Biopsychosocial Development in Transition-Age Youth: Implications for Treatment

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Acknowledgements

The Learning & Working RRTC is a national effort that aims to improve the supports for youth and young adults, ages 14-30, with serious mental health conditions to successfully complete their schooling and training and move into rewarding work lives. We are located at the University of Massachusetts Medical School, Worcester, MA, Department of Psychiatry, Systems & Psychosocial Advances Research Center. Visit us at:

http://www.umassmed.edu/TransitionsRTC

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Overview

- Why focus on transition-age youth and young adults
- EBT/P’s in development
- Example of comprehensive age-tailored approach
Serious Emotional Disturbance OR Serious Mental Illness OR Psychiatric Disability

MH diagnosis causes substantial functional impairment in family, social, peer, school, work, community functioning, or ADLs

Not pervasive developmental disorders, substance use, LD, ID (these can co-occur)
Prevalence rates of Serious Emotional Disturbance or Serious Mental Illness 4-9% (Costello et al., GAO)

Applied to 15-30 year olds in 2012 (Census estimate)

Yields estimate of 2.6-5.9 million with serious mental health condition in transition to mature adulthood

50% of psychiatric conditions have onset before age 14 and 75% before age 25 (Kessler et al 2005)
Major Causes of Burden Due to Disability
U.S. 15-24 Yr. Olds

Data from WHO Global Burden of Disease: 2004 Update, retrieved 5/2/13

INVESTING IN THE HEALTH AND WELL-BEING OF YOUNG ADULTS

Institute of Medicine and National Research Council Report
Released October 30, 2014

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www.iom.edu/youngadults
Psychotherapy is a psychosocial process

Unique cognitive and psychosocial development of YA’s, and their life circumstances renders “child” or “adult” interventions likely inappropriate
Key Finding and Recommendation: Health Care

While there are effective behavioral health treatments and strategies for adults, the efficacy of these treatments specifically for young adults is largely undemonstrated.

**Recommendation:** Develop evidence-based practices for medical and behavioral health care, including prevention, for young adults.

*(rec 7-4)*
Cognitive Abilities Changing

- Anticipation of Consequences (Steinberg et al., 2009)
- Complex strategic planning (Albert & Steinberg, 2011)
- Behavior & cognitive control towards emotional or distracting stimuli (Hare et al., 2009, Liston et al., 2006; Christakou et al., 2009)
Developmental Characteristics

Identify formation
- Distrusting authority
- Experimentation
- Self-Determination

Social development
- Peer influence (positive and negative)
- Mixed ages can be unappealing

Psychosexual development
- Sexuality and sexual relationships
- Resolving gender identity and sexual orientation
- Common age to have children
Psychosocial Development in Those with Serious Mental Health Conditions

Research limited to adolescence – but implications hold for emerging adults with histories of SMHC

- Individuals will vary in their level of development
- Individuals may be more mature in one area than another

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Mental health conditions are the major health concerns of this age groupbecause psychotherapy and other interventions are psychosocial in nature, the unique developmental qualities of transition-age youth call for age-tailored approaches
Developmental Changes Underlie **Abilities** to Function Maturely

- Complete schooling & training
- Head a household
- Obtain/maintain rewarding work
- Develop a social network
- Become financially self-supporting
- Be a good citizen
### Youth with SMHC Struggle as Young Adults

<table>
<thead>
<tr>
<th>Functioning among 18-21 yr olds</th>
<th>SMHC in Public Services</th>
<th>General Population/without SMHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete High School</td>
<td>23-65%</td>
<td>81-93%</td>
</tr>
<tr>
<td>Employed</td>
<td>46-51%</td>
<td>78-80%</td>
</tr>
<tr>
<td>Homeless</td>
<td>30%</td>
<td>7%</td>
</tr>
<tr>
<td>Pregnancy (in girls)</td>
<td>38-50%</td>
<td>14-17%</td>
</tr>
</tbody>
</table>
Functioning in Adults with Psychiatric Disorders; Young Adults Different from Mature Adults

- % of Respondents
  - 18-30 yr olds
  - 35-54 yr olds

  - Not Working: 18.3%, 24.2% (χ²(df=1)=31.4-105.4, p<.001)
  - Below Poverty: 8.9%, 21.8%
  - In School: 2%, 33%
  - Daily Friend: 18.3%, 33%
  - Not Married: 55%, 29.5% (χ²(df=1)=5.5, p<.02)
Peak age of arrest

44% of youth with intensive adolescent MH services arrested multiple times by age 25 (compared to 21% in the general population) (Davis et al., 2007)
Among young adults ages 18-25 with a serious mental illness 35% meet criteria for a Substance Use Disorder

SAMHSA (2014)
"In America, a *flapper* has always been a giddy, attractive and slightly unconventional young thing who, in [H. L.] Mencken's words, 'was a somewhat foolish girl, full of wild surmises and inclined to revolt against the precepts and admonitions of her elders.'"_6_
Typical Changes in Family Relations

Young people and parents must adjust to the growing need for independence while remaining emotionally related.
More Reasons to Focus on Transition-Age Youth

- They are functionally different from those older/younger
- The social and familial context of their lives are different from those who are older/younger
- The cultural context of their lives are different from those who are older/younger
Implications

Supports need to be developmentally & contextually appropriate

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Approaches with good evidence of efficacy in adolescents & adults (e.g. many cognitive/behavioral therapies) likely to be effective with this age group.

BUT less likely to seek therapy and more likely to dropout.

