

# POLICY IMPACT AT THE STATE LEVEL

## 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 available for young adults have often been developed for older adults and not been modified to meet the young person'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 these grant funds on state level policy and system changes. The brief highlights and summarizes data collected from each of the seven HTI jurisdictions, followed by a description of examples of policy and system change provided by the states.

### PREPARED BY

Nancy Koroloff, Ph.D.  
Janet S. Walker, Ph.D.  
Gwendolyn White, M.S.W.

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## State Support for Transition Inventory (SSTI)

The data presented were collected using the State Support for Transition Inventory (SSTI), a web-based survey tool developed by the Research and Training Center on Pathways to Positive Futures (Pathways RTC) at Portland State University in Portland, Oregon, and made available for use by the HTI jurisdictions. The SSTI recognizes the important role that state-level infrastructure and policies can play in helping local communities deliver services effectively. The SSTI is an assessment that gives stakeholders reliable, objective feedback about the extent to which the state has developed the capacity to support local efforts. The tool includes 26 items organized around six themes. Participants respond to each item on a 5-point scale from "fully developed" to "least developed". A higher score indicates a more fully functioning component of the system.

The SSTI is administered to individuals at the state level who are involved in state-level efforts to plan and fund services for youth and young adults with serious mental health challenges. This list of respondents usually includes administrators and/or staff from state divisions such as mental health, child welfare, education, and vocational rehabilitation. The SSTI can also be completed by youth and young adults; adult allies who are active in promoting,

planning or overseeing services at the state level; as well as other members of state level advisory groups.

The data from the SSTI were collected from the seven HTI states at two points in time. Time 1 (T1) data collection occurred when the HTI grants were beginning, and Time 2 (T2) data collection occurred toward the end of the fourth year of project implementation. Roughly 20 to 25 potential respondents were identified at the state level, and response rates ranged between 47% and 77%. One state was unsuccessful

in engaging state-level stakeholders at T2, and thus had data only at T1. (For more information on the SSTI, see Walker, Koroloff & Mehess, under review).

The following table displays the means for all states combined and reports means for the overall SSTI score and the six themes. On average, respondents rated their state at less than midway to being fully developed in each domain. The average ratings all moved in a positive direction between T1 and T2.

The next table demonstrates the pattern of significant changes in SSTI scores that occurred between T1 and T2. Individual states exhibited different patterns of change in scores. Three states reported positive change at the trend-level or better on the overall SSTI scores and on two to five themes (States A, D, and G). State A showed a trend-level increase on the overall SSTI score and a trend-level or better increase on five of the six themes, suggesting that that state has made major changes to its state infrastructure during the time of the grant. When all state scores were combined, a trend toward significance was found on one theme—workforce.

### Examples of Changes in Policies and System Structure at the State Level

When asked to describe specific state-level changes resulting from work related to the Healthy Transitions Initiative, stakeholders gave a variety of examples. Some of the more frequently mentioned types of state-level systems change examples fell within three general categories: changing policies and administrative structures, creating memoranda of understanding and other interagency agreements, and amending the state Medicaid plan.

### Changing Policy and Administrative Structures

Sometimes changing a name can make a big impact. One of the primary objectives of the Georgia HTI was to increase state-level recognition of the needs of young adults with mental health challenges across the state. To this end, the Office of Children and Families changed its mission and name to

