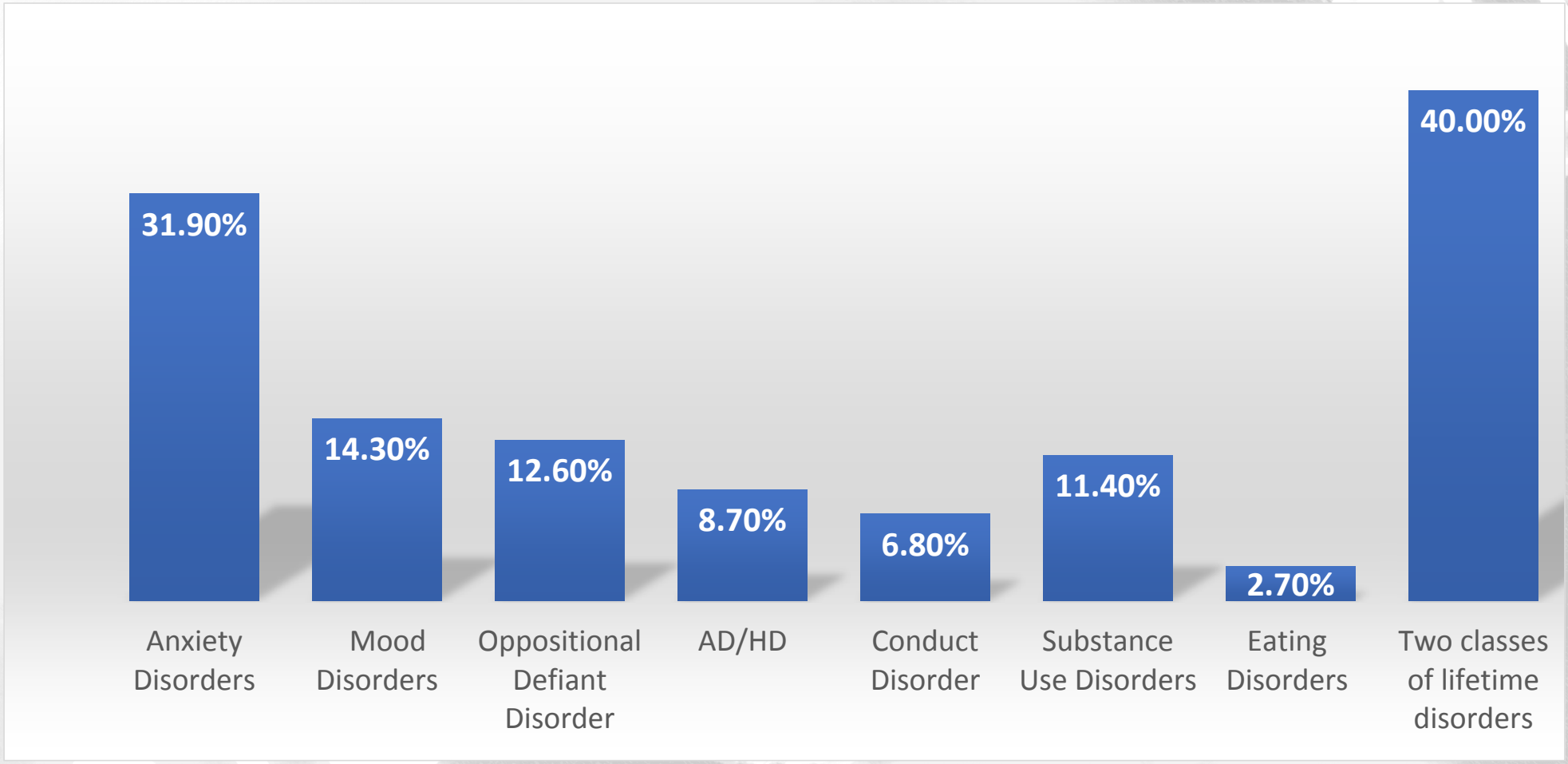
The NCS-A was a nationally representative face-to-face survey of 10,123 adolescents aged 13 to 18 years in the continental United States.

