# Table of Contents

**Preface**

**Chapter I, Introduction**

**Chapter II, Background: Issues for California’s Transition Age Youth and County Services**

**Chapter III, Resiliency/Wellness/Discovery and Transition Age Youth**

**Chapter IV, Cultural Competence**

**Chapter V, Youth Voice**

**Chapter VI, Co-Occurring Disorders**

**Chapter VII, Early Psychosis and TAY**

**Chapter VIII, Individualized Assessment**

**Chapter IX, Individualized Planning**

**Chapter X, Education**

**Chapter XI, Vocational and Employment Development**

**Chapter XII, Resource and Fiscal Issues**

**Chapter XIII, Housing**

**Chapter XIV, Social Activities**

**Chapter XV, Program Design**

**Chapter XVI, Recommendations for Implementation**
Many thanks to the individuals who participated in developing the CMHDA CSOC/ASOC Transition Age Youth Resource Guide

Noel O’Neill (Mendocino County) – Subcommittee Co-Chair (2002-present)
Deanna Cloud (Kern County) – Subcommittee Co-Chair (2003-present)
Anne Lesser (Humboldt County) – Subcommittee Co-Chair (2002-2003)
Heather Anders (CMHDA) – Subcommittee Staff

REGULAR COMMITTEE MEMBERS:
Barbara Bautista (ALLIANCE for Community Care)
Ed Cohen (UC Berkeley)
Christie Coho (Step Up on Second)
Harold Curtis (California Department of Mental Health)
Rick DeGette (Solano County Health and Social Services)
Ed Diksa (California Institute for Mental Health)
Renae Garcia (California Department of Mental Health)
Karen Hart (United Advocates for Children of California and California Mental Health Planning Council)
Joan Hirose (California Department of Alcohol and Other Drug Programs)
Wayne Munchel (Village-ISA)
Danielle Nir (Rebekah Children's Services)
Roberto Ramos (California Institute for Mental Health and United Advocates for Children of California)
Brian Salada (Santa Clara County DMH)
Vicki Smith (California Institute for Mental Health)
Sarah Taylor (UC Berkeley)
Vonza Thompson (ALLIANCE for Community Care)
Zoey Todd (California Department of Mental Health)
Marilyn Van der Moer (San Diego County DMH)
Richard Van Horn (Mental Health Association-Los Angeles)
Laura Williams (Sacramento County DMH)

CONTRIBUTORS:
Neal Adams (California Department of Mental Health and California Institute for Mental Health)
Alan Albright (Orange County DMH)
Lynne Brockmeier (Riverside County DMH)
Bob Brooks (California Alliance for the Mentally Ill)
Cameron Carter (UC Davis Medical Center)
Bill Cleere (ALLIANCE for Community Care)
Lauren Hall (Corporation for Supportive Housing)
Pam Hawkins (United Advocates for Children of California)
Rebecca Hawkins
Tiffany Johnson (California Youth Connection)
Darin Lounds (Corporation for Supportive Housing)
Judy Ludwig (Community College Foundation)
Rita McCabe-Hax (California Department of Mental Health)
Karolin Schwartz (Santa Cruz County DMH)
Chris Steele (Community College Foundation)
Laura Stewart (Child Welfare League of America)
Tim Stringari (San Mateo Community College District)
Youth from Humboldt County, San Diego County and Stanislaus Counties

Many thanks to The California Institute for Mental Health (CIMH) for funding the art contest for the TAY Resource Guide cover art.


**PREFACE**

This Transitional Age Resource Guide has been prepared to provide support and direction to counties to better serve our youth. We must have a better understanding of what our young consumers’ actual needs are in order to be able to respond with the programs and services necessary to help them succeed. This Guide offers an in-depth look at the challenges faced by youth who have been involved in the mental health and foster system. At both the state and county level, we as caregivers recognize that we can do a much better job of providing services during these critical years.

The release of this Resource Guide comes at the time when California’s counties are beginning to plan for implementation of the Mental Health Services Act. The Mental Health Services Act has served to raise the public’s awareness of need, providing an unprecedented opportunity to develop new programs that address populations that have historically been underserved. Transitional Age Youth are among the most deserving of our attention and assistance as they grow towards independence. By investing in this vulnerable population, we can help secure their futures and enrich the entire community.

The Resource Guide details many common issues a young person faces as they grow towards adulthood. The Guide offers the administrator and provider with timely and current perspectives and recommendations for achieving realistic solutions to challenges and barriers. We hope that this document will provide readers with one more resource as they strive to create a local vision that will support their community’s youth.

I want to acknowledge and thank the many youth and adult contributors to this Guide. Their wisdom, expertise, and dedication to this project resulted in a finished product that is pertinent, useable, and easy to understand. We are proud to present this document as the next step toward building a system of community support for Transitional Age Youth.

As the Director of the California Department of Mental Health, I invite the reader to accept the challenge of truly working toward the development of inclusive and effective services for youth.

---

STEPHEN W. MAYBERG, PH.D.
Director, California Department of Mental Health
INTRODUCTION

“We live in an era when rapid change breeds fear, and fear too often congeals us into a rigidity which we mistake for stability.”

—LYNN WHITE
INTRODUCTION

The creation of the Transition Age Youth (TAY) Resource Guide began three years ago when the California Mental Health Directors Association (CMHDA) brought together the Children’s and Adult’s System of Care Committees to brainstorm ways the two groups could better serve the Transition Age Youth population. A priority task for the newly appointed Transition Age Youth Subcommittee (TAY Committee) was the development of a TAY Resource Guide. The objective of the Guide was to provide County managers, direct services staff, contracted providers, and others with information about:

- the issues facing TAY and their families in the mental health system;
- promising practices with TAY and their families;
- the types of services currently available or in need of development;
- case studies of successful TAY programs;
- information about potential resources to develop or enhance TAY services;
- recommendations for the minimum requirements for a TAY system of care to address the issues related to TAY psychological development, practice, program implementation, and policy.

The initial plan for the Resource Guide did not anticipate the size of the document we are now presenting in its finalized form. Original ideas were far more modest; however, as members joined the core group, the project began to take on a life of its own. The topics and content expanded as the complexity of the project became more apparent. Initial discussions focused on gathering cutting edge information that would assist county administrators in the planning and evaluation of programs for the transitional age population. The subcommittee was also eager to gather information from counties that might address the variety of viewpoints that currently exist about how to serve this group. An overarching goal was to cluster facts and articulate some of the most basic challenges all counties face in adequately providing comprehensive care for this group. We agreed there was no reason why each county should operate in a vacuum without the benefit of successes and knowledge gained in other parts of the State.

It took some months to establish a routine that would be effective in gathering together both the core members of the TAY Resource Guide Subcommittee and the writers and experts of individual chapters. It was initially challenging at first as we attempted to fully understand exactly how we would approach our mission. We settled on a methodology by which we made an outline of the chapters we wanted to cover, and we agreed that if we were to finish the task in a reasonable length of time we would need to meet by conference call weekly. We developed the habit of focused planning on subsequent calls so that we could invite experts in the topic at hand to assist us in understanding the content areas. A draft of the chapter was generated from the call and reviewed by the entire committee for application of information to real life mental health programs across the State. Some chapters were modified numerous times to reflect the reality as it is experienced in different settings. This approach served us well, though it has been time-consuming.

It was important for the committee to involve the youth voice into our document so that it would be anchored in the actual wisdom of the transition age youth themselves. This was accomplished in two ways. We held focus groups located in four locations from one end of the State to the other. Much valuable information was forthcoming, especially when the youth asked if they could present their findings to the committee in person in Sacramento. This was an enlightening occasion. The second way we gained input was that we invited specific youth from three different counties to join conference calls and dialogue with us about the way youth like to spend their
leisure time. They shared their ideas, visions and experiences, and they taught us new ways of thinking about old problems.

The reader will notice variation from chapter to chapter in the voice of the writer. This is because there are a number of writers and the committee felt it was important to honor this differentiation rather than editing each chapter to sound alike. Some chapters are more extensively researched based upon the subject matter and degree to which the author had expertise in academic realms. All of the chapters have been reviewed with an eye towards accuracy, while also attempting to appeal to the direct service provider.

As the TAY Resource Guide unfolded and we came across information that was critical in the planning of new programs, we all agreed that we wanted to formalize this understanding in a series of recommendations that would stem from each chapter’s research. The primary authors of each chapter were asked to summarize recommendations, which can be found at the end of each chapter. In addition, Chapter XVI serves as a consolidated list of recommendations in four general areas: 1) developmental issues of TAY; 2) organizational and systems change issues for counties, providers and state agencies; 3) practice and program issues, such as promising practices; and 4) policy and fiscal issues. If we were to keep the chapters to a reasonable length, we would need appendices with more detailed information on certain topics.

We envisioned a document that would largely be an electronic resource. This would make it manageable to update and easy to store. Instead of limiting the Resource Guide to another hard copy manual that would gather dust on some storage shelf, we wanted to create a Resource Guide that was alive with links and websites that could shed information and ideas on this important subject. We also intend to produce a limited number of paper copies, but only as needed, and using an efficient “on-demand” cyber publishing plan.

Finally, it is important to acknowledge the spectacular diversity of individuals that have made up the committee from beginning to end. We have had small and large counties represented; rural and urban; numerous non-profit organizations; the State Department of Mental Health, the State Department of Alcohol and Drug Programs as well as California Institute for Mental Health participation and amazing support and direction from the Directors’ Association itself. The CMHDA provided all the subcommittee support and organization of meetings and calls. The committee also had members from the University of California, Berkeley School of Welfare who lent us an exceedingly valuable perspective. The U.C. Berkeley members, together with ALLIANCE for Community Care from Santa Clara County, were gracious enough to edit the entire document. Most importantly, we have had the youths and their families inform and educate us about their concerns. This document is unique because it was done as a labor of dedication and passion for the young people everywhere who are trying to find their way in a complicated and often unforgiving world. No one received any extra pay for their contributions. We sincerely hope that the efforts found here will make it just a little easier for youth in our care to successfully take the steps necessary to achieve success in the adult world.
CHAPTER I

OVERVIEW

“Everyone has an invisible sign hanging from their neck saying, ‘Make me feel important.’ never forget this message when working with people.”

—MARY KAY ASH
CHAPTER I
TRANSITION AGE YOUTH SUBCOMMITTEE RESOURCE GUIDE

OVERVIEW

The Transition Age Youth (TAY) Resource Guide was designed to provide county managers, direct services staff, contracted providers, and others with information about:

- the issues facing TAY and their families in the mental health system;
- promising practices with TAY and their families;
- the types of services currently available or in need of development;
- case studies of successful TAY programs;
- information about potential resources to develop or enhance TAY services;
- recommendations for the minimum requirements for a TAY system of care to address the issues related to TAY psychological development, practice, program implementation, and policy.

To begin the overview of the TAY Resource Guide, we present the important perspectives about mental health services for transition age youth from a parent and youth. Then the developmental issues of TAY are discussed, setting the stage for the population targeted by this Guide. A history of the Children’s System of Care (CSOC)/Adult System of Care (ASOC) Subcommittee on Transition Age Youth (CSOC/ASOC TAY Subcommittee) is presented along with excerpts from the CSOC and ASOC framework that are especially relevant to developing a TAY System of Care. Finally a brief overview of the Guide’s chapters is presented.

FAMILY AND YOUTH PERSPECTIVE

Parent Perspective
As a parent with a teenager in the mental health system it was important to me that my teenager learn skills designed to transition her to adulthood. Instead, she was taught skills to help her transition to the adult system of care. These services taught her how to attend individual and group therapy consistently, how to “get along” in a group home and how to cooperate with a point system. In other words, transition services were designed to teach her how to be a good mental health client.

Youth Perspective
Though receiving mental health services, I wanted to be like other teenagers. I wanted to go to high school, attend school dances, music concerts, go to the mall and “hang out” with my friends. I wanted to get a part time job and learn how to drive a car. Instead, I went on group outings in the van with the other mental health kids where we learned how to be members of a supervised group in the community. I went to a small non-public school where the coursework was significantly below my grade level, making it difficult to learn anything at all. I did, however,

---

1 There are many terms describing our young adult population: youth, emerging adults, young adults, etc. The Subcommittee chose to use TAY since we are primarily interested in transition issues, as discussed below in this chapter. Also, the term is currently in wide use throughout county and state agencies.

2 The CSOC and ASOC committees were established by the Governing Board of the California Mental Health Directors’ Association (CMHDA).
learn to manipulate the rules and regulations of group homes and in-patient facilities. Without the common understanding and equal “buy-in” of all partners, youth, parents and providers, transition age services cannot succeed.

DEVELOPMENTAL ISSUES

Challenges of the Developmental Stages of Adolescence and Young Adulthood
The normal developmental tasks of transition age youth are greatly complicated by mental health challenges and cultural factors. To create good policies, design effective programs, and provide meaningful services valued by young people it is critical to consider the impact of these factors.

Developmental Stages of Transition Age Youth
According to Erik Erikson, the job of an adolescent is to try out different identities, and to integrate the various roles into a coherent self-image. Next, young adults will learn to establish and maintain intimate relationships with a partner, family, and significant others. In addition, the young person may have unresolved issues from an earlier stage such as trust, autonomy, conscience, and a sense of competence. Abraham Maslow talks about the hierarchy of needs: when an individual has food, clothing, shelter and safety, they seek love, belonging, esteem of self and others, and an understanding of life purpose. A young person must accomplish these difficult tasks while managing the pressures of peers, adult expectations, and societal demands. At the same time they are preparing to become economically self sufficient, to live independently, to create a satisfying social life, to develop ideological views, and to establish a meaningful place in the larger community.

The developmental tasks mentioned above are challenging for every young person. Emotional difficulties exacerbate the challenges. Young people may need additional adult support at the time they appropriately resist adult support as they strive to establish themselves as autonomous individuals, and look for advice and support from their peers.

With a further overlay of cultural differences from the mainstream society, transitioning to adulthood can become truly daunting. Cultural differences may manifest themselves in norms, values, and beliefs about sexual identity, race, ethnicity, language, class, and poverty. Culture also shapes the experience of symptoms and their meaning, coping style, and stigma related to emotional difficulties. A young person will strive to negotiate their identity and to develop the capacity for intimacy within the dual context of their family’s culture and the dominant culture. The result is a highly complex, multi-dimensional situation in which each young person operates within a unique bio-psycho-social system.

Implications
Because of the complexity of these factors, all those working at a policy, program, or service level must be aware of the stages of youth development and of cultural issues, and must have an understanding of how they may impact a youth’s needs, preferences, and responses. To develop effective services, youth representatives of various cultures of the targeted population must have a voice in developing policy, designing programs and services, and in their evaluation. Youth outreach is of particular importance for this age group, since young people may reject adult-initiated services as they move toward increased autonomy. Services must be individualized and sensitive to individual differences of developmental stages and culture, as well as mental health issues. Evaluation must include assessment of equity in access and outcomes.
While transitions are a normal part of the tasks of emerging adulthood, we are particularly interested in three transitional processes (which are the focus of this Resource Guide):

1. from the children’s system of care to adult community life;
2. from the children’s system of care to the adult system of care; and
3. from the community to the adult system of care after experiencing new problems or exacerbation of previous problems during late adolescence or young adulthood.

**HISTORY OF THE CMHDA CSOC/ASOC TAY SUBCOMMITTEE**

In October 2001 there was a meeting between the CMHDA Children’s System of Care (CSOC) Committee and the CMHDA Adult System of Care (ASOC) Committee to discuss the many issues that transition age youth encounter. It was decided that a “next step” be the creation of a subcommittee of the two committees to focus primarily on transition age youth. The subcommittee would have co-chairs – one from the Children’s side, and one from the Adult side. It was decided by the subcommittee chairs to have a small but representative group of TAY, family members, and those who provide services to this population. The committee would meet primarily via conference calls and would occasionally have in-person meetings where particular issues would be presented and discussed. The committee started meeting on a regular basis in March 2002. It presented information at the 2002 ASOC Partnership Conference, and is planning on providing regular updates at conferences where both CSOC and ASOC Coordinators and Managers are present.

Once the TAY Subcommittee was up and running, the group would set a priority objective: to develop a comprehensive TAY Resource Guide that could assist county mental health staff and others in the development of TAY services within the basic principles established by the CSOC and ASOC, and those established in the latest research and practice models for transition age youth.