TABLE 1: SSTI MEAN AND THEME MEANS: ALL STATES COMBINED

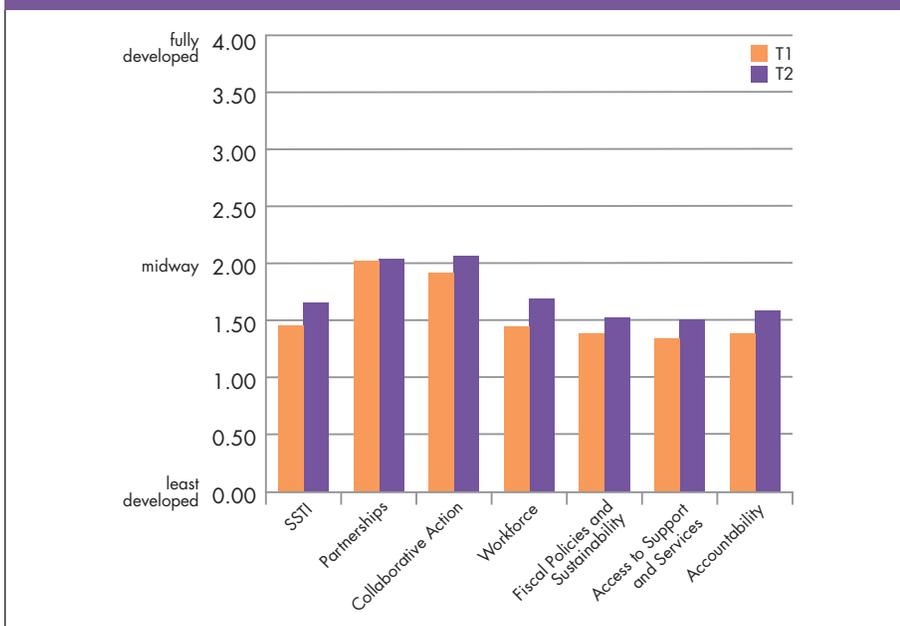


TABLE 2: STATE-LEVEL (SSTI) CHANGE FROM T1 TO T2

State	All	A	B	C	D	E	F	G
SSTI		++	n/a		+			+
Partnerships			n/a					
Collaborative Action		++	n/a					++
Workforce	+	+++	n/a		++		+	++
Fiscal Policies and Sustainability		+	n/a	--				
Access to Supports and Services		++	n/a		++	+		+
Accountability		++	n/a					+

'+' 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 ----  
n/a state did not collect T2 data

include a focus on services to young adults up to age 26. The now-renamed Office of Children, Young Adults and Families is charged with ensuring that young adults with mental health needs receive appropriate services. It is also required to work closely with the Office of Adult Mental Health Services to assure a smooth transition. Both of these units are under the umbrella of the Division of Community Mental Health.

Oklahoma decided that in order to impact policy, the needs of young people had to be explicitly identified within state-level statutes. The bylaws of the Oklahoma Department of Mental Health and Substance Abuse Services were amended in 2012 to emphasize the state's accountability for providing services and supports to young people with complex behavioral health needs. In 2014 an amendment was passed that clarifies the definition of "young adult in transition" and provides diagnostic and functional criteria that define eligibility for services as a young adult. Prior to this amendment, two sets of eligibility criteria existed, one for children and one for adults. Neither fit the developmental challenges exhibited by young adults.

Maryland has implemented a single, uniform-practice model that is now a required part of contracts with vendors that provide services for young adults. The model incorporates elements of the Transition to Independence Process (TIP) model, peer/family support, and evidence-based practice elements drawn from supported employment and Assertive Community Treatment. This intervention was implemented as part of the statewide mental health

plan and is now the standard for services to youth and young adults in Maryland. The state is developing training materials and has purchased a fidelity protocol for the portion of the standard intervention that is a modification of TIP.

Missouri blended its HTI state advisory group with the Missouri Interagency Transition Team, an existing state-level group required by the federal Department of Education. This group brings together leaders from the state departments of developmental disabilities, child welfare, mental health, and education. The group meets quarterly to discuss challenges related to youth and young adults with mental health disorders. Many staff and providers were on both state level committees prior to this merger, and combining the two groups is intended to increase collaboration and efficiency.

### **Developing Memoranda of Understanding**

Memoranda of Understanding (MOUs) and other interagency agreements are often used to formalize arrangements among several organizations or state divisions about how they are going to serve a particular group of consumers or behave in a specific situation.

In Maine, an MOU was developed that involves the Department of Corrections, the Department of Education, Department of Health and Human Services, and the Department of Labor. The MOU defines transition age as 14 to 26 and directs state offices serving young people to implement a comprehensive transition planning process as well as supports for young people who are entering, exiting, or navigating state services. This MOU is intended to ensure that

planning and services to youth and young adults are:

- Transparent
- Strengths-based
- Inclusive of authentic participation of youth and young adults
- Meaningful
- Sustainable

The MOU provides detailed guiding principles for all state departments who work with transition age youth to follow. In addition, it specifies practice standards specifying for example that all youth receiving state services will have a written individualized transition planning document. The MOU also includes background information on why the MOU was developed and who was involved in its development, including youth, providers, and representatives from all of the state agencies. Once fully implemented, each state agency will ensure that all transition policies and practices meet the standards outlined in this agreed upon MOU.

In Wisconsin, an MOU was crafted between Wraparound Milwaukee's Project O'YEAH, which provides services to older adolescents and young adults, and the Milwaukee County Behavioral Health Division of Adult Community Services. As Project O'YEAH developed, staff sought cooperation and collaboration on issues such as housing, employment, and education. Opportunities to work with the Division of Mental Health and Substance Abuse Services in Milwaukee and other adult service providers began to emerge. The resulting local MOU outlined a process for referral, assessment, and provision of services to youth and

young adults aged 17 to 24. Each party agreed to have an identified contact person, to share information (with permission of young adult) and to participate in each other's planning meetings. Under the MOU, Wraparound Milwaukee agreed to cover the cost of case management within Project O'YEAH for youth up to age 18, and the adult community services system agreed to assume the costs for case management post 18. This agreement allows the young person to be involved in services in both systems for a short transition period and ensures that Medicaid or other insurance is continued. Although this MOU applies to Milwaukee County, the state is now exploring how to build upon this example in other counties and at the state level.