J Am Acad Child Adolesc Psychiatry. 2010 Oct; 49(10): 980–989. Dr. Kathleen Ries Merikangas, Ph.D, Ms. Jian-ping He, M.Sc., Dr. Marcy Burstein, Ph.D., Ms. Sonja A. Swanson, Sc.M., Dr. Shelli Avenevoli, Ph.D., Ms. Lihong Cui, M.Sc., Dr. Corina Benjet, Ph.D., Dr. Katholiki Georgiades, Ph.D., and Dr. Joel Swendsen, Ph.D. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2946114/

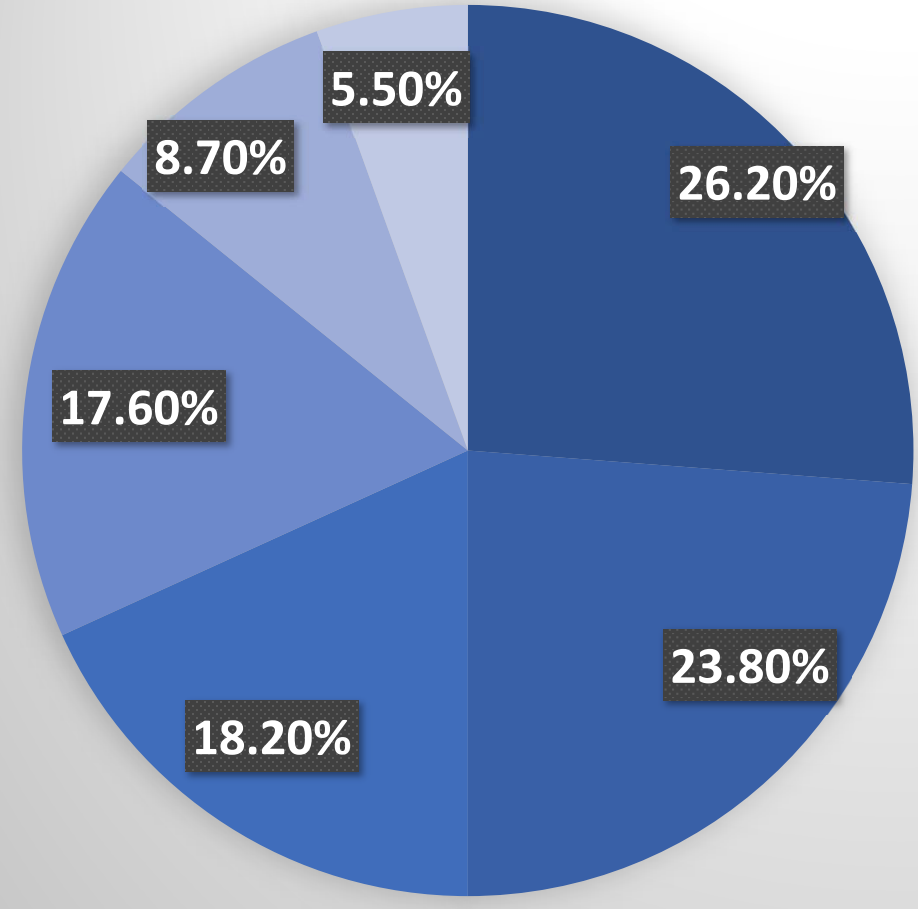
Prevalence of Any Mental Illness (AMI) and Severe Mental Illness (SMI) Among US Adolescents aged 13-18



Lifetime Prevalence of Mental Disorders in US Adolescents 13-18 years



Estimated Risk of Major DSM-IV Disorders at Age 18



- Anxiety Disorders 26.20%
- Substance Use Disorders 23.80%
- Mood Disorders 18.20%
- Behavior Disorders 17.60%
- AD/HD 8.70%
- Other Disorders 5.50%

Leading Causes of Death Among Adolescents in the U.S.