**THE CSOC AND ASOC FRAMEWORKS**

Guidance for the development of this resource document comes from both the Children’s (adopted August 15, 2002) and the Adult (adopted September 14, 2000) Frameworks. The frameworks are the result of a process that encompassed the following:

- the mission/vision/concept statement of each framework describes how a system of care will carry out its mission within the context of expressed values;
- the Outcomes describe states or conditions that arise out of a program having achieved its goals; and
- goal statements describe the commitments that program principals will make in order to achieve the desired outcomes.

Each framework illustrates what the CMHDA believes are the basic principles and values that need to be in place in order to address the variety of issues found both for the child and the adult who are faced with mental illness. Additionally, the frameworks outline the involvement of the family and the community, which will be needed to assist the young person towards a life with voice, choice and skills necessary to live with dignity and independence. The Transition Age Youth Subcommittee has drawn on concepts taken directly from the frameworks to point us in the correct direction as we ask the question, “How can a youth facing concerns of mental illness
successfully transition from the community or from Children’s Service to the world of being an independent adult who is focused on his/her recovery and discovery?"

*The Children’s framework states:*

“Children and families will be supported through transitions, including changing one program to another, moving to less intensive services, returning from out of home placement to home/community. Youth will be supported from children’s system of care services to adulthood.” In regard to program design, the framework goes on to say, “…Service providers, agency administrators, and policy makers will partner with youth and family members to incorporate their experiences and knowledge into designing the service delivery system…”

*The CSOC Framework also addresses transitional age youth:*

“Youth ages 14-25 who have been in the children’s system of care are often extremely vulnerable to homelessness, unwanted pregnancy, hospitalization, incarceration, exposure to violence, and exacerbation of mental illness. To improve successful transition to adulthood, it is essential that the children’s system of care partner with other agencies to address needs in all domains including education, vocation, housing, income, life skills training/preparation, health, mental health, and social/recreational opportunities. For youth with serious mental illness, seamless transition to adult services is critical to effective management. Because needs and preferences of youth differ from adults, services must be designed specifically for this population.”

*The Adult framework states:*

“Transition services into and out of ASOC services should be strong, specific, planned and collaborative.” For the Transition Age Youth: “Specific planning must occur between CSOC and ASOC to develop individual transitions for children who might need to access ASOC Services. CSOC should consider transition plans at an appropriate age depending upon the needs of the child. ASOC should be brought into case planning at age 16; if it appears that the child is likely to require adult services. The first priority for joint planning is to build a bridge for the young person to assume incremental responsibility for managing his or her own independence, as culturally appropriate using education, employment, and other community support services to assure recovery. Integrated CSOC and ASOC services should be available to the young person and his or her family and community, depending on individual needs, during the period 16-25.”

*Services during this period may include:*

- Collaborative case plans with schools, community colleges, independent living programs, child welfare services, job training agencies, and linkages to community and individual benefit programs;

---

3 “Discovery” is a client-driven process of identifying strengths through the dreams, goals, aspirations, and desires of TAY.
Service plans that identify the needs of the young person in the areas of employment, job training, health care, drug and alcohol abuse prevention, healthy relationships, information education, counseling, socialization, housing, and independent living skills;

- Assistance with identifying the means for health insurance and educational linkages;
- Continuation of Wraparound services with a goal toward independence, if it has been found beneficial by the child and family under CSOC;
- Continuation of family or guardian participation in case planning for transition age youth;
- Creating services that address specialized needs of youth who are at high risk of dropping out of mental health services;
- Peer support drop-in and other natural supportive centers;
- Specific outreach to youth who are homeless or at risk for becoming homeless;
- Services for youth who have had juvenile justice system involvement and are therefore at high risk for becoming involved in the adult justice system.

In summary, the TAY Subcommittee has formulated the chapters that follow based upon the principles drawn from an already agreed-upon standard that is known to represent the values of the counties across the State, as well as principles from nationally recognized promising practices. This resource document will not attempt to duplicate what can already be found in the frameworks, but rather, gather information on this topic in an organized and articulate manner.

**A Note about the Writing Style of Chapters in This Guide**

Each chapter was researched and drafted by one or two experts, and then reviewed by the Subcommittee. The Subcommittee chose not to control the authors’ writing styles except to create uniformity (as much as possible) in the use of technical language, definitions, and policy statements. Each chapter, then, was meant to speak with a voice of its own. Each chapter was also meant to be used independently for specific content areas.

**Brief Overview of the Chapters with Statement of Needs**

There are a total of 16 chapters in this resource guide. These topics have been carefully selected to reflect important areas of concern when planning for a successful transition for a youth to an adult status. It is quite challenging for any youth to grow into adulthood, and yet we know the clients we serve are facing special challenges over and above expectations the world may hold. This Resource Guide assumes that the youth is a whole person in a social context, and that the transition should be approached as an ongoing process, with many important players.

**Chapter I: Overview** – gives a fairly comprehensive overview of what the subcommittee is attempting to do in producing the resource guide. The chapter includes an introduction from the family viewpoint; a presentation of developmental issues that one might consider in discussing the TAY population; a history of the CMHDA CSOC/ASOC TAY Subcommittee; and excerpts drawn from the CSOC and ASOC Frameworks to support the direction the resource guide is taking. Additionally, there is an overview of all the chapters.

**Chapter II: Background: Issues for California’s Transition Age Youth and County Services** – presents recent statewide data to give a profile of transition age youth currently using services, discusses developmental, legal, and funding issues that affect TAY access to care, and presents the results of a statewide survey of current TAY services to determine the kinds of collaborative programs and strategies that are currently in place and identify current gaps.
Chapter III: Resiliency/Wellness/Discovery and Transition Age Youth – speaks to the issues of risk factors, resilience and wellness for youth. How do our youth manage to survive and even blossom in spite of adversity? How can we support and promote wellness in transition age youth?

Chapter IV: Cultural Competence – focuses on cultural competency issues in working with TAY and their families. The strengths and natural resources that a client and family bring to the table are most important. The well-researched information presented here informs us that all TAY work should be done within the context of the client’s family and culture.

Chapter V: Youth Voice – is perhaps most important. This is an opportunity for the youth voice and experience of the family to be heard. We take specific feedback from the youth consumer about how to shape future services. We reveal the outcomes of youth focus groups assembled to talk about the transitional experience.

Chapter VI: Co-occurring Disorders – explores the relationship between mental illness and substance abuse. This chapter has ideas and suggestions about how to approach youth who may need an intervention to address both challenges simultaneously. Best practices are discussed.

Chapter VII: Early Psychosis and TAY – gives a well-researched presentation on the latest empirical information about youth who experience new psychotic symptoms during the transition age years. There are emerging practices that can guide counties in providing critical early interventions.

Chapter VIII: Individualized Assessment – tells how to go about conducting an accurate and useful assessment of the strengths and needs of a youth and his/her family.

Chapter IX: Individualized Planning – focuses on the individual student and how to generate a culturally competent plan that may in fact change this teen’s life. Because the plan is client/family driven, it includes elements that make the difference for a youth in obtaining the skills and maintaining his/her health that are needed to be successful in his/her new adult world. This chapter answers the question: What resources should be included in a transitional plan?

Chapter X: Education – focuses on education for the TAY and how schools can be an important partner to county mental health. Both at the high school and the college level, the collaboration between mental health, the family, and the educational setting is critical. We explore this relationship in some detail.

Chapter XI: Vocational and Employment Development – a topic that young people speak the most about. “How can I earn the money I need? How can I learn the skills that will win me a job that is rewarding?” We focus on the cooperatives that exist between Mental Health and the Department of Rehabilitation. Employment is seen as a necessary treatment modality. The chapter also reviews benefits a TAY may be eligible for.

Chapter XII: Resource and Fiscal Issues – deals with the all-important money factor. How can a county create a transitional program that is fiscally sound? How can counties access the needed flexible funding to do the job of assisting youth transitioning to adulthood? Read this chapter and hopefully new ideas will emerge, and if not, at least you as a county, know you are already at the cutting edge!
**Chapter XIII: Housing** – is about the most important concrete need. Without a place to live, the young person has nowhere to transition to. What are counties doing to address this problem? What are the best practices?

**Chapter XIV: Social Activities** – deals with recreation and socialization. While focusing on all the important topics covered by other chapters, sometimes we forget that young people need to have fun! Transition age programs, keeping in mind the whole person, will support the youth in activities that grow relationships, build constructive socialization as well as talents, and help to develop emotional intelligence.

**Chapter XV: Program Design** – includes a variety of current practices and promising practices that counties can learn from as they struggle to define what is the best practice for their own community. These presented models are working right now! We hope counties find facts that may be useful as they fine-tune their transitional age programs. Many useful recommendations evolve from this chapter.

**Chapter XVI: Recommendations for Implementation** – is the final section of our Resource Guide that brings all the information together in a series of recommendations in the areas of TAY developmental issues, policy and practice strategies, organizational and systems change, and policy/fiscal issues. This chapter summarizes our work as a committee and our sincere hope is that these findings will assist counties in planning programs that will be truly effective for the transition age youth of our State.
CHAPTER II

BACKGROUND: ISSUES FOR CALIFORNIA’S TRANSITION AGE YOUTH AND COUNTY SERVICES

“Listening, not imitation may be the sincerest form of flattery.”

— JOYCE BROTHERS
Chapter II

Background: Issues for California’s Transition Age Youth and County Services

Executive Summary

Transition Age Youth (TAY) with serious mental illness are subject to profound disorientation on reaching age 18 and moving from the Children’s into the Adult system of care. Loss of parental responsibility and leaving the Child Welfare, education and juvenile criminal systems, combined with changes in funding streams available for mental illness care, can take away needed supports even though the TAY may not be ready to enter the “adult” world. Because of this reduction in the available support systems, the percentage of young people receiving county mental health services in California drops sharply for those over 17.

Only about one-third of California counties have specific programs to help TAY make the transition from the Children’s to the Adult system of care. There is an urgent need for every county mental health department to create a TAY policy with active participation from TAY representatives. This policy should address the needs of youth aged 14 to 24 and include assistance in employment preparation as well as access to the widest possible spectrum of community resources and services. The services provided to TAY should be client-driven, strength-based, recovery-oriented and culturally competent.

Background: Issues for California’s Transition Age Youth & County Services

There are sharp differences between the Child and Adult public mental health service systems in California. One indicator of the difference is shown by the rate of service utilization. The following table shows rates of service use by three age groups: 14-17, 18-21, and 22-25. There is a decrease of close to 50% in the number of young people served by county mental health after age 18, compared to youth aged 14-17.

How do we explain the drop-off in the rate of service use? There are several explanations having to do with both institutional as well as developmental issues:

- legal status
- funding streams
- adolescent developmental needs
- attitudes of policy makers
- clinical diagnostic practices

![](source: California Department of Mental Health, Client Services Information System, 2001-2002.

Based on 2000 Census.

There are also similarities in the systems: both systems are vastly underfunded and serve only a fraction of those who need public mental health services; a large portion of incarcerated children and adults have significant mental health disorders; neither system has resources to provide early intervention or prevention services; and both systems rely on other public resources to assist individuals to achieve their goals.
**LEGAL STATUS**

Because of the inherent vulnerability of children, many areas of law attempt to protect them, including parental responsibility, child welfare, juvenile justice, compulsory education and special education systems.

- Children and youth depend on parents/caregivers who have a legal responsibility to provide their food, shelter, clothing, and health and mental health care.\(^7\) In addition to legal requirements, the fact that most children have deep connections to parents and families means that effective treatment will acknowledge the importance of families and will usually include them. Parental responsibility includes giving permission for most medical treatment, including permission for most mental health services.
- The Child Welfare system is designed to protect the child from parental neglect or abuse.
- The Juvenile Justice system is designed to provide an age-appropriate response to juvenile offenders.
- Education: All children must be educated until they reach age 18 or receive a high school diploma or equivalent.\(^8\) Children with disabilities that interfere with their ability to benefit from their education have a right to receive those services through Special Education necessary to achieve educational benefits through age 21.
- Autonomy:
  - Most adults with psychiatric disabilities make their own health care decisions.\(^9\) Only adult conservatees have limitations comparable to those of minors in their ability to consent to treatment. Family members of adult clients are included in mental health services only with client permission, in contrast to treatment with minors, where professional standards require the inclusion of parents and other caregivers in direct treatment.
  - Transition Age Youth with mental health needs may not be aware of their need for mental health services, may not know how to access them, may be sensitive to the stigma of mental health services, and may reject identifying with adult mental health clients whom they perceive as being “disabled,” with the stigma associated with that status.

**FUNDING**

Funding for mental health and related supportive services is fragmented and often tied to rigid eligibility criteria.

- MediCal-eligible children with a mental health diagnosis that meets medical necessity criteria are federally entitled to receive mental health services through the Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program. This includes those in the dependency and juvenile justice systems. A broad variety of types of services may be

---

\(^7\) Exceptions occur for children over the age of 12 who seek free confidential services connected to child abuse, substance abuse, and/or issues related to pregnancy or sexually transmitted disease.

\(^8\) For ages 16-18 Education Code sections 48200 permits a minimum of 4 hours per week in a continuation school and/or ROP program, or other educational program, and exempts those who are disqualified by physical or mental condition, or because personal services are required by a dependent.

\(^9\) With the exception of involuntary detention for assessment or treatment.
provided when appropriate, and a large proportion of these costs are reimbursed to counties by federal and state funding.\footnote{10}

- Students in Special Education prior to high school graduation have federal entitlement to mental health services that assist the child to achieve educational benefit, although reimbursement technicalities and recent State funding shortages make this an underfunded and therefore underutilized resource.
- MediCal-eligible adults may receive mental health services. However, the reimbursement is approximately half of that for EPSDT program services and the types of services eligible for reimbursement are more restricted than for children.
- There are no adult entitlements comparable to EPSDT and Special Education entitlements. MediCal-eligible adults are entitled to medically necessary services through their managed care plan. Non-MediCal-eligible adults usually must meet a means test as well as stringent mental illness criteria to access public mental health services.

Funding sources reported by counties in the following table reflect these points. (Multiple funding sources may be used for a single individual.) The table shows a steady decline in use of Medi-Cal and IEP funding in the older age groups, with a concurrent increase in reliance on county funding.

**NUMBER OF TAY SERVED BY CALIFORNIA COUNTIES 2001-02\footnote{11}**

<table>
<thead>
<tr>
<th>Funding Sources</th>
<th>Age 14-17</th>
<th>Age 18-21</th>
<th>Age 22-24</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Funding Sources</td>
<td>75,403</td>
<td>35,823</td>
<td>25,284</td>
<td>136,510</td>
</tr>
<tr>
<td>MediCal Funding</td>
<td>47,533 (63%)</td>
<td>18,213 (51%)</td>
<td>11,529 (46%)</td>
<td>77,275</td>
</tr>
<tr>
<td>County Funding</td>
<td>32,389 (43%)</td>
<td>19,944 (56%)</td>
<td>15,391 (61%)</td>
<td>67,724</td>
</tr>
<tr>
<td>IEP Funding</td>
<td>12,430 (16%)</td>
<td>1,934 (5%)</td>
<td>34 (0%)</td>
<td>14,398</td>
</tr>
<tr>
<td>Healthy Families</td>
<td>34 (0%)</td>
<td>1 (0%)</td>
<td>0 (0%)</td>
<td>35</td>
</tr>
</tbody>
</table>

\footnote{10} In spite of this it is estimated that about half of those eligible for services do not receive them. (California Mental Health Planning Council: California Mental Health Master Plan, Chapter 3, 2003, available at http://www.dmh.cahwnet.gov/MHPC/reports.asp.)

\footnote{11} Source of data: California Department of Mental Health, Client Services Information System, 2001–2002.
**DIAGNOSTIC PROFILE**

The following table shows the distribution of diagnoses for various aged youth and young adults from 2001-2002 statewide data. Rates of diagnoses vary by age group.