Utah is in the process of preparing administrative guidelines that will cover the Utah Division of Child and Family Services, Utah Division of Juvenile Justice Services, Utah Division of Substance Abuse and Mental Health, and Utah Division of Services for People with Disabilities. Under review at this time, the guidelines ask each of the four Divisions to identify a "youth to adulthood" unit and a lead staff person who will be recognized as a champion for youth in transition in each division. The guidelines provide a mechanism for the four divisions to work together to collaborate on youth-in-transition services and create service guidelines including a checklist of core competencies needed by 14 to 25 year olds to support successful transition to adulthood. All divisions will work to help young people develop these competencies through local services. In the future, the four divisions plan to adopt a common

screening instrument, to share data, to ensure youth and young adult input into each division's planning process, and to undertake other activities that will bring increased awareness to the needs of young adults.

### **Amending the State Medicaid Plan**

Another important target for policy change is each individual state's Medicaid plan. The Medicaid plan determines which services can be reimbursed via Medicaid funding, as well as who can provide the service and for which individuals.

Missouri amended its Medicaid plan to allow young people 16 to 25 years old to choose whether to receive services under the youth Medicaid plan or the adult Medicaid plan. Typically, young people choose to stay in youth-oriented services, because these services tend to be more consistent with their preferences. This change encourages community mental health centers to develop specific services geared to young people ages 16 to 25.

Several states revised their Medicaid plans to cover peer and family support services. Utah's state Medicaid plan was amended in 2012 to make peer and family support services reimbursable. In Oklahoma, peer recovery support services can now be offered and reimbursed through Medicaid for individuals 16 and older. Oklahoma has also approved new descriptions and procedures for Peer Recovery Support Services. Missouri changed its state Medicaid rules to allow family support providers to work with parents or other caregivers of young adults up to age 25. Prior to this change, family support services ended when the young person reached age 18.

### **Other Creative Solutions**

Maryland funds a staff position for a young adult at On Our Own, the statewide adult consumer organization. This young adult provides technical assistance and consultation to adult consumer groups around the state about outreach and programming for young adults with serious mental health challenges.

Oklahoma has extended its subsidy for housing for young adults who graduate from the HTI or system of care (also known as Children's Mental Health Initiative) projects. In the past, these young adults would lose housing if they left the project and that would delay progress to remain in service. Now young adults can stay in subsidized housing as long as they continue receiving some form of community health services.

Georgia uses resources from other federal grants to build capacity for a Certified Parent (CPS) and Youth Peer Specialist (YPS) workforce. A curriculum has been developed for the CPS-Parent, and three groups of parents have been trained including the Family Liaison from the local HTI project. The CPS-youth curriculum is currently under development and is being informed by a young adult group of advisors created for this purpose. In the meantime, some young adults from the local HTI community have successfully completed the CPS-Parent training and become certified.

Most HTI states have expanded opportunities for youth-directed leadership and advocacy. For example, in Maryland, young people are leading peer support groups, have developed their own marketing

initiatives, and serve on multiple advisory boards and best practice panels. A group of young adult leaders met with the state Mental Health Commissioner to advocate for continued state funding of the youth coordinator positions that bridge child and adult service systems in local communities. In Utah, the State Youth Advisory Board has youth representation from child welfare, juvenile justice, mental health, substance abuse, and disability. The board organizes annual children's mental health campaign, social media and networking projects, and other educational activities.

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

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Diane Sondheimer  
*Deputy Chief*  
Child, Adolescent and Family Branch  
Substance Abuse and Mental Health  
Services Administration

Eric Lulow  
*Public Health Advisor*  
Child, Adolescent and Family Branch  
Substance Abuse and Mental Health  
Services Administration

Debra Cady  
*Public Health Advisor*  
Child, Adolescent and Family Branch  
Substance Abuse and Mental Health  
Services Administration

Elizabeth Sweet  
*Public Health Advisor*  
Child, Adolescent and Family Branch  
Substance Abuse and Mental Health  
Services Administration

James Wotring  
*Director*  
National Technical Assistance Center  
for Children's Mental Health  
Georgetown University, Center for  
Child and Human Development

Lacy Kendrick Burk  
*Executive Director*  
Youth M.O.V.E. National

Sybil Goldman, M.S.W.  
*Senior Advisor*  
Senior Policy Associate  
National Technical Assistance Center  
for Children's Mental Health  
Georgetown University, Center for  
Child and Human Development

Teresa King, B.A.  
*Training and Technical Assistance  
Resource Specialist*  
National Federation of Families for  
Children's Mental Health and  
National Technical Assistance Center  
for Children's Mental Health  
Georgetown University, Center for  
Child and Human Development

Kathryne A. O'Grady  
*Director of Child Welfare Policy*  
National Technical Assistance Center  
for Children's Mental Health  
Georgetown University, Center for  
Child and Human Development

The Healthy Transition Initiative States  
Georgia  
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Wisconsin

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### Additional Copies of the Issue Brief are Available From:

National Technical Assistance Center for Children's Mental Health  
Georgetown University Center for Child and Human Development  
3300 Whitehaven Street, NW, Suite 3300  
Washington, DC 20007  
Phone: 202-687-5000  
Fax: 202-687-1954  
Website: <http://gucchd.georgetown.edu>

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