- Accidents, or unintentional injuries, claim the highest number of teenagers -- nearly 50% -- according to 2010 data published by the Centers for Disease Control and Prevention.
- Within this category, motor vehicle accidents claim 73% of teenagers' lives in the U.S and is also the leading cause of death among adolescents globally.
- Drugs and alcohol are often a contributing factor to the unintentional injury deaths.
- The second, third and fourth causes are Suicide (11-13 individuals per 100,000) followed by Homicide and Physical Illness.

https://www.livestrong.com/article/1003934-leading-causes-death-us-among-teens/ - LiveStrong.com
http://www.who.int/maternal_child_adolescent/epidemiology/adolescence/en/ - World Health Organization
https://www.cdc.gov/nchs/data/nvsr/nvsr66/nvsr66_06.pdf [Table 5] (U.S. CDC)

Incidence of Suicide Among Adolescents and Young Adults

- Suicide is the 10th leading cause of death in the U.S.,[1] the 3rd leading cause of death for youth aged 10–14[21] and the 2nd leading cause of death for people aged 15–24.[2]
- More than 90% of children who died by suicide had a mental illness.[3]
- An estimated 20 percent of youth receiving treatment for emotional or behavioral problems have either contemplated suicide or attempted suicide.[4]
- Less than 40 percent of youth at risk of suicide receive treatment.[5]

1. Suicide Facts at a Glance 2015 (n.d.). Retrieved October 23, 2015, from http://www.cdc.gov/violenceprevention/pdf/suicide-datasheet-a.pdf 2."10 Leading Causes of Death By Age Group, United States, 2015" (2015). Retrieved June 1, 2017, from https://www.cdc.gov/injury/images/lc charts/leading_causes_of_death_age_group_2015_1050w740h.gif 3. U.S. Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institute of Mental Health. Retrieved January 16, 2015, from http://profiles.nlm.nih.gov/ps/access/NNBBJC.pdf. 4. *U.S. Department of and Human Services (2002). Results from the 2002 National Survey on Drug Use and Health. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. 5. U.S. Department of Health and Human Services (2002). The National Household Survey on Drug Abuse Report. U.S. Department of Health and Human*

Delay between Onset of Mental Illness and Receipt of Treatment

50 % of all chronic (lifetime) cases of mental illness begin by age 14.

75% of all chronic (lifetime) cases of mental illness begin by age 24.

Despite the availability of effective treatments, there are long delays — sometimes decades — between the first appearance of symptoms and when people get help.

The average delay between onset of symptoms and interventions is 8-10 years.

Children-MH-Facts-NAMI.pdf https://www.nami.org/Learn-More/Fact-Sheet-Library - data from the National Institute of Mental Health
Kessler, R.C., et al. (2005). Prevalence, Severity, and Comorbidity of 12-Month DSM-IV Disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593–602. Retrieved January 16, 2015, from http://archpsyc.jamanetwork.com/article.aspx?articleid=208671

Prevalence of Disabilities Among Youth in the Foster Care System

- Among youth in Foster Care, approximately 30 % experience physical, sensory, developmental and/or psychiatric disabilities -compared with the national average of 5 % for school-age children.
- Those with disabilities are 1.5 to 3.5 times more likely to experience abuse or neglect than youth without disabilities.
- Research suggests that disabilities are often caused and/or exacerbated by abuse.

National Council on Disability, "*Youth with Disabilities in the Foster Care System: Barriers to Success and Proposed Policy Solutions*", February 26, 2008

Prevalence Mental Disabilities and Outcomes for Youth "Aging Out" of Foster Care

- According to a study by Casey Family Programs, foster care alumni ages 20 to 33 experience mental health disabilities at a rate of 54 percent, versus 22 percent for the general population.
- Youth who "age out" of foster care are less likely to achieve academic milestones, including high school graduation and enrollment in post-secondary education.
- These individuals are more likely to be homeless and lack access to even the most basic health care.
- They experience high unemployment, unstable employment patterns, and earn low incomes, which in turn leads to decreased opportunities to achieve financial self-sufficiency and increased independence.