**MENTAL HEALTH DIAGNOSIS FOR YOUTH SERVED BY CALIFORNIA COUNTIES 2001-02**

<table>
<thead>
<tr>
<th>Diagnosis/Age</th>
<th>Age 14-17</th>
<th>%</th>
<th>Age 18-21</th>
<th>%</th>
<th>Age 22-24</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>612</td>
<td>0.81%</td>
<td>2119</td>
<td>5.92%</td>
<td>2550</td>
<td>10.09%</td>
</tr>
<tr>
<td>Psychotic Disorders</td>
<td>1159</td>
<td>1.54%</td>
<td>2617</td>
<td>7.31%</td>
<td>2292</td>
<td>9.07%</td>
</tr>
<tr>
<td>Bipolar</td>
<td>3354</td>
<td>4.45%</td>
<td>3832</td>
<td>10.70%</td>
<td>3220</td>
<td>12.74%</td>
</tr>
<tr>
<td>Depressive Disorders</td>
<td>20161</td>
<td>26.74%</td>
<td>9281</td>
<td>25.91%</td>
<td>6474</td>
<td>25.61%</td>
</tr>
<tr>
<td>Post-traumatic Stress Disorder</td>
<td>2668</td>
<td>3.54%</td>
<td>856</td>
<td>2.39%</td>
<td>505</td>
<td>2.00%</td>
</tr>
<tr>
<td>Other Anxiety Disorders</td>
<td>1929</td>
<td>2.56%</td>
<td>1380</td>
<td>3.85%</td>
<td>1179</td>
<td>4.66%</td>
</tr>
<tr>
<td>Substance-related Disorders</td>
<td>1203</td>
<td>1.60%</td>
<td>1937</td>
<td>5.41%</td>
<td>1539</td>
<td>6.09%</td>
</tr>
<tr>
<td>Cognitive Disorders</td>
<td>18</td>
<td>0.02%</td>
<td>43</td>
<td>0.12%</td>
<td>33</td>
<td>0.13%</td>
</tr>
<tr>
<td>Personality Disorders</td>
<td>90</td>
<td>0.12%</td>
<td>232</td>
<td>0.65%</td>
<td>152</td>
<td>0.60%</td>
</tr>
<tr>
<td>Adjustment Disorders</td>
<td>10819</td>
<td>14.35%</td>
<td>4234</td>
<td>11.82%</td>
<td>2507</td>
<td>9.92%</td>
</tr>
<tr>
<td>ADHD/ADD</td>
<td>5545</td>
<td>7.35%</td>
<td>715</td>
<td>2.00%</td>
<td>134</td>
<td>0.53%</td>
</tr>
<tr>
<td>Disruptive Behavior Disorders</td>
<td>14350</td>
<td>19.03%</td>
<td>1302</td>
<td>3.63%</td>
<td>33</td>
<td>0.13%</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>61908</strong></td>
<td><strong>82.10%</strong></td>
<td><strong>28548</strong></td>
<td><strong>79.69%</strong></td>
<td><strong>20618</strong></td>
<td><strong>81.55%</strong></td>
</tr>
</tbody>
</table>

As seen in the table, diagnostic issues change as youth age:

- The rate of schizophrenia diagnosis is 12 times greater for young adults aged 22-24 than for youth aged 14-17. Similarly, young adults are diagnosed with other psychotic disorders 6 times as frequently as youth, and bipolar disorder 3 times as frequently as youth.
- Rates of diagnosis for depressive disorders remain about the same, with about 25% of young people in services affected.
- ADHD/ADD and PTSD diagnoses are vastly reduced throughout the transition years.

While some of the changes are due to the typical age of onset of certain mental illnesses, the process of assigning a diagnosis is not necessarily objective, and may depend at least partly on contextual elements, including funding issues, social attitudes, age, class, and ethnic and racial discrimination.

**COUNTY SURVEY OF SERVICES TO TAY**

Additional descriptive data helps understand how counties have responded to the needs of TAY. Information about mental health services to TAY was gathered in a survey of county mental health agencies. Highlights of the results are summarized on the next page.

---

12 Source of data: California Department of Mental Health, Client Services Information System, 2001-2002.
13 Methodology: The TAY Committee developed 16 questions. Surveys were sent to 58 County Mental Health directors in December 2003. Fifty-three Directors or their designees responded. Several questions were found to be ambiguous, and were discarded. The Questionnaire is in Appendix A.
44 of 52 responding counties (85%) reported that their counties have services or programs available specifically to address the needs of TAY who are receiving public mental health services.

20 counties (38%) reported that their county mental health systems had outreach efforts that targeted transition age youth, as reflected in Chart #1, below.

**CHART #1: DOES YOUR COUNTY MENTAL HEALTH SYSTEM CONDUCT OUTREACH EFFORTS TARGETING TRANSITION AGE YOUTH?**

- Yes 20 (38%)
- No 32 (60%)
- No Answer 2 (2%)

17 counties (33%) reported that specific policies and procedures that address services for TAY have been developed. See Chart #2.

**CHART #2: HAVE SPECIFIC POLICIES AND PROCEDURES BEEN DEVELOPED IN YOUR COUNTY MENTAL HEALTH SYSTEM THAT ADDRESS SERVICES FOR TRANSITION AGE YOUTH?**

- No 17 (33%)
- Yes 33 (63%)
- No Answer 2 (4%)

31 of 52 counties (60%) reported that they assign staff to work specifically with Transition Age Youth who have mental health conditions.
- 41 counties (77%) reported that the county formed collaborative partnerships with other agencies or entities in developing or delivering services to Transition Age Youth who are receiving mental health services.
- 22 of the 52 respondents (42%) reported that their mental health system tracks data specific to transition-age youth; 30 (56%) do not track TAY-specific data. See Chart #3 below.

**Chart #3: Does Your County Mental Health System Track Data Specific To Transition Age Youth?**

- 22 counties (42%) reported that the county mental health system conducts ongoing system planning or assessment activities specifically focused on the needs of Transition Age Youth with mental health conditions. See chart #4 below.

**Chart #4 (Question 9): Does Your County Mental Health System Conduct Ongoing System Planning Or Assessment Activities Specifically Focused On The Needs Of Transition Age Youth (TAY)?**

- Just three counties (6%) reported youth voice in policy level decision making.
A wide variation in the age ranges included in “transition age” was reported (see Chart #5): transition age started at 14 to 18 and ended at 19 to 25 years old. Total years included ranges from 2 to 11 years. Twenty-six (26) counties (52%) end transition age services at age 21, when Medi-Cal eligible youth are no longer included in the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program. The only age served by all reporting counties was age 18.

**Chart #5**

- Counties identified their strengths and weaknesses regarding TAY services (Number of counties reporting strength or weakness follows each statement in parentheses).

**Strengths:**

- Collaborative relationships with other agencies (19)
- Awareness of TAY needs (8)
- Small town/county and good relationships (5)
- Collaborative or seamless transition to adult services (4)
- Youth advocacy and including youth in planning (2)
Housing resources for TAY (2)

Weaknesses:

- Lack of resources (funding and staff) (19)
- Lack of housing (6)
- No or limited specialized services (6)
- No formal TAY system, policies and/or services (6)
- Limited public transportation (3)
- Lack of youth involvement in policy development (3)
- Difficulty covering large geographical area (2)
- Counties identified the characteristics of their TAY population that are “prevalent enough to require special services” as seen in Chart #6.

**Chart#6: What are the characteristics of your TAY population that are prevalent enough to require special services?**

- Substance Abuse Issues 43
- Homeless or formerly homeless 28
- Aged out of Children’s Services 29
- Cultural Issues 19
- Youths who self-identify as transgender 8
- Youth who are parents or pregnant 19
- Other 11

Conclusions:

1. There are disparities of care for transition age youth that result from a combination of institutional and developmental factors. Efforts are needed to correct these disparities by increasing outreach and creating the kinds of services that are needed by this unique age group.
2. The fragmentation of funding and the rigid rules for categorical eligibility hamper efforts to integrate and individualize services. Efforts at local, county and state levels are needed to reduce fragmentation and increase flexibility for use of funding.
3. Counties report making progress in developing policies, infrastructure, and services for TAY, but more needs to be done. There is a need for more designated TAY resources (funding and staff) as well as community supports such as housing, specialized services, and public transportation, among other services. There is also a need for agencies to collaborate and maximize resources.
CHAPTER III

RISK, RESILIENCE AND WELLNESS FOR TRANSITION AGE YOUTH

“One thing life has taught me: if you are interested, you never have to look for new interests. They come to you. When you are genuinely interested in one thing, it will always lead to something else.”

—ELEANOR ROOSEVELT
CHAPTER III

RISK, RESILIENCE AND WELLNESS FOR TRANSITION AGE YOUTH

One way to think about the services we provide is that, to be successful, they should be designed to promote wellness and minimize or reduce the risk factors that make people vulnerable to the onset or re-emergence of Emotional and Behavioral Disorders (EBD) (Masten, 2001). Promoting wellness requires a focus on strengthening “protective factors” such as individual, family and community strengths, social supports, competence, etc. These concepts are especially pertinent to the Transition Age Youth (TAY) group, since as a result of developmental and systemic factors, they are at a threshold in their lives when there are increased opportunities for either recovery or decreased functioning. This section will explore the concepts of risk, resilience, and protective factors, and the role they play in developing interventions that support the achievement of wellness for TAY.

WHAT IS “RESILIENCE”? 

Resilience has to do with an individual’s ability to maintain stable functioning in the face of adversity. Stable functioning should be defined in the terms of the individual’s developmental context. Emerging adulthood (the period from the late teens to the late twenties) is characterized by exploring identity and new life-course possibilities (Arnett, 2004). This exploration typically co-exists with unstable aspects of lifestyle (such as frequent residence changes) and relationships to others characterized as “in-between” adolescence and adulthood. For TAY, stable functioning may mean the ability to proceed with the developmental tasks of emerging adulthood, even if not fully accomplishing society’s expectations of having residential stability, obtaining stable employment, completing school, or establishing a family. In this regard, for TAY with EBD the term “discovery” (Clark, 2002) is a better summary of these developmental tasks rather than “recovery,” which is defined as the ongoing “process in which people are able to live, work, learn, and participate fully in their communities” (New Freedom Commission on Mental Health, 2003, pg. 5). Given the developmental tasks of exploring opportunities for housing, employment, school, and social relationships, the process of discovering interests, dreams, strengths and values is the key to establishing an adult identity and making life-course decisions (Clark, 2003).

There are three distinct populations of TAY who will face different types of adversity in the transition to our adult service systems. The first population consists of adolescents being served in the children’s systems of care. These youths are entering adulthood already burdened with an illness that will most likely continue, such as those diagnosed with schizophrenia, co-occurring substance use and mental disorders, and severe and persistent affective disorders, among others. These youths will require continuous service through the transition into adulthood in the domains described throughout this TAY Resource Guide. The objective of recovery would apply to this group as they mature into adulthood.

The second population consists of adolescents with emotional disorders that may reflect child, adolescent and family adjustment issues such as less severe conduct disorders, adjustment disorders, and, for some children, Post-Traumatic Stress Disorders (PTSD). These children and adolescents, while not completely free of recurring problems under adverse circumstances, will

---

14 For others, PTSD may have lifelong sequelae and result in later disorders that meet target population criteria for adult systems of care.
most likely not develop more serious mental disorders. However, to the extent resources are available, they still need appropriate services to prevent the onset of more serious problems, and help them move on in their developmental tasks.

The third population consists of individuals who develop new disorders in late adolescence and early adulthood (or disorders that have not been assessed previously). The onset of some disorders (such as psychoses, bipolar disorder, and addictive disorders) are known to have their first onset in late adolescence and early adulthood, and thus come to the attention of mental health professionals (Kessler et al., 1996). (See, for example, the chapter on Early Psychosis). We do not yet have the tools to predict which children and adolescents will develop these disorders later in life, although there are some research findings of the correlates for later disorders, such as the likelihood of children diagnosed with conduct disorders or ADHD to develop later co-occurring disorders (Costello, Armstrong, & Erkanli, 2000).

Risk factors that predict a person’s response to adversity or stress have been categorized as risk traits (e.g. genetic predisposition; neurological impairments) and environmental effects (i.e. exposure to violence; chronic poverty; family support). Researchers agree that there is significant interaction between traits and the environment (Fraser, Kirby, & Smokowski, 2004). For example, a genetic marker for a disorder does not guarantee that the disorder will eventually surface. The environmental context is highly influential and can shape risk factors (i.e. prenatal and early age stressors have effects on brain development in childhood (Dawson, Ashman, & Carver, 2000) and they can moderate risk factors during later development beyond childhood and adolescence. Some risk factors rise to the top of the priority list since they elevate chances for negative outcomes. Suicidal thoughts, substance abuse, and risk-taking behavior, among other high risk factors, imply the need to muster all available supports and strengths in the environment in order to reduce the immediate risks. Where and how to intervene in these various kinds of risks requires an understanding of how much control the individual has over them and what factors the individual, family and community can muster to overcome them.

Being “resilient” has to do with how well a person is protected from risk factors and adversities. The concept of personal resilience applies not only to those facing impossible odds, such as survivors of extreme violence or disasters, but also includes basic competencies that are very amenable to intervention for most people, even under moderate or severe levels of stress (Masten, 2001). The characteristics that help individuals maintain stable functioning through adversity are “protective factors.” These include individual factors (e.g. an easygoing disposition, competence in school or other activity, high self esteem); family factors (e.g. parental warmth and availability or other caring adult relationship); and community factors (e.g. availability of resources in a neighborhood). Some of these factors were established in early childhood (such as parental warmth) and continue to benefit the individual throughout adulthood (Masten & Coatsworth, 1998); others represent an ongoing process of interaction between the individual and environment.

The research into resilience and protective factors has resulted in a heightened awareness of the importance of competencies, strengths, and assets in the prevention of such negative outcomes as teen pregnancy, sexually transmitted disease, substance use, adolescent and adult antisocial behavior, and PTSD. This shift in thinking away from the one-sided deficit approach of psychopathology was an important precursor to strengths-based models for systems of care. Practitioners know that a focus on symptoms and problems alone cannot support recovery,
without the mobilization of personal, family and community resources. Helping a person strengthen and maximize protective factors is probably the most important and long-lasting outcome that can be achieved. These factors can continue to provide benefit long after the intervention ends.

**WHAT IS “WELLNESS”?**

Because an EBD can affect so many aspects of a person’s life, it makes sense to think about the overall goal of our interventions as maintaining or increasing our clients’ wellness. The wellness approach is a holistic framework that is congruent with the recovery movement. There are five “pathways to wellness” as proposed by Emory Cowen, a founder of prevention and early intervention (Cowen, 1994):

1. Forming wholesome early attachments;
2. Acquiring age-appropriate competencies;
3. Exposure to settings that favor wellness outcomes;
4. Having the empowering sense of being in control of one’s fate; and
5. Coping effectively with stress.

Originally developed to support early interventions for very young children and families, these pathways can easily be adapted to services for transition age youth. In addition to the effects of wholesome early attachments, ongoing wellness for adolescents and transition age youth requires meaningful and continuous relationships with caring adults. Age-appropriate competencies for TAY include such things as work and study skills, skills in social relationships, etc. TAY need exposure to settings that support their developmental tasks and strengths (such as supportive group housing), and some TAY need extra help avoiding negative settings (such as a drug-using peer group). Like all people who benefit from feeling in control of their lives, TAY do better when they are in charge of decisions about their treatment, living situation, and personal goals. TAY with emotional disorders needs extra help coping with the normal stresses of becoming independent, made even more difficult by the burdens of their EBD.

Within a wellness framework, for example, the goal “reduction of symptoms”, if it is truly congruent with the client’s own goal, would contribute to the achievement of wellness via the pathways of increased ability to cope with stress and an increased sense of competence. Similarly, relapse prevention involves skill building (learning to identify early symptoms and managing them effectively) as well as the utilization of internal and external resources for support (Walling & Marsh, 2000). In another example, providing assistance to a TAY in completing college financial aid forms similarly contributes to overall wellness by allowing the individual to develop competencies useful in adult life (self-advocacy, writing, and money management, among others).

The wellness framework allows for a multi-factor approach in justifying and designing interventions. It assumes that the strengthening of one pathway to wellness will influence others, and that success in one outcome will have long-lasting effects in later development and with multiple outcomes. Facilitating a young person’s entry into, and completion of, college classes has the short term effects of increasing coping abilities and building competencies, and the potential long term effect of building personal resilience factors that will be needed to participate in the labor force throughout adult life.
A key strength of the wellness framework is that it is “culturally relative”—in the context of the individual’s social and cultural environment, each person can define his or her pathway. For example, the importance of “being in control of one’s own fate” is culturally determined—some cultural traditions place more emphasis on the interdependence among the individual, family, community, and spiritual roots than in our mainstream culture, which places a high value on individual independence. As discussed further in this TAY Resource Guide, a wellness-oriented individualized assessment and planning process, putting the TAY and family at the center of decision-making, and a focus on strengths and resources, will ultimately result in appropriate, culturally sensitive interventions geared towards improving wellness.16

One more concept directly related to resilience and wellness is worth mentioning. Longitudinal studies have found that some children and youth with significant early risk factors for such outcomes as EBD and involvement with criminal justice have much better life adjustment in adulthood than expected. One important factor that these adults refer to is a “turning point” that marked a significant change in their lives. Examples of turning points from a cohort born in the mid-1950s include finding a religious or spiritual direction, marriage, parenthood, military service, and some type of vocational calling (Werner & Smith, 2001). Some of these turning points, like military service, had more impact on disadvantaged youth than on others whose families were well off. Other turning points may have become meaningful for later generations. For example, former foster youth often describe their experience with mentors as a turning point in their lives. Even traumatic events sometimes have the paradoxical long-term effect of building inner strength and maturity. Transition Age Youth are ripe for such turning points because of their developmental life stage. The adults in the Werner study stressed that turning points are important factors in their own right (this is supported by more recent research in developmental psychology), and that opening opportunities for youth and young adults to experience them is a requirement for our service systems.