Developmental tailoring can focus on outreach & retention:
- Is your waiting room too young or too old?
- Have you helped them know what to expect from therapy?
- Have you helped them assess looming gaps in health care coverage?
- Do you text appointment reminders?
- How’s your working alliance?
Common Issues

Examples:
- Context: group treatment settings that include much older or younger individuals may not appeal
- Be aware of substance use complications
- Immature Identity Formation – resist urge to parent or be authority, allow for experimentation
- Identity Formation Process – incorporate youth voice/ownership
Implications cont’d

Need supports to launch adulthood

- Families continue to be an important resource to their emerging adult child
- Many families in the public sector struggle with poverty, single parenting, mental health, substance use, incarceration
- Delicate dance of maximizing family as resources while supporting self-determination skills
- Inclusion of other social network members, but less stability

System considerations

- Youngest adults still involved with child system
- Adult services often not developmentally tailored
- Funding of treatment/services have age barriers

Prevalence of disrupted, complex, developmentally inappropriate treatment or services
What constitutes evidence?

- When clinical trials are conducted within the age group (e.g. study of college intervention)

- When clinical trials are conducted across a variety of ages
  - Have enough individuals in the transition age group
  - Conduct analyses to detect age differences
The current evidence base
Evidence Based Treatments in Development

Most in feasibility research stage
Motivational Interviewing (MI)

Interpersonal style of therapy characterized by:

- Affirming client choice and self-direction
- Using directive and client-centered components
- Context of a strong working alliance
- To resolve client’s ambivalence about target problem, and increase perceived self-efficacy to address the problem

Miller & Rose, 2009
Multisystemic Therapy for Emerging Adults
MST-EA

Adaptation of Multisystemic Therapy – 17-20 year olds with serious mental health conditions and justice system involvement
Thank You!

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- The emerging adult participants and their social network members


Arrest Rate in Adolescent Public Mental Health System Users

Malleable Causes of Offending and Desistance

Juveniles
- antisocial peers

Adults
- peers influence less
Transition-Age Offenders with SMHCs

- Simply addressing mental health needs found unsuccessful in reducing offending in adults.
- Wraparound approaches have had good outcomes in reducing antisocial behavior in youth with SMHC but is designed for children, not young adults.
Inclusion and Exclusion Criteria

- 17-21 year olds with a diagnosed serious or chronic mental health condition
- Recent arrest or release from incarceration
- Living in stable community residence (i.e., not homeless)
- Excluded if actively psychotic, harmful to self/others
Standard MST  
*(with juveniles, no SMHC)*

- Intensive (daily contact) home-based treatment delivered by therapists; one therapist/family caseload = 3-4
- Promote behavioral change by empowering **Young Adults**
- Individualized interventions target a comprehensive set of identified risk factors across *individual, family, peer, school, work, and neighborhood domains*
- Integrate empirically-based clinical techniques from the cognitive behavioral and behavioral therapies with the best evidence for this age group
- Duration: 4-14 months
MST-EA Treatment Focus
(17-21 yr olds w MI)

- Antisocial behavior, mental illness, & substance abuse
- Leveraging, developing & strengthening the social network
- Targeting housing & independent living skills, career goals, & parenting (as needed)
- Integrating a Life Coach & Psychiatrist/PNP for EA’s into the MST Team
MST-EA Team

- 3 Therapists
- On-Site Supervisor
- Off-Site Consultant
- 0.2 Psychiatrist/Nurse Practitioner
- Life Coaches (4, totaling 1.0FTE)
- Full Team Caseload = 12
MST for Emerging Adults

MST-EA Elements

- Treatment of Antisocial Behavior
- Mental Health, Substance Use, and Trauma Interventions
- Social Network
- Housing & Independent Living
- Career Goals
- Relationship Skills
- Parenting Curriculum
MST-EA Coaches

- Young adult who can relate
- 2, 2hr visits/week, 1 hour curriculum, 3 hours fun
- Reinforces relationship skills in natural environment
- Curriculum topic chosen by client and therapist
- Supervised by clinical supervisor
MST-EA Coach Curriculum

- Engagement with EA
- Goals & Values
- Education
- Housing
- Transportation
- Nutrition & Meal Planning
- Money Management
- Legal Issues/Social Services
- Household Management
- Health & Safety
- Stress & Coping
- Social Skills & Relationships
- Sexual Health
- Pregnancy & Parenting
- Employment

- Career Development
Treatment Retention

- Incomplete Tx minimum # weeks of treatment = 11
- Complete Tx ranged from 4 to 12 months

- Restrictive Placement 13%
- Mutual agreement 12%
- Engagement Lost 13%
- Completed Treatment (goals met & sustainable) 62%
Basic Findings are Encouraging

Substance Use

Majority of the 25 cases to date (84%) have presented in need of treatment for substance-related problems.

NOTES:
- 22 + screens: 21 THC, 3 opiate, 1 cocaine
Working by LC Condition

- VocLC
- BasicLC

Baseline | During Tx | Post Tx
0.1 | 0.6 | 0.6

0.2 | 0.5 | 0.5

Baseline
During Tx
Post Tx

Baseline
During Tx
Post Tx
Common Themes

- **Youth Voice**: all developing models put youth front and center, and provide tools to support that position.
- **Involvement of Peers**: supports; several interventions try to build on the strength of peer influence.
- **Struggle to balance youth/family**: delicate dance with families, no clear guidelines.
- **Emphasize in-betweeness**: simultaneous working & schooling, living w family & striving for independence, finishing schooling & parenting etc.