National Council on Disability, "*Youth with Disabilities in the Foster Care System: Barriers to Success and Proposed Policy Solutions*", February 26, 2008

Extending Foster Care Services from age 18 until 21 Positively Impacts Educational and Vocational Outcomes

- An important recommendation of the "*Fostering Connections to Success and Increasing Adoptions Act of 2008" was to extend foster care services from age 18 until 21.*

- Studies show that youth who remain in foster care past 18 are more likely to:

  - ✓ Obtain a high school diploma and enroll in college
  - ✓ Increase their lifetime earnings
  - ✓ Achieve a greater benefit-cost ratio of earnings from employment versus public assistance.

National Council on Disability, "*Youth with Disabilities in the Foster Care System: Barriers to Success and Proposed Policy Solutions*", February 26, 2008

Mental Illness Among Incarcerated Youth

- 65 to 70 percent of youth involved with the juvenile justice system have a diagnosable mental health disorder and nearly 30 percent of those experience *severe* mental health disorders.[1]

- Disruptive disorders, such as conduct disorders and substance use disorders, are most common (46.5 percent); followed by anxiety disorders (34.4 percent); and mood disorders (18.3 percent), such as depression.[2]

- Incarcerated youth age 18-22 are more likely to have a mental illness than younger adolescents in the juvenile justice system.

[1] Skowyra & Cocozza, 2007 [2] Shufelt & Cocozza, 2006

Most Common Diagnoses Among Incarcerated Youth

- The most common diagnosis for boys is Oppositional Defiant Disorder or Conduct Disorder, often with additional diagnosis of ADHD and/or Alcohol dependence.

- The most common diagnosis for girls is Depression, often with additional diagnosis of Oppositional Defiant Disorder and/or Alcohol Dependence.

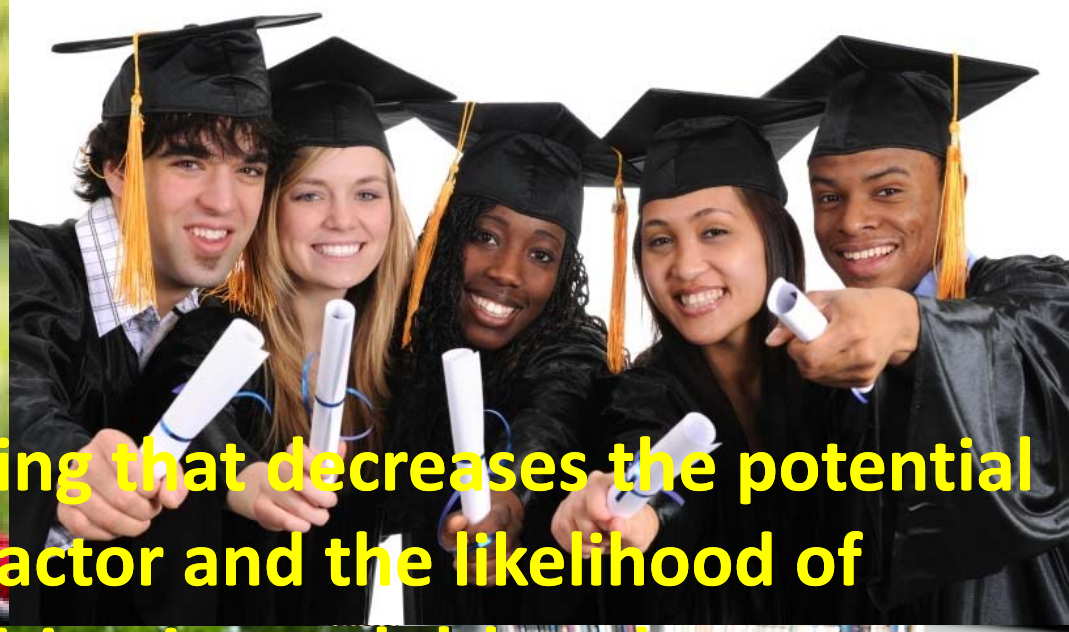
National Center for Mental Health and Juvenile Justice. (2007). Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System. Delmar, N.Y: Skowyra, K.R. & Cocozza, J.J. Retrieved January 16, 2015, http://www.ncmhjj.com/wpcontent/uploads/2013/07/2007_Blueprint-for-Change-Full-Report.pdf

A Risk Factor is anything that increases the probability that a person will experience harm and a poor transition into adulthood.