SUPPORTING WELLNESS FOR TRANSITION AGE YOUTH

Services for a TAY that strive to address the individual’s known risks, utilize and strengthen the available resources and strengths, and open opportunities for positive turning points, will most likely help TAY establish their own pathway “on the road towards wellness.” Masten and Coatsworth (1998) identify three categories of service strategies based on the concept of resilience: (a) risk-focused, (b) resource-focused, and (c) process-focused strategies.

Risk-focused strategies target the identification, prioritization, and reduction of risks. Typical interventions might include those that ensure safety, minimize stressors, or prevent negative outcomes such as homelessness. Resource-focused strategies seek out and capitalize on protective factors and strengths, such as mentoring and peer-to-peer programs, opportunities for social activities, and individualized educational plans that support a student’s talents. Process-focused strategies are those that affect more global characteristics, such as competence, self-efficacy, and self-regulation. Interventions designed to promote success, accomplishments, and increased self-esteem would fall into this category. Obviously, many of our services cast a wide net and attempt to achieve multiple objectives among these three categories. It would be hard to implement an intervention that did not. Considering that much of the research points to the cumulative effects of risk and protective factors (rather than one or two important ones), services that incorporate as many of these objectives as possible are likely to yield positive results.

16 Clark, Deschenes & Jones provides more comprehensive guidelines for the development and operation of quality transition age service systems.
How can we incorporate the concepts of risk, resilience and wellness into developing interventions for TAY? Fraser and Galinsky (2004, pg. 389) outline a systematic process to identify an individual’s risks and protective factors in selecting and tailoring evidence-based practice strategies:

1. Define problem(s) collaboratively with client & family. What are the risk factors for the problem(s) and protective resources (i.e. strengths\(^{17}\)) that can be utilized?
2. Identify the desired outcomes to be achieved (also with client & family).
3. Select appropriate resources (services, interventions, informal supports) that can be expected to reduce risks and promote protective factors, and can be linked to achieving the desired outcomes (through the best available evidence).
4. Modify or adjust the care plan to the individual’s cultural and contextual environments, and client preference.
5. Implement the interventions as close as possible to existing practice guidelines while matching individualized preferences and context.
6. Evaluate progress towards reducing risks, promoting protective factors, and achieving targeted outcomes.

These guidelines were written to be used with clients of all ages and their families. We think they are particularly relevant to TAY and TAY systems of care, in conjunction with the assessment and planning guidelines in Chapters VIII and IX of the TAY Resource Guide.

The following chapters of the TAY Resource Guide make the concepts presented in this chapter “come alive” and address pathways towards wellness in the significant domains for TAY: education, employment, living situation, and community-life adjustment. The stakeholders involved in the TAY Resource Guide’s development have an unwavering belief in the potential of TAY and their families to use their strengths and resources to support recovery, and in the ability of a TAY system of care to allow that to happen.

\(^{17}\) “Strengths Discovery” (Clark, 2003), is an ongoing process of identifying protective factors (i.e. dreams, positive personal characteristics, personal and familial resources) while involving and empowering TAY and their families. Strengths Discovery is an integral part of identifying and implementing services that are highly individualized. This focus also ensures that any attention to risk factors will also result in promoting recovery, since their identification will lead to the mobilization of strengths and supports rather than to the potentially stigmatizing and disempowering effects of deficit-based decisions about treatment.
REFERENCES


CHAPTER IV

CULTURAL COMPETENCE AND TRANSITION AGE YOUTH

“We do not see things the way they are; we see things the way we are.”

— TALMUD
CHAPTER IV
CULTURAL COMPETENCE AND TRANSITION AGE YOUTH

OVERVIEW

This chapter presents Cultural Competence in Transition Age Youth (TAY) programs and practices not as a distinct concept or idiom, but as a foundation to the formulation of this entire manual, and as an integral component of quality care, equity, and social justice. As such, the California Mental Health Director’s Association (CMHDA) TAY Subcommittee included this chapter on cultural competence and TAY with the expressed intent to infuse its concepts and principles. This manual is culture-based; therefore, each section presents information from a cultural competence perspective and recognizes such elements as race, ethnicity, age, gender, sexual orientation, socioeconomic status, geography, cross-cultural relations, religion, and language. The participation and involvement of TAY and their family members in the design, development, implementation, evaluation, and ongoing monitoring of programs and services is also recognized. In addition, there is an understanding that these efforts must occur at all levels of a system and in the provision of services to all young people with emotional and behavioral difficulties and their families.

CULTURAL COMPETENCE

Cultural Competence is a multilevel and multidimensional set of principles and practices, the aim of which is to: a) eliminate disparities and increase access and utilization; b) provide for more appropriate treatment; and c) improve outcomes for people in need of services. The expectation is that these individuals, regardless of race, ethnicity, gender, age, socioeconomic status, geographic location, religion, or language, receive the best available services they need with dignity, respect, sensitivity, appropriateness, appreciation, and their full participation, as well as that of their family members and community. In California and across the country, recent efforts around cultural competence, not exclusive to TAY, have revolved around the implementation of system-wide reform efforts. These efforts have involved system planning such as in development of new cultural competence managed care standards, institutional change protocols for system self-assessment and system-wide change to address disparities, and especially efforts to address the areas of quality of care and access. At its core cultural competence is about equity and social justice. This chapter is not presented as a TAY cultural competence checklist, linear in scope, but as a framework that can be used in local planning for system change and for new services. There are four overarching themes that should be considered in efforts to address culturally competent TAY programs and practices: a) elimination of disparities; b) quality and appropriateness of care; c) outcomes; and d) systemic change. Each of these issues will be addressed in this chapter.

Elimination of Disparities
To set the context for cultural competence in California, let’s look at the current and emerging demographics of the State.\(^{18}\) Thirty-four percent of persons in California nineteen years of age or younger are what the census refers to as White Alone/Not Hispanic. Conversely, 66% of this same age segment is individuals from racially and ethnically diverse groups, with the greatest proportion occurring in the Hispanic/Latino population (43.5%). Similarly, when looking only at those young people ages 10 to 19, we find similar distributions, roughly 37% White Alone/Not Hispanic.

---

\(^{18}\) This information was taken from the California Department of Finance website: www.dof.ca.gov.
Hispanic and about 63% from racially and ethnically diverse communities. Therefore, data has shown that the number of White Alone/Not Hispanic and Hispanic/Latino populations is relatively the same for individuals under the age of 19 as it is for individuals over the age of 19 years old. Additionally, language needs to be addressed when planning services to TAY and their families. The U.S. Census Bureau reports that in California 12.4 million individuals or 39.5% of the population speak a language other than English at home, and 8.1 million Spanish speaking individuals alone speak English less than very well. The implication is that as this state continues to grow, its diversity will increase dramatically, and programs and services will have to keep pace in order to continue providing culturally and linguistically responsive and relevant mental health care.

In the provision of health and mental health services in the United States there exist service disparities and inferior health and mental health status has been documented for racially, ethnically, and linguistically diverse communities (National Center for Health Statistics, 1998; DHHS, 2001; Institute of Medicine, 2003). Further, minority groups are less likely to utilize mental health services more likely to drop out of mental health services at higher rates, and more likely to be misdiagnosed by practitioners. They often receive a poorer quality of care despite having similar prevalence rates of mental health disorders when compared to other groups. Young people in California from diverse populations have numerous unmet mental health needs which subsequently expose them to our system’s most undesirable consequences: homelessness, incarceration, hospitalization, and misdiagnosis; poorer quality of care, out-of-home placements, and school failure. In fact, Hispanic/Latino American and African American youth have the highest high school drop out rates in California and nationally (See Taylor-Gibbs and Huang, 2003). Hispanic/Latino American and African American youth are more likely to attend schools with less experienced teachers and with difficult social environments (such as overcrowded classrooms and numerous episodes of violence) and they are less likely to participate in advanced coursework in math and science. They are also more likely to engage in high-risk behaviors; for example, Hispanic/Latino American young women have the highest rates of teen pregnancy (Fuligni and Hardway, 2004).

A 2001 issue of Focal Point which focused on youth in transition reported that young adults ages 15-24 were more than twice as likely to suffer a psychiatric disorder compared to 45-54 year olds. However, at the same time, insurance coverage for young adults ages 18-25 was weaker and more tenuous than for all other age groups. Additionally, Yohalem and Pittman (2001) stated that when one looks at vulnerable youth, it is impossible to ignore the fact that cultural and social diversity play a significant role. They suggested that many diverse youth have faced discrimination on multiple fronts in the very systems designed to help them. As a result, their disproportionate confinement within the justice system, their over-representation in special education, foster care and out-of-home placements, and their experience with institutionalized racism within the health care system is well-documented. Transitioning foster care youth who were at the most vulnerable period of their lives were cut off from most services merely because

---


20 See also www.futureofchildren.org for more information.


they reached a cut-off age. Half of these transitioning young people did not complete high school; about half were unemployed; fewer than 20% were economically self-sufficient; 25% had been homeless at least one night; and 60% of the females had given birth. These outcomes are important to understand when developing or improving mental health services and those of other TAY-serving agencies.

Providing culturally competent mental health services to TAY is about providing culturally appropriate services to all young people who need them. However, the fact that diverse young people are over-represented among vulnerable populations is a critical aspect to this population that we cannot ignore. Clark and Davis (2000) stated that in order to be culturally competent, mental health professionals and systems must demonstrate sensitivity and responsiveness to individual variation in gender, ethnicity, sexual orientation, social class, and other unique orientations and needs of each TAY and his or her family members. This responsiveness and sensitivity are essential to quality care. Taylor-Gibbs and Huang (2003) noted that race and ethnicity play a major role in child and adolescent development. It is important for programs and practices for TAY to address these developmental constructs when developing, implementing, and evaluating services, and to address safeguards against increasing disparities for diverse TAY. Sue, et al. (1992) stated the need and rationale for a multicultural perspective in our society, particularly in counseling and education. There is a high need for a multicultural approach to culturally competent assessment, practice, training, and research.

There are important policies and accepted standards that guide the provision of culturally competent mental health services. These can be summarized under federal and state policies, how culture and cultural competence have been applied by the Department of Mental Health (DMH), and the relationship between cultural competence and evidence based practices. First, we begin with the federal and state regulations, which mandate such provision of services. Title VI of the Civil Rights Act of 1964 and the Americans with Disabilities Act of 1990 provides protections to individuals receiving services from being excluded from participating in, or denied benefits of, or being subjected to discrimination by any federally financed program or activity on the basis of race, color, or national origin. Also, the U.S. Department of Health and Human Services, Office of Minority Health, issued national standards for culturally and linguistically appropriate services in Health Care, which addressed the need to ensure that all people entering the health care system receive equitable and effective treatment in a culturally and linguistically appropriate manner. These standards where developed as a means to correct inequities that have existed in the provision of health services and to make those services more responsive to the individual needs of all service recipients.

At the state level, several California statutes have addressed issues related directly to or in connection with culturally and linguistically appropriate services and service provision, including the Welfare and Institutions Code Sections 4341, 14683, 14683 (b), 14684 (h), 5600.2, 6600.2 (g), 5600.9 (a), 5802 (a)(4), 5855 (f), 5865 (b), 5880(b)(6), as well as California Government Code Sections 7292, 7295, and 7296.2. Lastly, in 1998 the California Department of Mental Health mandated county mental health departments to create Cultural Competence Plans, with the purpose of establishing standards and plan requirements for county mental health plans.

---

23 Some of the information in this section on Cultural Competence was taken, in part, from the California Department of Mental Health’s (DMH) Revised Addendum (4-2002) Plan for Culturally Competent Specialty Mental Health Services (CCP) and the Adult System of Care (ASOC) and Children’s System of Care (CSOC) frameworks. In addition, other referenced sources within this section were included to give the section more clarity, uniformity, purpose, and vision.

24 Revised Addendum (2002). Required Components for Implementation of Specialty Mental Health Services: Consolidation of Specialty Mental Health Services (Phase II).
(MHPs) toward achieving cultural and linguistic competency. As stated in the mandate, its intent was to assist MHPs in creating a more responsive and accessible system for Medi-Cal beneficiaries in the delivery of quality and cost-effective specialty mental health services.

Second, it is important to describe cultural competence and its application to California’s public mental health system. The recognized definition of culture by DMH comes from Cross, et al (1989) and is defined as the integrated pattern of human behavior that includes thought, communication, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group. Additionally, they define cultural competence as a set of congruent practice skills, knowledge, behaviors, attitudes and policies that come together in a system, agency, or among consumer providers and professionals that enables that system, agency, or those professionals and consumer providers to work effectively in cross-cultural situations. Additionally, the DMH Emergency Regulations for Managed Care, Title 9 of the California Code of Regulations, Section 1705, defines culturally competent services as a set of congruent behaviors, attitudes and policies in a system or agency to enable effective service provision in cross-cultural settings.

Third, given the current demographic composition of California’s child, youth, and young adult population, it becomes essential for TAY programs and the provision of related services to recognize, adopt, and commit to providing culturally and linguistically competent mental health services. “Evidence Based Practices” (EBPs) may have achieved acceptance due to rigorous testing; however, that does not always mean that the practices have been adequately tested with sub-groups such as ethnically – or culturally – different groups of people. It is critical that practices that have been deemed evidence-based or effective recognize the importance of culture in determining what is effective for diverse populations, as well as address issues of access to services and the utilization of those services. Cautious optimism should be the guide when determining what populations these EBPs are applied to. Further, cultural and language considerations should drive the types of outcomes that are important to research and evaluation efforts, and to strive for in service implementation.

Quality and Appropriateness of Care
The Surgeon General’s Supplemental Report on Mental Health stated that culture and language affect the perception, utilization, and outcomes of mental services (DHHS, 2001). Consequently, the provision of culturally and linguistically appropriate mental health services are critical components for any programming designed to meet the needs of diverse communities. The report suggested that mental health programming should include such components as language access for persons with limited English proficiency; services provided in a manner that is congruent, rather than conflicting with cultural norms; and the capacity of the provider to convey an understanding for the consumer’s worldview, level of acculturation, and real-life experiences, among other factors. To be effective, services must incorporate culturally sensitive assessments and responsive treatment modalities. In addition, a service provider’s awareness of their own cultural orientation, their skills with different cultural groups, language capacity, and their knowledge of a consumer’s background are essential to improving access, utilization, and the quality of mental health services for diverse populations. Depending on which segment of the TAY population you wish to target programming and services to (CSOC to ASOC; CSOC to community; or community to ASOC), there will be multiple cultural factors to consider. Therefore, ongoing appropriate and intensive assessment, training, evaluation, and community stakeholder involvement should be central components of any TAY programming.

Researchers agree that four critical areas need to be addressed when developing systems of care for TAY: employment, education, living situation, and community participation (see Clark and Davis, 2000). Entities which provide services to TAY must recognize the differing significance to
young people across cultures within these four areas. For example, when considering employment, it is likely that in some diverse cultures, many of the young people have already worked, either alongside parents, or as individuals, early on in life. The implication for providers is that in some cultures, employment may not always be a new experience or the most important outcome. In education, it is critical to become knowledgeable of the differing effects for diverse groups. For example, in California, racially and ethnically diverse young people are more likely to drop out of high school than other groups – the highest group comprising the Hispanic/Latino population. In addition, it may be the case that language will become a primary area to be responsive to for the young people in this state. It is also important to offer vocational and/or technical certification training programs as alternatives to mainstream education.

