Now is the Time Healthy Transitions (HT) Grant Profile

7-1-19

Grant Info

- **Type of Grant:** Discretionary Grant
- **Area of Focus:** mental health treatment and recovery support
- **Purpose of Grant:** The purpose of this program is to improve access to treatment and support services for youth and young adults ages 16 – 25 that either have or are at risk of developing a serious mental health condition. Individuals who are 16 – 25 years old are at high risk of developing a mental illness or substance use disorder and are at high risk for suicide. The intent of the program is to improve their life trajectory by identifying and intervening early.
- **Start and End Date of Grant:** 09/30/2014-09/30/2019
- **Amount of Award (all years):**
  - **Federal Award Amount:** $5,000,000
  - **State Award Amount:** $0
- **% Match Required:** None

Grant Info

- **Source of Funding:** Substance Abuse and Mental Health Services Administration, Center for Mental Health Services (CMHS)
- **BHDDH Project Director and Email Address:**
  - Denise Achin, denise.achin@bhddh.ri.gov
- **Subrecipient Agency/Agencies:**
  - Community Care Alliance
  - Thrive Behavioral Health (formerly the Kent Center)
- **Subrecipient Agency Contacts and Email Addresses:**
  - Community Care Alliance: bbennett@CommunityCareRI.org
  - Thrive Behavioral Health: blamoureux@thrivebhri.org

Evaluation Contractor:

- University of RI: lynda_stein@uri.edu

Overview

- Healthy Transitions (HT) provides a modified coordinated specialty care evidence based practice (EBP) to youth and young adults 16-25 who have or are at risk of having a serious mental illness, including first episode psychosis (FEP), and who also may have a co-occurring substance use disorder. It is expected that 500 individuals will receive/be enrolled in HT services and supports over the 5 years of the grant and that 2500 will be screened.
- The project's goal is to improve access to an array of developmentally and culturally appropriate services and supports that are designed with input from youth and young adults. To accomplish this goal, the focus will be on transforming a divided service system that provides different types of services, using different eligibility criteria, to youth/young adults of different ages. Expected individual outcomes include improved management of their mental illness, employment and school rates, decreased psychological distress, decreased substance use, improved family relationships and daily functioning, and improved health.

Required Activities

- Memorandum of Understanding with DCYF
- Developing a social marketing/communication plan within 6 months of the grant award.
- Hiring a full time Project Director to manage the project at the state level.
- Hiring a full time equivalent Youth Coordinator with lived experience
- Developing a finance plan that promotes the provision of a seamless cross-agency service delivery system and sustainability of the project at the end of year one of the grant
- Creating a state/tribal level transition team with key decision makers or identifying an existing committee with key decision makers who will be responsible for addressing challenges and providing solutions to implementation of this project
- Identifying a strategy to coordinate how the new five percent Mental Health Block Grant set-a-side funds for the treatment of early serious mental illness will be aligned with the Healthy Transitions efforts
- Development of interagency coordination mechanisms, including the development of a state/tribal/territorial Transition Team that works across systems to improve outreach, engagement and service delivery activities

Approach

- HT is an adaptation of the OnTrack NY Coordinated Specialty Care (CSC) evidenced base practice. CSC was developed for youth and young adults with first episode psychosis (FEP). RI modified it to broaden the eligibility to include youth and young adults who have or are at risk of having a serious mental illness, including FEP. Each sub-recipient conducts a Team that coordinates care in the community for program participants utilizing a shared-decision making model.
- Teams include: Team Leader (Clinician), 3 Clinicians, a Nurse, .20 Psychiatrist, a Case Manager, a Substance Use Disorder Specialist, and a Supported Employment Education Specialist (SEEs).
  - The individual and the team select the goals to be accomplished and develop an individualized treatment plan.
  - Most participants receive assessments and evaluations (psychiatric, nursing, functioning), medication management, counseling, benefits and services assistance (including wellness, education and/or employment supports).
- The Team works collaboratively to address Treatment Plan Goals and meet weekly to discuss individual case status and to address any issues that may occur. Services, by choice, are delivered in the community and at the Centers.

Approach (Cont'd)

- Community settings include, the home, libraries, schools, employment settings, the gym, recreational sites (both Centers have walking groups).
- Qualifying diagnosis plus meets 2.0 threshold on the World Health Organization Disability Assessment Schedule or no diagnosis but meets risk factor threshold on the Adverse Childhood Experiences Screening tool.
- The Governor's Council on Behavioral Health Youth Transition Subcommittee was used as the required State Advisory Committee.
- Individuals receiving treatment and recovery services will be administered a survey at baseline, at 6 month intervals post baseline, and at discharge. The survey tracks outcomes in areas including but not limited to: overall health, psychiatric symptoms, stability in housing, substance use, employment/income/education, criminal justice status and social connectedness