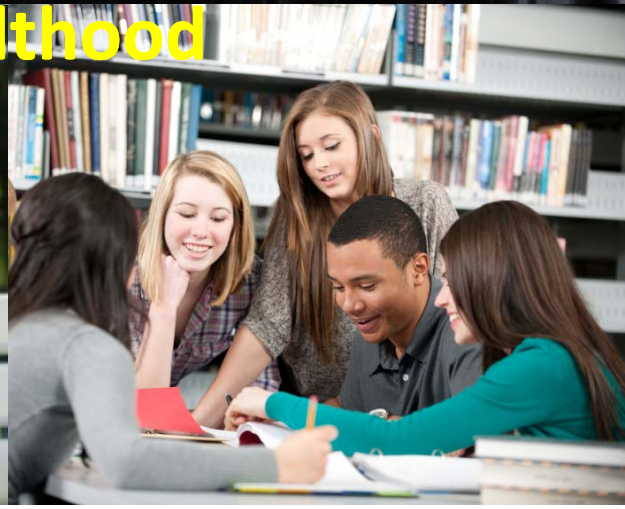
Risk Factors for Negative Outcomes & Poor Transitions into Adulthood

- Adolescents who experience foster placement and homelessness (e.g., Runaway Youth)
- Youth deeply involved in the juvenile justice system – i.e., those with a history of incarceration
- Youth who do not complete high school
- Giving birth or having fathered a child, particularly those unmarried or without a partner
- Unstable/Abusive Caretakers - Mental Illness, Incarceration, Substance Use
- Youth with serious psychiatric, intellectual and/or physical disabilities
- Youth with Substance Use Disorders (often co-occurring with mental disabilities)
- Youth from Low-income Households
- Youth from Violent Home, School and/or Community Environments

https://www.cdc.gov/violenceprevention/youthviolence/riskprotectivefactors.html https://youth.gov/youth-topics/juvenile-justice/risk-and-protective-factors http://www.who.int/en/news-room/fact-sheets/detail/adolescents-health-risks-and-solutions Dubow, EF, Huesmann, LR, Boxer, P, Smith, C. Childhood and adolescent risk and protective factors for violence in adulthood. Journal of Criminal Justice 2016; 45, 26-31. Lösel, F, & Farrington, D P. Direct protective and buffering protective factors in the development of youth violence. American Journal of Preventive Medicine 2012; 43(2), S8-S23.



A Protective Factor is something that decreases the potential harmful effect of a risk factor and the likelihood of a successful transition into adulthood



PROTECTIVE FACTORS

INDIVIDUAL

- High IQ
- Positive social skills
- Willingness to please adults
- Religious and club affiliations

PEERS

- Positive and healthy friends to associate with
- Engagement in healthy and safe activities with peers during leisure time (e.g., clubs, sports, other recreation)

FAMILY

- Participation in shared activities between youth and family (including siblings and parents)
- Providing a forum to discuss problems and issues with parents
- Availability of economic and other resources to expose youth to multiple experiences
- The presence of a positive adult (ally)

SCHOOL AND COMMUNITY

- Presence of mentors and support for development of skills and interests
- Opportunities for engagement within school and community
- Positive norms at school & in the community
- Clear expectations for behavior
- Physical and psychological safety

Why Focus on Employment?

Viewed by Many as an Essential Part of Recovery

Most Consumers Want to Work

Typical Role for Adults in our Society

Cost-effective alternative to day treatment

What are Some of the Benefits?

- Increased Income
- Improved Self-Esteem
- Increased Social and Quality of Life
- Better Control of Symptoms
- Reduced Substance Use
- Reduced Hospitalization

Evidenced-based Models of Care Serving TAY (Where the Primary Focus/Goal is not Employment)

The Transition to Independence Process (TIP) Model™

The Transition to Independence Process (TIP) Model™ is an evidence-based practice based on six published studies that demonstrate improvement in real-life outcomes for youth and young adults with emotional/behavioral difficulties (EBD).