Living situation includes living environment and family structure, among other factors that are highly culturally determined. For example, in some diverse communities living independent of the family is not necessarily a meaningful outcome, let alone a norm. So striving to motivate a young person to become independent of his or her family or community may actually be an inappropriate strategy reflecting a mainstream value system of independence and self-sufficiency, rather than a reliance on family and a more culturally inclusive view of interdependence and role-extended view of family. Policy planning and program designing for TAY must be cognizant of individualist cultural views, when collectivist worldviews may be more appropriate. Become aware of your service population’s cultural worldviews in addition to individual and family living situations.

Community participation in and of itself has some cultural implications. Although stigma can be a detriment to full community integration, it, it may play a larger role in racially and ethnically diverse communities. Community participation can take on differing manifestations (e.g., spiritual resources, transportation, general health care, behavioral management, leisure activities, etc.). Racially and ethnically diverse adolescents are more likely to be in poor physical health and engage in high risk behaviors. Compared to White Alone/Not Hispanic adolescents, youth from diverse communities and immigrant families are less likely to have regular access to health care. It is also important to differentiate between person-centered care and cultural competence. Person-centered care revolves around individual client needs, whereas cultural competence revolves around the client’s individual needs, the cultural interpretations of those needs, as well as the components of the system or program attempting to meet them. In a collectivist culture (often found in diverse communities) the adolescent is viewed from the family-self (self in relation to others) and in mainstream cultural worldviews it is more typically based on individual-self first. What would a family-centered approach mean for service design for TAY? This question must be considered when enhancing or developing programs and services for all TAY.
**Outcomes**

TAY outcomes should be culturally relevant and appropriate, as well as measurable, practical, and in the best interest of the young person in relation to his or her family. In addition, the outcomes should be driven by the young person and their family. Often, programs and services are driven by outcomes that are not necessarily congruent with the worldview of particular cultures. As a consequence, service strategies lead to meaningless results. In relation to quality of care and outcomes the Surgeon General’s supplemental report (DHHS, 2001) defined appropriateness as **receiving an accurate diagnosis or guideline-based treatment** based on a careful assessment and evaluation of a person’s symptomatology in relation to the diagnostic criteria established in the Diagnostic and Statistical Manual IV (pg. 17). If treatment efficacy is defined as the attainment of positive outcomes, then appropriate outcomes must be defined within the cultural context of the individual, given a culturally sensitive assessment. For example, the over-diagnosis of conduct disorder in young people from diverse cultures may characterize a lack of appropriateness in serving systems, and therefore, can lead to the establishment of less appropriate treatment and outcomes (DHHS, 2001).

Programs which provide services for diverse young people should take extra steps to gain feedback from them to establish the desired objectives of treatment, and hence the outcomes. It is critical to assess and evaluate your services’ capacity to gain this vital information. Further, utilizing the cultural formulation model, as prescribed in the DSM-IV, should be an essential component to any TAY program, whereas the following areas should be explored with each young person throughout their transition:

- Cultural identity of the individual
- Cultural explanations of individual’s illness
- Cultural factors related to psychosocial environment and levels of functioning
- Cultural elements of the relationship between the individual and provider
- Overall cultural assessment for diagnosis and care
- Family assessments and acculturation factors

The involvement of the family and community in the young person’s treatment, where appropriate, may have significant cultural relevance and result in more appropriate outcomes for both the young person and his or her family.

**Systemic Change**

Systemic change involves a dedicated and concentrated effort to transform systems. The goal of cultural competence therefore is not only to infuse its principles and practices for individuals, but also to establish a more comprehensive system transformation so that agencies ensure that cultural reflection, innovation, and acceptance exist at every level. The Institute of Medicine (2003) released a report titled *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, which set forth the following:

Systemic interventions to improve healthcare delivery for diverse populations include organizational accommodations that may promote equity in healthcare, policies that reduce administrative and linguistic barriers to care, and practices that enhance [consumers’] knowledge of and roles as active participants in the care process. These efforts are likely to be most effective when applied in a systemic, simultaneous, multi-level, coordinated fashion, and follow a well-developed strategic plan that has [consumers], their families, and the communities in which they live; clinicians;
administrative staff; and health systems leadership. Systemic interventions also include changes to healthcare law and policy that promote equality of healthcare delivery (p. 180).

Further, the Focal Point issue on transitioning young people revealed that successful transitions were facilitated when treatment planning, services, and supports:

- build in and build on what remains stable in the child’s life, particularly family relationships and relationships with others who are providing ongoing support;
- are individualized and family- and child-driven, taking into account the unique situations and the particular capacities, needs, cultural values and goals of children, their families, and their communities;
- capitalize on and enhance the strengths of the child and maintain activities, program involvement, and other supports which have worked in the past;
- anticipate and prepare for transition well in advance and maintain transition supports past the actual point when a setting or situation changes;
- are coordinated, while also managing and sharing information in a way that is both efficient and respectful to the young person and their family.

Furthermore, the series pointed out that much of the trauma associated with transition could be eliminated when transitions were made less frequent or when they were avoided altogether. However, the reality of our mental health service system is that transitions are unavoidable due to program designs and funding issues. The series added that implementing transition programs and plans based on the above list would be difficult to do well. As a result, each transition plan or program would have to fill in the specifics behind these generalities in ways that creatively address the challenges surrounding a given type of transition.

CONCLUSION

By the year 2050, diverse racial and ethnic groups will make up almost half of the total U.S. population. In California, this figure is already over half. Because of these demographic changes, human service systems must change or adapt programs and services to meet the needs of the largely diverse and growing number of young people and their families in this state. Systems and programs must consider cultural competence at the policy-making level, the organizational level, and the direct service level.

Applying effective TAY programs and practices which address issues related to cultural competence should be the norm in all program design. Evidence based practices should be implemented with cautious optimism, unless the program has been tested with the same cultural groups and languages of the local populations of diverse communities. Further work may need to be done to match the practice and make adjustments for the diverse community.

RECOMMENDATIONS

The following recommendations regarding cultural competence and TAY are offered to guide mental health systems in promoting a more culturally competent system of care. These recommendations were derived from a multitude of sources including the members of the committee, the cultural competence literature, and the good work in practice occurring across California.
1. Efforts to eliminate barriers to accessing mental health care for TAY including discrimination, bias, stigma, and costs need to be continued and expanded.
2. Efforts to eliminate disparities in access to and quality of mental health care for TAY need to be continued and expanded.
3. The involvement of family members and community in the young person’s treatment, where appropriate, is essential, given that this involvement will have significant cultural relevance and may result in more appropriate outcomes for both the young person and his or her family.
4. Mental health systems should include a description and an objective or goal for the delivery of services to TAY as part of any Cultural Competence mandates or requirements.
5. TAY should be specifically mentioned when describing unmet needs in your service populations.
6. Mental health professionals and systems must demonstrate sensitivity and responsiveness to individual variation in gender, ethnicity, sexual orientation, social class, and other unique orientations and needs of each TAY and his or her family members.
7. Programs or practices which have been deemed evidence-based or effective, if implemented, must recognize the importance of culture in determining what is effective for diverse populations, as well as address issues of access to services and the utilization of those services, through continuous quality improvement and program evaluation.
8. The selection of a treatment practice for TAY needs to be based on mutual decision-making between informed young people, their family members or caregivers, and their providers.
9. Programs and practices for TAY must address developmental constructs when developing, implementing, and evaluating services, and address safeguards against increasing disparities.
10. A multicultural approach to culturally competent assessment, practice, training, and research should underlie programs and practices for TAY.
11. Language must be addressed when planning services to TAY and their families.
12. Given the current demographic composition of the child, youth, and young adult population it becomes essential for TAY programs and the provision of related services to recognize, adopt, and commit to providing culturally and linguistically competent mental health services.
13. Ongoing appropriate and intensive assessment, training, evaluation, and community stakeholder involvement should be central components of any TAY programming.
14. Offer vocational and/or technical certification training programs as alternatives to mainstream education.
15. Policy planning and program designing for TAY must be cognizant of individualist cultural views, when collectivist worldviews may be more appropriate.
16. TAY outcomes should be culturally relevant, appropriate, and driven by the young person and their family, as well as measurable and practical.
17. Utilizing the cultural formulation model, as prescribed in the DSM-IV, should be an essential component to any TAY program.
18. A major goal of cultural competence is to infuse its principles and practices into daily activities, but it is also a more comprehensive attempt to transform systems into entities which include cultural reflection, innovation, and acceptance at all levels – systemic change involves a dedicated and concentrated effort to transform systems.
REFERENCES


CHAPTER V

YOUTH VOICE

“The universe is made of stories, not of atoms.”

— Muriel Rukeyser
CHAPTER V

YOUTH VOICE

Final Draft Report of
The Findings of the Transition Age Youth (TAY) Focus Groups Conducted for the
California Mental Health Directors Association (CMHDA) Transition Age Youth
Subcommittee and the California Institute for Mental Health (CIMH)

A report on the findings from four focus groups of transition age youth facilitated and
recorded by transition age youth in Modesto, Eureka, San Diego and Long Beach,
California in July, August and September of 2003

On November 5, 2003, several youth and some family members made a direct report to the
Transition Age Youth Subcommittee. They made many compelling statements about the
problems with the way services are provided:

“Requiring parental consent for treatment is a barrier to service,
because a youth may have run away from home and the parent
may be the cause of the person needing services” – Youth

“Should have a family detox even when the kids aren’t
using, so kids can see their parents get clean and sober.
Separation is devastating” – Youth

“You need to know you aren’t going to lose your
kids if you ask for help” – Parent

April 8, 2004
Sacramento California
ABSTRACT

All kids want is to be regular kids and not be judged by being in mental health.

Integrating consumer perspectives is a core value of California mental health services. To provide such input to the TAY subcommittee, youth focus groups were conducted in Stanislaus, Humboldt, Los Angeles and San Diego. Youth, from AB 2034 services (integrated services to people with psychiatric disabilities that are homeless) or from transition age youth Supportive Housing Initiative Act (SHIA) projects, facilitated the focus groups. The focus groups addressed what resources and services youth needed and what does and doesn’t help them to achieve their goals.

Key services the youth identified as important include:

- Employment and job training
- Education
- Housing subsidies
- Transportation
- Fun outings
- Mental health services

Youth also described helpful providers as being:

- Open-minded
- Able to listen to youth’s experiences
- Committed to working with them
- Helpful, friendly and outgoing
- Understanding

A major highlight of the endeavor was the meeting at which youth facilitators from the Humboldt and San Diego sites reported in person to the TAY sub-committee on their focus groups. The sub-committee was very impressed with the seriousness of the issues that youth and their families confront. The discussion with the sub-committee uncovered additional issues that were not highlighted in the focus group reports. The youth’s enthusiasm for the process and their willingness to speak with us were memorable.

BACKGROUND

PURPOSE OF THE FOCUS GROUPS

As the subcommittee developed themes for the chapters of this resource manual, members acknowledged the difficulty they were experiencing involving youth in the committee meetings due to scheduling problems. The members of the CMHDA, Adult System of Care (ASOC), & Children’s System of Care (CSOC) sub-committees on Transition Age Youth wanted input from youth to inform our work. There was difficulty involving youth on an ongoing basis in the sub-committee. To provide an opportunity for consumer feedback in this volume, we decided to conduct focus groups with transition age youth in established TAY programs (AB 2034 and SHIA).
PROCESS OF CONDUCTING THE FOCUS GROUPS

To encourage youth to speak candidly, we trained TAY to facilitate and take notes. Staff at TAY program sites asked youth in the programs if they were interested in facilitating these groups.

Youth from four sites volunteered to conduct focus groups. Two to three youth and staff from the four programs were trained in conducting and recording focus groups using a web-cast training format. The training was adapted, with permission, from Simon, J.S. (1999), Conducting Successful Focus Groups. The PowerPoint presentation emphasized that focus groups provide an opportunity for people to speak openly in a safe environment. In the training, the youth selected four questions to guide the focus groups:

1. What kind of resources do you need (anything, not just mental health services)?
2. Do you need services? Why?
3. What is helpful?
4. What isn’t helpful?

The youth facilitators identified and invited diverse groups of seven to ten youth to participate in the focus groups. The youth conducted the focus groups between July and September 2003. Youth from each site compiled the results of the focus group and submitted them to CIMH. CIMH staff compiled the results that are attached in the appendices.

REPORT TO THE CMHDA TAY SUBCOMMITTEE

After completing the focus groups, youth from one site requested that the youth be able to report the results in person to the TAY Subcommittee. The subcommittee scheduled a meeting with the youth on November 5th. Four youth, two from each of two sites, attended the meeting and elaborated on the information contained in the written summary. An added bonus was the participation of some of their family members. This fostered a lively discussion about the impact of separation on youth and their family members. Additional issues raised in the meeting are identified in the results section below.

RESULTS

The nature of the relationship that youth have with staff was identified as a major factor in successfully providing services. Youths said that it is important to have staff that is seen as caring, uncritical, and able to listen. The services most frequently identified as important were employment and job training and meeting basic needs. The reporting varied from group to group, making accurate totals regarding the frequency of particular responses difficult. The lists below include the responses that were mentioned at least four times amongst all groups:

1. What kind of resources do you need (anything, not just mental health services)?
   a. Job training/employment/work
   b. Education
   c. Section 8/money for furniture
   d. Open-minded people
   e. People who listen more closely and follow-up
2. Do you need services? Why?
   a. Job training
   b. Budgeting/Money Management
   c. Transportation
   d. Psychological Services, including depression/anxiety group
   e. People who are committed, care, listen, are helpful, friendly and outgoing

3. What is helpful?
   a. Staff/doctors/job coaches, personal service coordinators, program directors, nurses
   b. More fun/group outings

4. What isn’t helpful?
   a. Lack of sympathy
   b. Lack of services (e.g., counseling)
   c. People who are greedy, selfish, rude and stuck up

ADDITIONAL INFORMATION FROM THE YOUTH DIALOGUE WITH THE TAY SUBCOMMITTEE

Two youths from San Diego County, three youths from Humboldt, and the mother and aunt of one of the youths attended the November sub-committee meeting. This was an especially influential event because the youth’s mother and aunt (her sister) had just been reunited the day before, due to the youth’s efforts to bring his mother’s family together. His mother and her siblings had been separated and sent to different foster homes when they were young. The family told their stories and presented a painful picture of the devastating impact of our systems on the lives of children and, in turn, their children. The discussion highlighted the reasons that people in trouble, especially parents, are very reluctant to seek services for fear of losing their children.

Specific issues raised in the discussion with the youth included:

1. Barriers to serving youth
   a. Lack of confidentiality
   b. Requirement for parental consent for youth’s treatment
   c. Placing parents in residential treatment programs that don’t serve children, thereby separating the youth and parents
   d. Lack of information

2. Ideas to improve services
   a. Putting informational brochures in doctor’s offices
   b. Funds for youth to participate in community recreational activities, (e.g., entrance fee to the skate park). Youth want to do the things that all youth do.

GENERATION OF LOCAL ACTIVITY

Another unanticipated result of the project was that the youth in Humboldt decided that they wanted to do a focus group with law enforcement. It was successful in that the youth and law enforcement were able to listen to and hear their complaints and fears about one another. As a
result of the group, the youth and law enforcement officers were able to identify a joint activity in which they could partner – removing graffiti.

**CONCLUSIONS AND RECOMMENDATIONS**

Youth in the focus groups identified positive, supportive relationships with service providers and meeting basic needs (including employment) as important components of mental health services. Listening to youth and family stories in face-to-face dialogue highlighted the youth’s need for connection with their family, a need to belong. Recommendations include:

- Providers should consider entering into similar dialogues with youth as they may generate innovative ways to improve services.
- Youth need to be involved in various levels of program development, including participating in local advisory boards. Youth need to be compensated in some way for their time. In the SAMHSA Federal System of Care grants, they found that motivators to increase youth participation include stipends, transportation assistance, childcare, and food during the meetings.
APPENDIX #5.1

QUESTIONS AND SCRIPT FOR TAY FOCUS GROUPS

Conducted for the California Mental Health Directors Association Transition Age Youth Subcommittee and the California Institute of Mental Health

July, 2003

Set-up:
- Have people in a circle, preferably with something to write on, like around tables
- Have refreshments and something to drink
- Have paper and pencils/pens for people to write on
- Have the easel, flipchart and pens ready for the recorder
- Tent Cards: If the facilitator and recorder don’t know everyone in the group, you might want to have name tags for people or use “tent cards” (a piece of paper folded in half on the table in front of the person, with their name printed on the paper).

