APA Public Interest Government Relations Office

Transition Youth with Serious Mental Illness

BACKGROUND

The American Psychological Association (APA) is committed to issues impacting individuals with serious mental illness (SMI), including youth in transition from child welfare systems to adulthood. Transition youth with SMI encounter numerous obstacles as they transition from school and child welfare systems to their adult lives. Lack of appropriate transition services can result in substantial direct and indirect costs. The implications of such failure to provide these much needed services could have an adverse impact on the youths, their families, and institutions unprepared and ill-equipped to assist this important population.

FINDINGS

Prevalence & Costs:

- More than three million transition youth have SMI (Stoep et al., 2000)
- Prevalence of SMI is greatest among the population of 18-25 year olds (12%), compared to other adult populations (HHS, 2003)
- Among youth between the ages of 9-17, approximately five to nine percent have serious emotional disturbances (President's New Freedom Commission on Mental Health).
- Schizophrenia is the second largest cause of overall burden of all diseases (i.e. prevalence, long-term impact, lost productivity, cost of treatment) and accounts for one-third of all spending in the US on mental health treatment (approximately 3 percent of all health care spending) (Murray & Lopez, 1996; Samnaliev & Clark, 2008).
- Patients with bipolar disorder use three to four times the health care resources and incur more than four times greater costs than patients without a bipolar disorder (Bryant-Comstock, Stender, & Devercelli, 2002).
- Substantial indirect costs result from family care-giving, criminal justice system, and opportunity costs due to not working by transition youth or their caregivers (Samnaliev & Clark, 2008).
- Family caregivers of youth with SMI are likely to experience problems in health, mental health, and financial cost (Perlick et al., 2007).

Need for Transition Youth Services:

- Transition youth with SMI are at a three-fold increased likelihood to become involved with the juvenile justice system, compared to transition youth without SMI (Stoep et al., 2000).

Transition Youth with Serious Mental Illness
(continued)

- Transition youth with SMI are more likely to engage in substance use than are any other age group with SMI (HHS, 2002).

- More than 60 percent of transition youth with SMI do not complete high school**,** leaving many of these young adults unemployed, unable to benefit from continuing education, and without the skills needed to live independently (Hagner, Cheny, & Malloy, 1999).

- Most adolescents with SMI continue to have these conditions during adulthood, and many adults with psychiatric disorders developed these conditions at the threshold of adulthood (Davis & Hunt, 2005).

- Childhood diagnoses of Conduct Disorder, Oppositional Defiant Disorder, and Attention Deficit/Hyperactivity Disorder are not recognized in the adult system but are often precursors to more severe adult diagnoses (Davis, 2005).

- When transition youth with SMI age out of a social service system (e.g. special education, child welfare, juvenile justice), no other system or agency assumes responsibility for these individuals (Davis & Stoep, 1997).

Lack of Treatment Services:

- Cost of mental health services and dissatisfaction with those services often prevent transition youth from receiving appropriate treatment (HHS, 1999).

- Of 41 states surveyed, one-quarter of child state mental health systems and one-half of adult state mental health systems offered no transition services, and few provided any kind of transition service at more than one site. (Davis, Geller, & Hunt).

- Of 41 states surveyed, less than eight percent of adult systems and 22 percent of child systems offered any single type of transition service in more than one geographic location (Davis, Geller, & Hunt, 2006).

- People with SMI frequently receive inadequate care and have little access to evidence-based practices (Fixsen et al., 2005; Lehman & Steinwachs, 1998; Torrey et al, 2001; Wang et al, 2002).

Consequences of Failing to Act:

- Among young people with schizophrenia who stop taking their medication, more than 70 percent relapse in the first year and more than 90 percent relapse within two years (Gitlin et al., 2001).

- Having a serious mental illness can shorten a person's life by an average of 25 years (Parks et al., 2006).

- People with SMI live less healthy lifestyles, are less likely to be financially secure, are less likely to have access to quality care, have higher rates of chronic illness, and are more vulnerable to homelessness, unemployment, and alcohol consumption (Parks et al., 2006).

- Comorbidity of SMI and substance use disorders is high (Reiger et al., 1991), as is comorbidity of SMI and physical illness (Sokal et al., 2004).

Transition Youth with Serious Mental Illness
(continued)

- Using drugs or alcohol can nearly double the rate of relapse of schizophrenia (Maslin, 2003).

- Employment rates for people with SMI range from 10-20 percent (Anthony & Blanch, 1987; Pandiani et al., 2004).

- People with SMI often lack close relationships, are not able to play meaningful roles in their communities, and are frequent targets of criminal victimization (Hiday et al., 1999).

- Many people with SMI are poor, live in substandard housing or are homeless (Susser, Struening, & Conover, 1989) or incarcerated (Teplin 1994; Teplin, Abram, & McClelland, 1996).

Success of Treatment Services:

- With optimal treatment, most young people with schizophrenia (up to 90 percent in one study; Edwards et al., 1998) can attain full or significant remission within one year after the first episode (Silverstein & Bellack, 2008).

- The majority of people with SMI can improve their functional status and can over time assume valued social roles such spouse, employee, and student. (Bleuler, 1978; Ciompi, 1980; DeSisto et al., 1995a,b; Harding et al., 1987; Harrow et al., 2005; Huber et al., 1975; Huber et al., 1980;, Jablensky et al., 1992; Ogawa et al., 1987; Sartorious et al., 1977; Tsuang et al., 1979).

- Recovery from SMI is a function of the availability of comprehensive and coordinated psychological interventions (Harding et al., 1987b).

- A core component for recovery from SMI is being able to make choices for one's self and developing the skills needed to make those choices (Anthony & Liberman, 1992).

- Recovery-oriented interventions (i.e. supported employment, supported housing, supported education) are more effective than traditional interventions for people with SMI (Drake & Bellack, 2005; Mueser et al., 2004).

- Integration of psychological interventions with recovery interventions can produce outcomes superior to those from either intervention alone (McGurk et al., 2007).

- Most of the gains in establishing new, effective treatments for SMI have occurred with psychosocial treatment (Corrigan et al., 2008).

RECOMMENDATIONS

The American Psychological Association recommends:

- Providing comprehensive mental health and support services to transition youth, including but not limited to services in the areas of education, employment, housing, health, independent living preparation, mental health, psychosocial rehabilitation, substance use, residential treatment, social skills, dual diagnosis treatment, and homeless with mental illness.

Transition Youth with Serious Mental Illness
(continued)

- Providing comprehensive mental health and support services to transition youth which embody evidence-based practices and encourage youth with SMI to actively contribute in managing their own care.
- Promoting the "recovery" concept as the conceptual lynchpin for mental health systems of care and support services for transition youth.
- Encouraging adult mental health systems to specifically address the needs of transition youth who will be entering those systems.
- Encouraging adult and child mental health care systems at the state level to offer transition services in multiple geographic locations.
- Ensuring the integration of serious emotional disturbances (SED) into the understanding of SMI.
- Guaranteeing Medicaid eligibility through age 24 for transition youth with SMI.
- Increasing SAMHSA funding directed at technical assistance and research intended to develop evidence-based services for transition youth with SMI.
- Providing psychosocial interventions targeting the strains of caregivers for youth with SMI.
- Developing a professionally trained mental and behavioral health workforce to meet the needs of children, transition youth, and adults with SMI.

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