The TIP Model™ involves youth and young adults (ages 14-29) with EBD in an individualized process that facilitates their movement towards greater self-sufficiency and successful achievement of their goals.

Hewitt B. 'Rusty' Clark & Nicole Deschenes; *TIP Model Overview* http://tip.fmhi.usf.edu/tip.cfm?page_ID=18
http://www.tipstars.org/EmpiricalEvidence.aspx - Stars Training Academy – www.tipstars.org
Substance Abuse and Mental Health Services Administration, National Registry of Evidence-based Programs and Practices, 2012

Evidenced-based Models of Care Serving TAY (Where the Primary Focus/Goal is not Employment)

Assertive Community Treatment (ACT) Programs for TAY

ACT is a multi-disciplinary wrap-around case management model developed in the 1980s to provide treatment, rehabilitation and support services to individuals with severe and persistent mental illness (SPMI).

Individuals are served by multi-disciplinary teams, who tailor services and supports to meet the particular needs of each individual.

Team members collaborate to deliver integrated services to individuals in their "natural living" settings instead of hospitals and clinics.

Substance Abuse and Mental Health Services Administration, National Registry of Evidence-based Programs and Practices, 2012
Substance Abuse and Mental Health Services Administration https://store.samhsa.gov/shin/content//SMA08-4345/TheEvidence.pdf
NAMI Mnnesota http://www.namihelps.org/assets/PDFs/fact-sheets/General/Assertive-Community-Treatment.pdf

Evidenced-based Models of Care Serving TAY (Where the Primary Focus/Goal is Employment)

Individual Placement Support (IPS) Model

Individual Placement and Support (IPS) is a model of supported employment for people with serious mental illness (e.g., Schizophrenia, Autism Spectrum Disorder, Bipolar D/O.

IPS supported employment helps people living with behavioral health conditions work at regular jobs of their choosing.

To date, 25 randomized controlled trials of IPS have showed a significant advantage for IPS. Across the 25 studies, IPS showed an average competitive employment rate of 56% compared to 23% of controls. A meta-analysis of 17 randomized controlled trials found that people receiving IPS services were 2.4 times more likely to be employed than controls (Modini, 2016).

https://ipsworks.org/index.php/evidence-for-ips/

Design Features of Successful Vocational Programs for TAY

Woolsey, L., & Katz-Leavy, J., (2008) Transitioning Youth With Mental Health Needs to Meaningful Employment & Independent Living, Washington, D.C.: National Collaborative on Workforce and Disability for Youth, Institute for Educational Leadership. From Successful Transition Models for Youth with Mental Health Needs: A Guide for Workforce Professionals May 2009 – Issue 23 https://www.dol.gov/odep/ietoolkit/publications/376.pdf

Staff Who Maximize Engagement

Professional Development of All Staff Includes:

A Knowledge of Community Resources that Youth Need to Become Successful Adults

A Blend of Knowledge of Mental Health and Work Development Strategies Appropriate to Different Ages and Developmental Stages

A Balance Between the Expertise and Guidance that Adults Can Provide with the Peer Support and Sense of Youth Ownership that Youth Can Provide.

A Place to Call Their Own

A distinct program identity and
A separate physical location away from adult mental health services.

Mental Health America of Los Angeles (MHA LA) bought this vacant property in Long Beach in 1990 to use as the site for the Village serving adults with SMI.