As the participants come in, fill out the demographic sheet that is attached to this script. Please note that you don’t use people’s names on the demographic sheet or the recording sheets.

Facilitator Script:
Welcome everyone and thank you for coming. My name is _______________ and I am your facilitator for the day. My colleague, _________________________, will be the recorder for this focus group.

We are conducting this focus group to provide information on what youth want in their lives and the kind of help they think they need to do what they want. We are here to get information, not to solve specific concerns or problems. We need direct feedback from youth. We need positive and negative information, so please be honest and open in your responses. We are one of three places in the state that are conducting these focus groups: Modesto, Eureka and Los Angeles.

The reason we are doing this is because there is a statewide committee that is putting together a resource manual for mental health providers to use in developing services for youth our age (from 16 – 25). People on that committee want to make sure that they are hearing from youth. What we come up with here today will be included in that information manual, but it is important for you to know that the responses are kept anonymous. Names are not used in recording your answers to the questions.

This will take us about one and a half hours. If you need to go to the bathroom or take a stretch, just excuse yourself. We will take a break half way through if we need to.

In a few minutes, I’m going to talk about how we are going to do this focus group, but first, I would like everyone to introduce themselves.

EVERYONE INTRODUCES THEMSELVES
Before we go any farther, we need to set some guidelines for how we will act with one another in this group. We’ll call this a Comfort Agreement. The recorder will write down what we want to agree to. Some examples of what we might want to include are:

- There are no wrong answers
- We will listen to each person

FACILITATOR ASKS GROUP TO TELL WHAT IS IMPORTANT TO THEM AND MAKES SURE THE SUGGESTIONS ARE WRITTEN DOWN BY THE RECORDER. WHEN THE GROUP IS DONE, THE FACILITATOR ASKS IF EVERYONE AGREES TO WHAT HAS BEEN WRITTEN DOWN. MAKE SURE THAT EVERYONE NODS AGREEMENT.

Now, I’m going to describe what we are doing today. We have a series of four questions. When I ask a question, we will each take a couple minutes to jot down two or three answers. Then we will take turns going around in a circle answering the question. We will keep going around the circle until we run out of new answers. The recorder will write down what someone says. We won’t have a discussion and we won’t debate specific items. We are just trying to get information. Remember, there are no wrong answers.

We will do this with all four questions. When we have finished the questions, all the people in the group (not the facilitator or recorder) will take a pen and for each question put a check mark on what you consider the four most important answers under each question.

Are there any questions?

**Questions:**
We are trying to find out what you think will be helpful to you as you move forward to your adult life:

1. **What kind of resources do you need (anything, not just mental health services)?**
Facilitator will indicate one person to start. Keep the group moving along – no more than 15 minutes per question. If someone is taking too long, ask them to make the point in two or three words, or if you think you understand their point, summarize it and ask if that is what they mean. If someone wants to talk about what someone else says, remind them that we are not here to discuss the issues, only to list them. Tell them that people can hang out later to have a discussion about the points people raised. [Remember that people have to feel safe in order to say what they think. If other people are allowed to argue with them, they will not feel safe – you also won’t get through your focus group.]

2. **Do you need services? Why?**
[Facilitator picks a different person to start answering the question.] Cut off at 15 minutes.

3. **What is helpful?**
[Pick another person to start answering the question] Cut off at 15 minutes.

4. What isn’t helpful?
[Pick another person to start answering the question] Cut off at 15 minutes.

These are all important points, but we want to figure out which ones may be more important than others to you.

- Each of you take a pen and under each of the four questions, put a check mark beside the four answers you think are the most important. So make four check marks for question #1 and four for question #2, etc.
- After everyone makes their check marks, facilitator can point out which items have the most check marks for each question.

Closing:
Thank everyone for coming and let them know that they will get a copy of the results for their discussion group.

Reporting:
The recorder then types all the answers to each question and put the number of check marks by each item that has check marks. A sample form is attached. Send the information to Vicki V. Smith at vsmith@cimh.org.

SAMPLE COMFORT AGREEMENT (from training):
- There are no stupid questions
- Be responsible for your own learning – ask questions
- Listen when others speak
- Treat each other with respect
- Maintain confidentiality
- Accept people as they are
- Pay attention to individual differences

People to invite. Invite 7 to 12 people.
- People from 16 – 25 years of age
- People currently using services, or would use services if they were different
- People who are falling through the cracks

APPENDIX #5.2

Preliminary Draft Report of
The Findings of the TAY Focus Groups Conducted for the California Mental Health Directors Association Transition Age Youth Subcommittee and the California Institute of Mental Health

A report on the findings from four focus groups of transition age youth facilitated and recorded by transition age youth in Modesto, Eureka, San Diego and Long Beach, California in July, August and September of 2003.
### FINDINGS OF THE FOCUS GROUPS

(This section will be summarized in the final report and the grids will be moved to the appendices):

2. **What kind of resources do you need (anything, not just mental health services)?**

<table>
<thead>
<tr>
<th>Resource</th>
<th>Stanislaus</th>
<th>Humboldt</th>
<th>LA-Long Beach</th>
<th>San Diego</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>More $ for clothes</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Job Training/Employment/Work</td>
<td>6</td>
<td>X</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>$ For Furniture/Section 8 Housing</td>
<td></td>
<td></td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>$ for food</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$ for Transportation (taxi)</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Food, Housing &amp; Recreation</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access to Medical Care &amp; counseling</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access without parental consent</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confidentiality</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>7</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Open minded People</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People who listen more closely &amp; follow-up</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group Activities</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less prying</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>More Case Managers/PSCs</td>
<td>2</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Business Outlets</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direction</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Doctors</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Merchant</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Goals</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Money</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>To take options</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>True friends</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
2. Do you need services? Why?

<table>
<thead>
<tr>
<th>Service</th>
<th>Stanislaus</th>
<th>Humboldt</th>
<th>LA-Long Beach</th>
<th>San Diego</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Job Training</td>
<td>6</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Budgeting/Money Management</td>
<td>5</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>More Transportation Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Sometimes can’t accomplish goals on our own</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Don’t realize what is going on in situations</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Help in coping with dilemmas</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological Services</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crime Prevention group</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression/Anxiety groups</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. What is helpful?

<table>
<thead>
<tr>
<th>Service</th>
<th>Stanislaus</th>
<th>Humboldt</th>
<th>LA-Long Beach</th>
<th>San Diego</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 8 vouchers/Housing</td>
<td></td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Help in getting SSI right away</td>
<td></td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>More fun outings/group outings</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Positive reinforcement</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Funding for scholarships</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Free services with experienced staff</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friendly nonjudgmental staff</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Independent Living Programs</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case Managers</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peer Support</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bus Passes/transportation</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Groups/Counseling</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Help in contacting family

<table>
<thead>
<tr>
<th>Help in contacting family</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Devereux</td>
<td>1</td>
</tr>
<tr>
<td>Employment</td>
<td>1</td>
</tr>
<tr>
<td>CBCC</td>
<td>1</td>
</tr>
<tr>
<td>Nothing</td>
<td>1</td>
</tr>
<tr>
<td>Talking</td>
<td>1</td>
</tr>
<tr>
<td>The Village</td>
<td>1</td>
</tr>
<tr>
<td>Business Partners</td>
<td></td>
</tr>
<tr>
<td>People who are committed/care/listen/honest/helpful/friendly/kind/outgoing</td>
<td>8</td>
</tr>
<tr>
<td>Staff/doctor/job coaches/PSCs/program directors/nurse</td>
<td>6</td>
</tr>
<tr>
<td>Korean/Japanese staff</td>
<td>2</td>
</tr>
<tr>
<td>Specific staff</td>
<td>3</td>
</tr>
<tr>
<td>Other members</td>
<td>1</td>
</tr>
</tbody>
</table>

### 4. What isn’t helpful?

<table>
<thead>
<tr>
<th>What isn’t helpful</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Outings with older people with disabilities</td>
<td>2</td>
</tr>
<tr>
<td>People who don’t smell good</td>
<td>1</td>
</tr>
<tr>
<td>Not returning phone calls right away</td>
<td>3</td>
</tr>
<tr>
<td>Cop harassment</td>
<td>X</td>
</tr>
<tr>
<td>Lack of sympathy &amp; empathy/ People with bad attitudes/angry/ Prejudice against youth/ Blaming youth</td>
<td>X 5</td>
</tr>
<tr>
<td>Criticism of staff</td>
<td>5</td>
</tr>
<tr>
<td>No counseling services</td>
<td>4</td>
</tr>
<tr>
<td>Lack of stability</td>
<td>3</td>
</tr>
<tr>
<td>[Doesn’t] give benefit of doubt</td>
<td>2</td>
</tr>
<tr>
<td>A new job</td>
<td>1</td>
</tr>
<tr>
<td>Inexperienced people</td>
<td>1</td>
</tr>
<tr>
<td>Lack of knowledge/ education/unwise</td>
<td>2</td>
</tr>
<tr>
<td>Living in motels/ on the</td>
<td>2</td>
</tr>
<tr>
<td>street</td>
<td>None</td>
</tr>
<tr>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>Not going to sober living</td>
<td>1</td>
</tr>
<tr>
<td>People who don’t care</td>
<td>2</td>
</tr>
<tr>
<td>The others</td>
<td>1</td>
</tr>
<tr>
<td>Drug Dealers/gang members</td>
<td>3</td>
</tr>
<tr>
<td>People who are greedy/selfish/rude/ stuck up</td>
<td>4</td>
</tr>
<tr>
<td>People who don’t want to work/ don’t want to help</td>
<td>2</td>
</tr>
<tr>
<td>Members</td>
<td></td>
</tr>
<tr>
<td>Mom/sometimes family &amp; friends</td>
<td>3</td>
</tr>
<tr>
<td>US</td>
<td>1</td>
</tr>
<tr>
<td>British</td>
<td>1</td>
</tr>
</tbody>
</table>

Appendix #5.3  
Transition Age Youth Focus Group: Demographic Information

<table>
<thead>
<tr>
<th>County</th>
<th>Modesto</th>
<th>Humboldt</th>
<th>LA-Long Beach</th>
<th>San Diego</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Focus Group</td>
<td># of Participants</td>
<td>13</td>
<td>10</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>Male</td>
<td>8</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>5</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>16</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>17</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>18</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>19</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>20</td>
<td></td>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>21</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>22</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>23</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>24</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Ethnicity (optional)
<table>
<thead>
<tr>
<th>County</th>
<th>Modesto</th>
<th>Humboldt</th>
<th>LA-Long Beach</th>
<th>San Diego</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caucasian</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>African American</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Asian American</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Native American</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pacific Islander</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Earitrean</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses MH Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Doesn’t Use MH Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CHAPTER VI

CO-OCCURRING DISORDERS

“If we had no winter, the spring would not be so pleasant; if we did not sometimes taste of adversity, prosperity would not be so welcome.”

— ANNE BRADSTREET
CHAPTER VI

CO-OCCURRING DISORDERS

APRIL 2004

FOUR QUADRANT MODEL

“The four quadrant model is a viable mechanism for categorizing individuals with co-occurring disorders for purpose of service planning and system responsibility.” Christie A. Cline, M.D.

This paradigm identifies sub-groups with coexisting disorders.

<table>
<thead>
<tr>
<th>QUADRANT I</th>
<th>QUADRANT II</th>
<th>QUADRANT III</th>
<th>QUADRANT IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less severe mental disorder</td>
<td>More severe mental disorder</td>
<td>Less severe mental disorder</td>
<td>More severe mental disorder</td>
</tr>
<tr>
<td>Less severe substance abuse disorder</td>
<td>More severe substance abuse disorder</td>
<td>More severe substance abuse disorder</td>
<td></td>
</tr>
<tr>
<td>QUADRANT II</td>
<td>QUADRANT III</td>
<td>QUADRANT IV</td>
<td></td>
</tr>
</tbody>
</table>

The population of youth with both a high mental health and high substance dependence in Quadrant IV is at high risk and is the target population for the Transition Age Youth (TAY) Resource Guide. This is the quadrant that requires cross-training between mental health and alcohol and drug program practitioners, as well as the support of family members and other individuals in the TAY’s social network in order to provide integrated treatment.

When working with transition age youth, it is important to recognize that the systems of care within a county are often fragmented and driven by funding, rather than the actual needs of the youth. Services to transition age youth are exceedingly difficult to provide effectively due to perceived adult status of the youth and high degree of mobility and independence of youth.

“Treatment success derives from the implementation of an empathic, hopeful, continuous treatment relationship, which provides integrated treatment and coordination of care through the course of multiple treatment episodes.”

“When substance disorder and psychiatric disorders co-exist, each disorder should be considered primary, and integrated dual primary treatment is recommended, where each disorder receives appropriately intensive diagnosis-specific treatment.”

—Christie A. Cline M.D.
PREVALENCE

The United States Household Survey on Drug Abuse for 2002 indicates that among all persons aged 18 through 25 years of age who responded to the survey, 13.2% had a Serious Mental Illness (SMI). By gender, 16.3% of the populations within the TAY age group were males and 10% were females who experienced SMI. In that same age range, 21.7% experienced an alcohol or other drug dependence or abuse disorder.

The Substance Abuse and Mental Health Services Administration Report to Congress on Co-occurring Disorders provided explanations for high prevalence rates of substance abuse disorders among individuals with mental disorders, but the etiology is not yet clear. Dr. Marc Schuckit (NASMHPD/NASADAD, 1999) outlined three ways in which substance abuse disorders and mental disorders may relate to one another:

- The disorders may occur independent of each other;
- The mental disorder may place an individual at greater risk for substance abuse disorders (e.g., schizophrenia and anti-social personality disorder); and
- Drug abuse intoxication or withdrawal may result in temporary mental disorder syndromes.

Mueser et al. (1998) reviewed two decades of etiological theories related to co-occurring substance abuse disorders and mental disorders. Based on that analysis, they offered four general models that synthesize current thinking in the field regarding the etiology of co-occurring substance abuse disorders and mental disorders (Anthony, 1991; Kosten and Ziedonis, 1997; Kushner and Mueser, 1993; Lehman et al., 1989; Meyer, 1986; Weiss and Collins, 1992):

- **Common factor models** — High rates of co-morbidity are the result of risk factors shared across both severe mental illness and substance abuse disorders.
- **Secondary substance abuse disorder models** — Severe mental illness increases a person’s chances of developing a substance abuse disorder.
- **Secondary mental/psychiatric disorder model** — Substance abuse precipitates severe mental illness in people who would not otherwise develop a severe mental illness.
- **Bi-directional models** — Either severe mental illness or substance abuse disorders can increase a person’s vulnerability to developing the other disorder.

TRANSITION AGE YOUTH (TAY)

It is accepted knowledge that all youth, who have the developmental task of leaving home as a goal, will have to meet significant challenges in their individuation. This task of “leaving home” can be difficult to address when the youth suffers from a mental illness and a substance related disorder. Even youth who are blessed with good health and who are free of disabilities can find this transition bewildering. However, youth who have co-occurring psychiatric and substance-related disorders can encounter major barriers to continued emotional and physical health because
of inadequate communication and coordination of services. TAY youth who lack housing, transportation, and other supports are especially at risk of not reaching this developmental task. Youth who have a co-occurring disorder and are also involved in the child welfare system are triply-challenged by the additional task of negotiating emancipation and achieving independence with limited supports.

Youth with co-occurring disorders are going to need resources to overcome each of their disorders. Some resource-building treatment strategies include:

- There should be no wrong door as an entryway to treatment. Whatever agency the youth uses to request help must ensure that the youth has access to services from partner agencies. These services may include mental health and substance-related treatment as well as housing, training, rehabilitation resources, and therapeutic courts. This is critical because when the youth needs help, it must happen in the moment or the opportunity may be lost. With the youth’s permission, there should be collaboration and coordination of the youth’s treatment plan. Substance abuse programs, from the continuum of abstinence to harm reduction, recognize that recovery is incremental and the road to recovery has its ups and downs. Providers should strive to reduce barriers to the provision of appropriate, coordinated, and integrated services for TAY youth, which include different funding streams, philosophical differences, lack of cooperation and collaboration, and the lack of cross training.

- Once the youth acknowledges the substance use problem, and agrees to receive support, all significant social supports of the TAY youth should be involved in the treatment planning process including the youth, his or her family, school, social services or probation, mental health, and Alcohol and Other Drug (AOD) providers as well as other members of the youth’s support network. Providers must acknowledge that the youth is the holder of the privilege, and thus he or she must agree to how the treatment is organized. In the event the youth does not acknowledge the need for services, all providers and members of the support system should continue to encourage the individual until engagement and maintenance in treatment occurs.

- Youth who are homeless or otherwise without stable living conditions will find it difficult to embrace recovery from substance use. Therefore, ensuring that basic needs are met is a critical step in providing care to these youth. This is especially true for TAY with a background in the foster care system whose priorities may be focused on obtaining the basic necessities of living.

- Because of TAY’s age-appropriate need for independence, providers should work to balance client-driven treatment planning with a solid supportive structure to prevent the individual from becoming “lost” in the process of recovery.

- Foster youth are most vulnerable to treatment failure because they may not have the financial and emotional resources to support them in recovery. The youth who suffered trauma from growing up in a domestically violent or an abusive or negligent home is especially vulnerable. If appropriate, family support services can strengthen the youth and the entire family system. By building on the strengths of the youth, his or her family, and his or her support system, counselors can draw on the resources that each participating party brings to the intervention. Using a strength-based approach, the treatment team can develop and implement a realistic, attainable plan for recovery that improves the functioning of each participant.
**TREATMENT STRATEGIES**

- Place a strong emphasis on family involvement. Youth need to feel secure and feel the support of his or her immediate family members and broader social network. No matter what the circumstances of the relationships within the family are, the youth and the family should be engaged in securing solutions to a better relationship. For a variety of reasons, some youth have disengaged from their families and/or support groups and will not have functioning social networks. In these situations, efforts should be made to help the youth build natural supports as part of the treatment process.

- Develop an individualistic case plan. Each client has unique circumstances with individualized sets of goals and objectives. A “cookie cutter” or “one size fits all” approach will not be effective. As Dr. Pablo Stewart has noted, there are instances where the substance use is a manner of self-medicating for long standing untreated mental illnesses. It is for this reason that MH and AOD staff need to work closely together and use a universal chart where entries from both Departments are available to the other and to additional participants of the treatment team.

- Explore the strengths of the youth. Recovery based goals will be founded upon the youth’s vision of his or her future. The treatment planning team will need to focus the discussion in a hopeful and supportive manner.

- Providers need to consider that what is happening for the youth may in fact be a “system issue,” meaning that the youth may be acting out symptoms for other family members or for a significant other. By including the whole family group and/or the significant other, there is a greater likelihood that a true solution will be found. A youth’s crisis is an opportunity for the family constellation to enhance communication and improve functioning for the future.

- Woman and girls with co-occurring disorders often come from a background of family violence, and the sequelae of trauma endured may be what is driving the mental illness or substance involvement.

---

**The special needs of girls are described by the National Mental Health Association:**

“The forces that pre-dispose adolescent girls towards delinquency are believed to be different than those that pre-dispose adolescent boys. In fact, some studies show that mild to moderate depression in girls may put them at greater risk for antisocial behavior and delinquency. Women and girls with co-occurring disorders also have substantially different treatment needs than men and boys. Females with co-occurring disorders may engage in high-risk sexual behavior, have more complicated health conditions, and have histories of exposure to physical and sexual violence. In fact, there is growing evidence that women with co-occurring disorders are more likely to have experienced childhood physical and sexual abuse than severely mentally ill women without substance use problems.”
There are distinct differences in the prevalence of co-occurring disorders related to gender, socioeconomic status, and ethnicity that require specific attention. With the influx of many immigrant families into California, the therapeutic team must be cognizant of the role of immigration, of women in their countries of origin, and the potential isolation of men and/or women here due to lack of language facility, potential acculturation opportunities and difficulties, socioeconomic status, and expectations of both parents and children as they transition from one culture to another. In addition to cross training, cultural competency is a critical subject to providers who render services to those individuals with co-occurring mental and substance-related disorders.

APPENDIX

1. Action for Mental Health and Substance-Related Disorders: Improving Services for Individuals at Risk of, or with, Co-Occurring Substance Related and Mental Health Disorders. SAMHSA (1998)


3. Dual Diagnosis: Counseling the Mentally Ill Substance Abuser. Katie Evans, and J. Michael Sullivan (c2001)


8. Improving Treatment Compliance: Counseling and Systems Strategies for Substance Abuse and Dual Disorders. Dennis C. Daley and Allan Zuckoff (c1999)


11. Mental Health Assessment and Diagnosis of Substance Abusers. NIDA (1994)

CHAPTER VII

EARLY PSYCHOSIS AND TRANSITION AGE YOUTH

“The soul would have no rainbow if the eyes had no tears.”

—MINQUASS TRIBE
CHAPTER VII

EARLY PSYCHOSIS AND TRANSITION AGE YOUTH

Psychosis is a particularly relevant topic for Transition Age Youth (TAY), given that the typical onset of schizophrenia is between the ages of 16 and 25. The incidence of schizophrenia increases for individuals ages 15-18, during the already-challenging transition to adulthood and between child and adult mental health services, when many youth “fall through the cracks.” Furthermore, as discussed in Chapter II of this manual, adult services are not always accessible or appealing to young people and this is especially true of TAY who are vulnerable when experiencing a first psychotic episode.

Though the incidence of schizophrenia and other psychotic disorders is low compared to incidence of mood or anxiety disorders, with approximately 1% of individuals affected, it is perhaps one of the most disabling mental conditions and therefore warrants considerable attention. Psychotic disorders severely inhibit social, educational, and community functioning. Individuals with long-term psychosis are more likely to be involved with the criminal justice system, have difficulty finding and maintaining employment, and receive public assistance. In addition to these other outcomes, it is particularly distressing that the lifetime risk of suicide is high for individuals with psychotic disorders, with close to one in ten completing a suicide, and up to 50% attempting it. The risk of suicide is greater for individuals who experience stigma associated with mental illness, those who use substances, and youth. The rate is especially high for individuals experiencing a first break; one study found that over 15% of participants in an early psychosis program attempted suicide before beginning treatment.

Given the risks associated with psychotic disorders, it makes sense to allocate significant resources towards programs that will minimize its impact on individuals and their families, particularly in the early stages of the illness when adverse consequences may be avoided. However, clinical, ethical, and administrative barriers complicate treatment of first-episode psychosis. This chapter discusses the controversies around early intervention; reviews access to care, assessment, and first-episode treatment guidelines, highlights an early intervention program for TAY, and provides a listing of web resources for further information.

CONTROVERSIES AROUND EARLY INTERVENTION

29 Siris.
30 Siris.
A lively debate is taking place in the research literature around the costs and benefits of early intervention in psychosis. The arguments for and against early intervention are summarized in Figure 1.

Further complicating the early intervention debate is research on the effects of Duration of Untreated Psychosis (DUP). DUP is of particular interest to clinicians and researchers because it is one of the few areas in which mental health practice and policy can have a direct impact on client outcomes. Some researchers argue that untreated psychosis is neurotoxic, meaning that the chemicals released during a psychotic episode have a permanent damaging effect on the brain. However, little evidence has been found to support this theory. Longer DUP does appear to be associated with lower rates of remission as well as an increase in positive symptoms of psychosis and decreased social functioning, suggesting that unnecessarily long DUP should be avoided.

Though it is important for mental health administrators and clinicians to be aware of these controversies and to attend to current research, the reality is that TAY experiencing first-episode psychosis must have access to developmentally appropriate mental health services. A rich clinical literature attests that TAY has unique service needs that warrant specialized treatment. A young person with a psychotic disorder may not see herself as having much in common with a 50-year-old client who has been in the system for many years, and is likely to feel uncomfortable in a treatment setting where many of the consumers are older adults with chronic mental illnesses.

---

34 McGorry, & Yung.
36 Shaw, & Singh.
40 Clark, & Davis (Eds.).
**FIGURE 1**  
**ARGUMENTS FOR AND AGAINST EARLY INTERVENTION IN PSYCHOSIS**

<table>
<thead>
<tr>
<th>For</th>
<th>Against</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobilizes and maintains family and social supports, which is especially important as many TAY, regardless of whether or not they have a mental illness, have fragile emerging support networks(^41)(^42)</td>
<td>Limitations in assessment inhibit accurate diagnosis in the early stages of the illness and it is inappropriate and unethical to provide antipsychotic treatments to individuals who do not have a psychotic disorder(^43)</td>
</tr>
<tr>
<td>Reduces length &amp; severity of psychotic episodes and lowers rates of hospitalization(^44)</td>
<td>The effectiveness of early intervention is inconclusive. Early intervention appears to have a positive impact within the first year of treatment, but gains are lost within 5 years(^45)</td>
</tr>
<tr>
<td>Decreases suicidality(^46)(^47)</td>
<td>Continuity and quality of care and medication compliance for individuals with long-term, severe mental illness have a greater effect on outcomes than early intervention(^48)</td>
</tr>
<tr>
<td>Prevents disruption in achievement of educational and vocational goals(^49)(^50)</td>
<td>If limited resources are allocated disproportionately to a specialized early intervention teams, people with documented, long-term illnesses may receive inadequate treatment(^51)</td>
</tr>
<tr>
<td>Lowers rates of substance abuse(^52)(^53)</td>
<td>Short-term, specialized programs for early intervention cause discontinuity in treatment because clients will eventually transfer to a program for adults with chronic mental illnesses(^54)</td>
</tr>
<tr>
<td>Supports retention of social skills(^55)</td>
<td></td>
</tr>
<tr>
<td>May speed recovery from first break(^56)</td>
<td></td>
</tr>
<tr>
<td>If offered during prodromal phases, may inhibit psychosis(^57)</td>
<td></td>
</tr>
<tr>
<td>Establishes a pattern of treatment compliance that will contribute to later adherence to treatment and better long-term outcomes(^58)</td>
<td></td>
</tr>
</tbody>
</table>

\(^{41}\) McGorry, & Yung.  
\(^{43}\) Pelosi, & Birchwood.  
\(^{44}\) Tee, Ehmann, & MacEwan.  
\(^{46}\) Addington, Williams, Young, & Addington. Suicidal behavior in early psychosis.  
\(^{47}\) McGorry, & Yung.  
\(^{48}\) Linszen, Dingemans, & Lenior.  
\(^{49}\) McGorry, & Yung.  
\(^{50}\) Tee, Ehmann, & MacEwan.  
\(^{51}\) Pelosi, & Birchwood.  
\(^{52}\) Tee, Ehmann, & MacEwan.  
\(^{53}\) McGorry, & Yung.  
\(^{54}\) Pelosi, & Birchwood.  
\(^{55}\) Tee, Ehmann, & MacEwan.  
\(^{56}\) McGorry, & Yung.  
\(^{57}\) McGorry, & Yung.  
Access to care is critical in providing services to TAY experiencing a first psychotic episode. Some of the symptoms of psychosis, such as social withdrawal and suspicion of strangers, inhibit help-seeking. These symptoms are compounded by many adolescents’ desire for autonomy and belief in their invulnerability, further hindering intervention. Finally, many young people and their families fear the stigma associated with mental illness, particularly psychosis. Three suggestions for overcoming these barriers to treatment are:

1. Community education to increase awareness of psychosis and to decrease stigma (see Web resources section for examples)
2. Clinician education to encourage accurate diagnosis and timely referral to appropriate services
3. Sensitivity to the needs of young people and families during what for most is a frightening and distressing experience

It can also be helpful to remind families that though researchers are still studying the causes of psychotic disorders, it is clear that genetics and biology contribute to the development of psychotic disorders. Many early theories of psychosis overemphasized the role of families in causing the disorder, thus contributing to the stigma.

Careful assessment of first-episode psychosis is essential as it informs the course of treatment. To ensure a correct diagnosis, it may be necessary to delay administration of antipsychotic medication for up to 48 hours to rule out substance-induced psychosis or other co-morbid conditions. In addition to the general clinical assessments used for clients presenting with any symptoms of mental illness, the following areas are useful in an evaluation of first-episode psychosis:

- Length and progression of prodromal and psychotic periods
- Substance use
- Personality, strengths, and coping skills of the individual with psychosis, and his or her response to the symptoms (i.e. for some individuals, hallucinations and delusions are not experienced as unpleasant)
- Circumstances of referral and cultural background
- The family system and its resources

Given the potential for harm to self or others in first episode psychosis, risk assessments for suicidality, grave disability, violence to others, potential for victimization by others, treatment non-compliance, and flight risk are also necessary. An evaluation by a psychiatrist should also be completed as soon as possible.

---

60 Yung, Phillips, & Drew, In.
65 Power, & McGorry, In.
66 Power, & McGorry, In.
Before discussing treatment guidelines, a few myths about early psychosis must be addressed:

**Myth 1:** First-episode psychosis is always an indicator of long-term disability. Studies show that up to 85% of consumers presenting with first-episode psychosis recover with appropriate treatment, and many exhibit no psychotic symptoms in follow-up assessments.

**Myth 2:** Hospitalization is required. Depending on the personality of the consumer, his or her home environment, and the community supports available, a first-episode psychosis can be treated on an outpatient basis.

**Myth 3:** Individuals with psychosis lack insight. Research suggests that consumers with first-episode psychosis can be involved in treatment planning and are often aware of their state.

Debunking these myths suggests that while first-episode psychosis is cause for concern, it is not necessarily cause for alarm. Clinicians working with TAY experiencing a first psychotic episode and their families should follow the system of care principles guiding the rest of their work:

- include the consumer and his or her family as much as possible in treatment planning;
- be sensitive to the consumer’s cultural background and beliefs about mental illness; and
- provide treatment in the least restrictive environment possible. Collaboration with the consumer is particularly important given the developmental and symptom-related issues described above (e.g. need for autonomy, suspicion of strangers).

In the past, psychodynamic interventions were favored in the treatment of psychosis. More recently, medication combined with Cognitive-Behavioral Therapy (CBT) is the treatment of choice. In the early stages, CBT is useful in helping consumers understand their illness and the treatment options. Later, once a relationship has been developed, CBT may be helpful in challenging the positive symptoms. Though CBT appears beneficial as an early intervention, the evidence on long-term outcomes is less encouraging.

In addition to CBT, psycho-education for the consumer and his or her family related to the illness, stress management, and problem-solving is helpful. Family interventions have been found to be especially helpful when consumers are recovering from an acute psychotic episode that resulted in hospitalization; during this vulnerable transition stage, family therapy helps to stabilize the consumer, prevent relapse, and increase treatment compliance.

**EXAMPLE OF AN EARLY PSYCHOSIS INTERVENTION PROGRAM FOR YOUNG ADULTS**

Established in 1992, the Early Psychosis Prevention and Intervention Centre (EPPIC) in Melbourne, Australia is a unique 18-month program exclusively for young people between the

---


69 Kulkarni, & Power. In.


71 Kulkarni, & Power. In.

ages of 15-24 who are experiencing first-episode psychosis. Each consumer is assigned a case manager and doctor who individually tailor a program of individual, family, and group interventions to the consumer’s needs. A major component of the program is its partial day treatment, offered Monday through Friday. Several 10-week groups are offered throughout the day, and consumers attend groups based on their interests and their treatment teams’ recommendations. The program is organized into five “streams”: social recreational, vocational, creative expression, health promotion, and personal skills development. Additional programs are offered as needed based on the current participant pool.

In a naturalistic study (i.e. not a randomized controlled trial) of EPPIC day program participants compared to EPPIC participants not involved in the day program, researchers found that though the day participants had a lower pre-morbid level of functioning as compared to non-day program participants, at the six-month follow up, the two groups did not differ significantly along any measure. In interpreting these results, it is important to remember that a study using a quasi-experimental (non-random) design cannot control for pre-existing differences in the treatment and comparison groups that could influence the outcomes, and therefore the results must be viewed cautiously. However, the EPPIC day program shows promise in its potential to alleviate some signs and symptoms of psychosis.

In addition to the day program, EPPIC also provides community education about early psychosis prevention and intervention and runs a small (16 bed) inpatient facility.

EPPIC was implemented as a resource-rich program, but has also demonstrated that it is cost-effective when compared to other public mental health services. In a study of direct costs over twelve months, EPPIC was less expensive than traditional mental health services for psychosis. The authors of the study caution that these results are preliminary and that further research is needed, but the EPPIC model appears promising in light of the clinical and cost-effectiveness data.

WEB RESOURCES

Early Psychosis Prevention and Intervention Centre (EPPIC) http://www.eppic.org.au/
Described above, EPPIC is a program based in Australia focusing on treatment of early psychosis in young adults.

Promotes research and discussion of issues related to early psychosis.