MHA LA has two Transitional Age Youth Centers, one in Long Beach and another in Lancaster (above)

Mental Health Intervention Without the Stigma

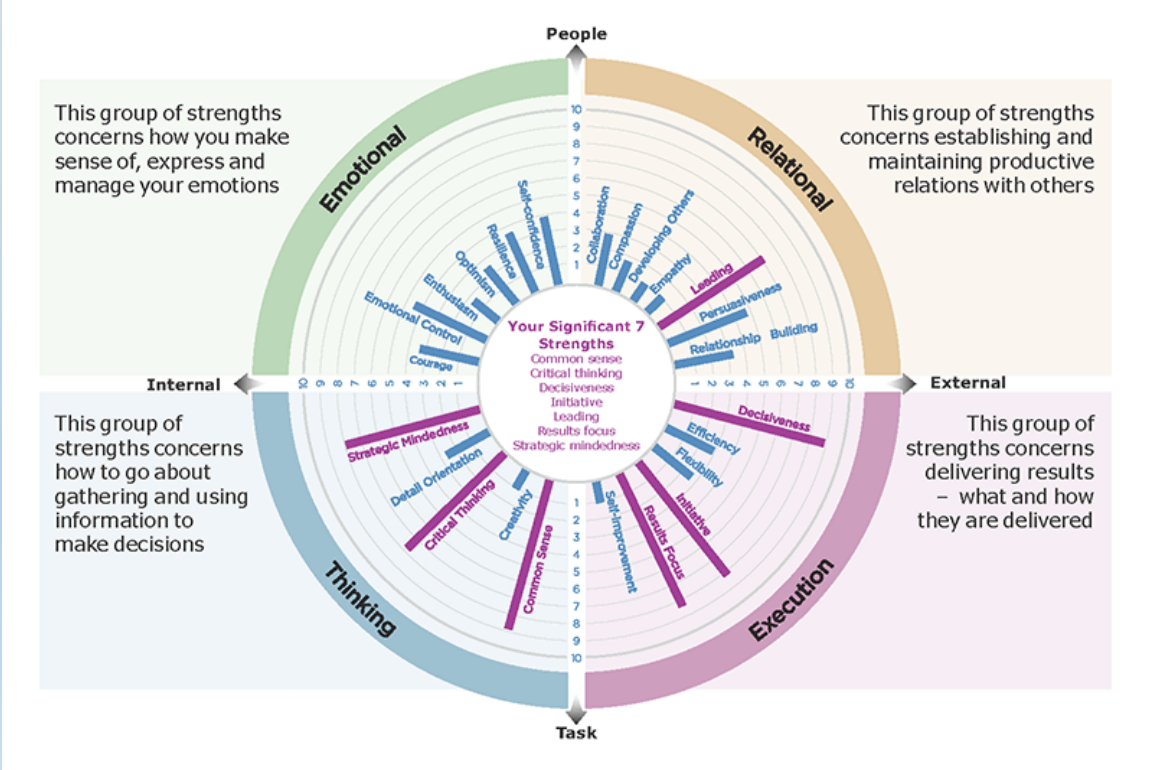
On-site mental health services which utilize
non-traditional treatment approaches

An "**anywhere, anytime" treatment approach** with counseling and services integrated into daily activities, such as talking over coffee or lunch, at the grocery store or while playing pool.

Assessment and Service Planning Processes that Build on Individual Strengths

Utilization of specific assessment and service planning processes that assist Consumers addressing their current needs and interests

Processes that can be used to develop individualized person-centered service plans that are rooted in the individual's strengths and interests.



Housing is a Critical Part of the Service Mix for Older Youth

Housing is an important part of the service mix for older youth.

Some operate their own transitional housing units.

Other establish partnerships in the community for the use of transitional housing units

Employment: Preparing for it, Finding it, Keeping it

Individualized exposure to work and employment pathways for all youth, **regardless of the severity of their condition.**

A "Place and Train" approach as opposed to and "Train and Place" is essential.

All Consumers must set career goals and design a plan to get there, and have opportunities for work-based learning.

Meeting youth "where they are".

Supporting employers by providing a "Win-Win" situation for their participation by offering incentives such as subsidized wages during the youth's training and Job Couching on and off site.


"We do not believe in ourselves until someone reveals that deep inside us something is valuable, worth listening to, worthy of our trust, sacred to our touch. Once we believe in ourselves we can risk curiosity, wonder, spontaneous delight or any experience that reveals the human spirit."
~E.E. Cummings