Open the Doors http://www.openthedoors.com/english/01_00.html
This organization is launching a global program to fight stigmatization of individuals with severe and chronic mental illnesses.

74 Francey. In.
**Peer Support for Parents of Psychosis Sufferers**
http://www.psychosissupport.com/
Though the organization is based in Canada, this website includes information by and for parents of individuals with a psychotic disorder that would be useful to families anywhere.

**Prevention and Early Intervention Program for Early Psychoses (PEPP)**
http://www.pepp.ca/index.html
Canada-based program for early psychosis treatment that emphasizes a case management model. From their website, you can download manuals on screening, assessment, and treatment.

**Reaching People Early**
http://www.rethink.org/reachingpeopleearly/
A project of the England-based Rethink program, a nonprofit organization providing public education and research on severe mental illnesses. Reaching people early focuses on early intervention for a wide range of mental illnesses, including schizophrenia. Their 9-page report, which discusses treatment options during 8 stages of mental illness, from the first signs to recovery, is available at http://www.rethink.org/reachingpeopleearly/pdfs/Reaching People Report3.pdf

**The Teenage Brain: Culture and Schizophrenia**
Fascinating website for PBS program on the brain discusses development of schizophrenia in teens across cultures. You can also view a video showing how dopamine works in the brain: http://www.pbs.org/wnet/brain/episode3/video.html
CHAPTER VIII

TRANSITION AGE YOUTH ASSESSMENT

“Ask questions from your heart and you will be answered from the heart.”

— OMAHA TRIBE
When doing Transition Age Youth (TAY) assessments, providers are responsible for assuring that the strengths, abilities, hopes, and dreams — as well as the needs and challenges — of individuals and families seeking help are fully identified, appreciated and understood. This is the task of assessment. In turn, assessment supports the creation of responsive, efficacious plans and services that are person and family centered, as well as consistent with the expressed values, culture and wishes of those receiving services.

But assessment is more than the mere gathering of information; it is the start of building a trusting, helping, healing relationship, the forging of an alliance upon which to build a plan responsive to the needs of the youth and family. We can begin to say that the assessment is person-centered, when, in the process of assessment:

- Each TAY is viewed as a person of worth and is respected as such;
- Each TAY has the right to self direction, (i.e. to choose their own values and goals and to make their own decisions\(^9\)); and
- Each assessment is an ongoing event that unfolds as the youth reveals more of himself or herself.

While there is no question that the accuracy and quality of information is important, how it is collected is perhaps even more critical. In many instances it is easy to confuse the process of assessment with the requirements of paperwork and forms, but ultimately assessment is all about building a relationship.

A recent text on treatment planning suggests that: ‘A semi-structured [interview] format is recommended as the best means of gathering information from the patient [sic]...this ensures that all interview information that is generally helpful or needed in formulating a clinical picture of the patient is obtained.’\(^{10}\) While the use of semi-structured interview guides has its benefits, the “conversational and less formal” approach, which focuses on “bonding” with the TAY rather than collecting information or promoting a particular service, is more appropriate if services are to be person-centered.\(^{11}\) One of the best ways to engage a TAY or family is to focus on their goals, hopes, wishes and dreams. This is especially true with youth who may form important treatment decisions based on one visit with a provider depending upon how the youth felt the chemistry was. This is also very closely tied to a strengths oriented approach that is at the heart of notions of recovery, wellness and resiliency.

There are always certain record keeping requirements that the State contract demands, as stipulated in contracts between county mental health plans and State Department of Mental Heath. The demands of documentation requirements and the process of successfully assessing TAY have to be balanced. While it is important to be mindful of addressing the various life domains found in a comprehensive bio-psychosocial assessment, it is equally important to

---


consider “how” this activity takes place. If the Medi-Cal provider views the assessment task in a routine manner, simply attempting to “fill out the form”, it is likely to result in a less than satisfactory experience for the youth. Keeping in mind a “forward looking” approach will help the clinician focus on an appropriate and effective interview process. As Daniel Levinson reminds us is in his “Seasons of Life”, youth hold a dream or image of themselves in the adult world that guides their decision making. If the clinician does not allow that image to emerge during the assessment process, than the youth may quickly loose interest. The information will thus not be meaningful.

The words triage, screening and assessment are often used interchangeably resulting in some degree of confusion for everyone. While they are related processes they also represent distinct clinical functions. For the purposes of our discussion here, the following definitions are offered:

- **Triage**
  a process of assigning priorities for access to treatment based on urgency and risk, typically but not necessarily used in emergency or crisis situations

- **Screening**
  a cursory or preliminary assessment process for determining the need and appropriateness of services, often times used in initial determination of eligibility, level of care, etc.

- **Assessment**
  an in-depth gathering of data and information, typically conducted at the initiation of treatment, needed to understand an individual or family’s needs as a pre-requisite for developing a plan of care

Too often an assessment begins by focusing on what is wrong, (i.e. the clinician starts off with a crisis approach that sets the initial tone with a problem or deficit attitude). In a recovery oriented person-centered approach, the challenge is to think about more positive, inviting, and affirming ways of helping and engaging the TAY and his/her family who may be seeking help. The need to accept and “meet the person on their own terms” is an oft recited phrase, but what this really means in responding to an individual’s or family’s request for assistance needs further consideration. Sometimes simply asking the neutral and inviting question “How can I be of help?” begins to realign some of the inherent and at times undermining power differentials in the relationship between the provider and the TAY seeking services. This begins to set the stage for a more positive and productive course. There are times when this process is framed as one of alliance building or engagement. While this may at one level be accurate, the importance of the tone, quality and experience of the relationship cannot be over-estimated. Treating TAY with dignity and respect should always be our standard of practice and guiding rule — regardless of the circumstance.

Another approach is to actually begin with some form of an orientation where the clinician provides some preparatory information, rather than immediately engage in data gathering and assessment. There are multiple levels of orientation to consider: orientation to the larger concept of mental health, orientation to the service organization and available services, and/or orientation to a particular program. Depending on the needs, experience, knowledge and sophistication of the TAY and his/her family, all three levels of orientation might be indicated. Although providers are very familiar with the mental health and substance abuse service process, many of the youth and families coming to seek help are not. For many people, each new experience in seeking services
brings with it anxiety and uncertainty. Both TAY and adults will frequently come with fears and misconceptions, not knowing what to expect. Beginning with an explanation or overview of the whole process can go along way towards reducing anxieties, beginning to build the alliance, and supporting the assessment.

The importance of a strengths-based approach to assessment cannot be underestimated. A focus on problems and deficits often leads to feelings of shame, blame and failure. This does not promote or support engagement and does not set the stage for recovery. A deficit approach emphasizes a negative perspective and often leaves the individual and family feeling that they are the problem. When a youth is made to dwell on past mistakes, chances are he/she will not want to return to that setting or treatment provider. There is a real opportunity to be empowering even in the process of gathering assessment information. In a strengths-based and person-centered approach, the focus is on action rather than uncovering all of the problem areas. This helps to build trust, cooperation and meaningful involvement by the TAY and his/her family. Regardless of the philosophical orientation or the training of the provider, a strength-based approach can be quite effective. Some models such as White’s Narrative approach, Solution Focused paradigms, or cognitive behavioral therapy lend themselves to defining the strengths of a family system and capitalizing on these as resources to be used as building blocks in future sessions.

In responding to a request for assistance, be it self-referral or involuntary commitment, the first step is to engage the TAY as a partner in telling his/her story and gathering information. Based upon the information gathered, understanding is the next step. If assessment is about what, understanding is about why.

Serving diverse multicultural multi-ethnic communities — where the issues of stigma, avoidance and the ability to trust mental health professionals is a real concern — can further complicate the task of assessment. However, with careful attention to each TAY, and sensitivity to their unique cultural and ethnic background, success in building a relationship and learning about their needs can be achieved.

Assessment is often described as being both “initial and ongoing.” Assessment should definitely not be considered a one-time event. While information and understanding is necessary to start the service process, achieving a personal vision of discovery, recovery and wellness is inevitably a dynamic process, which continuously incorporates new information generated in each individual’s journey. As the youth progresses through treatment, his/her response to the intervention provides further information that has the potential to set new directions and priorities. The life of a youth is not static and rapid changes are occurring apart from our efforts to assist. Accordingly assessment becomes an integral part of the helping relationship. If recovery is a process of growth and development, assessment and the gathering of information over time becomes an essential component.

Although there are no standard rules or proscriptions for the proper period of review and update of an assessment, it should be timely and relevant to the process of providing services. As a guiding principle, a formal and comprehensive reassessment should be considered in the provision of long-term services at minimum every year; in all likelihood more focused reassessments will occur more frequently. Since a youth can generate so much activity in a brief period, and dramatic decisions can happen quickly, shorter-term plans are probably more helpful.

In more short-term or acute service settings; the period of reassessment should correspond to the
time frames in each youth and family’s plan and be related to the anticipated or average length of
services. Midpoints are often convenient times for some formal reassessment. The transition age
youth who continue beyond the customary duration of services are also good candidates for
reassessment.

If assessment is about gathering information, then it is reasonable to ask how much is enough?
What is the right amount of data? What is the right level of detail? The answer: an amount of the
information sufficient to adequately understand the TAY and his/her family. In considering the
scope of assessment and the range of topics to address, perhaps one type of information is more
important or essential than all the rest: identifying the strengths of the TAY and his/her family.
Knowing about a person’s hopes, dreams, accomplishments, and self-esteem helps to better
understand their challenges and needs. In fact, as Jay Haley contends, as a youth is preparing to
leave home, if there are challenges that keep a family off balance, the youth will need to stay in
the home to assist with finding the solutions. It is always better to conduct the assessment in the
context of the entire family system, so the strengths of the system can be drawn upon to help
launch the youth into adulthood.

Detail and depth should not be confused with breadth. It is important that every assessment is
comprehensive. The full range of issues, topics and domains must be considered for each
individual and family. However, tailoring the process to each TAY and circumstance requires the
skill and experience of a trained and capable provider. Being person-centered in all phases of
treatment must be reflected in the assessment process as well. Individualizing the breadth
(comprehensiveness) and depth (level of detail) for each assessment assures that it is person-
centered. At the same time, organizing the data gathering into domains or broader topic areas will
minimize the risk of overlooking critical information. While being broad or comprehensive is a
general criterion, the depth or detail of an assessment may vary depending on the immediacy and
severity of a TAY’s circumstances and the treatment setting. Not all domains require the same
depth of inquiry or detail, at the same time.

Given the changing demographics of American society and the increasing diversity of
communities, attending to the issues of culture in the process of assessment is critically important.
Since the assessment phase often initiates the process of responding to need, assuring the cultural
competence of our assessment is essential. In many respects a person-centered approach that
focuses on the unique needs of each youth and family is the essence of a culturally competent
approach. It is important to remember that culture does not refer only to matters of race and
ethnicity but also to the myriad ways in which people self-identify and affiliate. Understanding
this is central to any notion of being person and family centered. Remembering Erikson’s fifth
stage of development, this is especially true for the TAY. Youth are strongly involved in creating
an identity versus facing an overwhelming sense of diffusion, so the provider is wise to focus on
the areas where the TAY have focused their attention. We must strive to understand the
individual and family in the context of their developmental stage, their culture and experience —
and we must also be aware of the ways in which culture can create barriers in our efforts to
respond.

When a youth has embraced an identity that feels authentic, often the TAY is ready to move into
Erikson’s stage of intimacy versus isolation. As providers we need to understand that in the
assessment phase, the youth may feel most comfortable bringing along that significant other and
we can view this as an adjunct rather than an interruption. In later sessions, it may be that the
partner of the youth will provide pivotal data or inspiration for an effective intervention that will
produce positive change.
A framework for considering human diversity can be thought of using the *ADDRESSING* mnemonic and includes the following factors:

- Age and generational influences
- Developmental and acquired Disabilities
- Religion and spiritual orientation
- Ethnicity
- Socioeconomic status
- Sexual orientation
- Indigenous heritage
- National origin
- Gender

In summary, assessment is the first and therefore an important step in initiating a person-centered plan and supporting an individual’s and family’s recovery.

**APPENDIX:**

- StrengthDiscoverModule.txt; Robert Wagner and “Rusty” Clark
  [http://tip.fmhi.usf.edu](http://tip.fmhi.usf.edu)
- Conducting the Initial Interview; Brian Salada
Several different theoretical approaches emphasize the importance of establishing a positive connection with the client in the initial interview session. Typically, the first session is seen as an opportunity to acquire information that will be necessary in assessing the client’s needs, resources, and goals for therapy. Moreover, it is a time to find out some background information about the client’s life experiences. However, the most important outcome of the first session is to establish a positive working relationship with the client. If this is not accomplished, a second session may never occur.

From one perspective, the initial interview may also be defined as a distinctive assessment phase during which the clinician conducting the assessment will try to gather information about the client that will be used in guiding the type of treatment that is later employed. The initial session often also involves some degree of actual treatment. The process of empathic listening while a client describes his or her problems can itself be seen as a form of treatment intervention. Therefore, the distinction is not always clear between the phases of assessment and treatment; both are part of an intertwined ongoing process.

One way of looking at the assessment process is to highlight the basic components of this initial phase. That is what needs to occur in term of basic guidelines for the assessment process. In their book, Introduction to Counseling and Guidance, Gibson and Mitchell emphasize six basic principles as a framework for beginning the delicate process of the individual assessment.

1. Each individual human being is unique, and this uniqueness is to be valued despite the typical pressures to standardize and categorize a client’s emotional and behavioral issues. Assessment is a means of emphasizing the uniqueness of the individual and this uniqueness is to be valued.
2. Each person is distinct from others. Individual assessment seeks to identify the special talents, skills and interest of the person. The clinician should focus on the strengths and challenges of the individual. It is important to recognize that we all have shortcomings and that identifying them can be part of the process of overcoming them.
3. The direct participation of the person in his or her assessment is a necessity. The person should be directly and willingly involved in the assessment process. The client should have opportunities to clarify and expand on the clinician’s interpretation of information presented.
4. Assessment instrumentation (e.g., forms) can inhibit accurate assessment. It is important that clinicians receive appropriate training on the instruments that are used in the assessment, and that they recognize the limitations of instruments as well as their potential.
5. A goal of assessment should be to identify the potential of each person. The process should be one of optimism and the identification of positive goals and positive planning.
6. Human assessment follows established professional guidelines. Therapists need to be aware of their professional ethics which govern the assessment process.

In the book, *Theories of Counseling and Psychotherapy: A Multicultural Perspective* (Ivey, D’Andrea, Ivey and Simek-Morgan), the authors discuss the use of the five-stage interview model in therapy. The first stage is defined as establishing rapport and structure. The purpose of this phase is to build a working relationship with the client and to enable the client to feel comfortable with the interviewer. Explaining the purpose of the interview is an important component. Providing this structure helps keep the session on task and to inform the client what the counselor can and cannot do.

During stage one the counselor needs to utilize important micro-skills such as culturally and individually appropriate attending behaviors as well as the ability to observe client reactions. This is related to adjusting the pace and structure to meet individual and cultural needs. Establishing rapport early will later translate to an empathic bond between the client and therapist.

This initial phase may take place over a period of weeks. For example, working with acting out youth may require additional time to build rapport. As an example, Ivey et al. note that in Aboriginal Australia, social workers often spend more than half of the interview focusing on the family and social interconnections before even asking about the issue to be discussed. In contrast, it is noted that many middle-class people in North America often start talking about their problems quickly. However, it is still emphasized that rapport and trust need to be developed throughout the session.

There is also a great deal of emphasis placed on conducting the first interview in Strategic Therapy. The initial assessment phase often involves assessing the communication and relationship patterns between family members. In his book, *Problem Solving Therapy*, Jay Haley discusses specific stages of the first interview and emphasizes the need to immediately engage the family members in a positive and supportive manner. For example, the first stage is referred to as the *social stage*. During this phase the family members are greeted and made comfortable. All family members should be involved in the action, and particularly during the greeting phase. Haley indicates that the therapist should speak to each family member and find out his or her name. Information can include hobbies, interest, vocation, and so on. No discussion of the problem should occur prior to completion of the social stage. The analogy Haley uses is that of courtesy behavior one would use with guests in their own home. That is, everyone is greeted and made comfortable.

Haley also points out that that talking about personal problems to someone can be embarrassing. It is important to note the mood of the family. Family member’s feelings may range from unhappy to desperate. The therapist should try to match the mood of the family. The first session is a time to note the relations between the family members by observing how family members sit in relation to one another and how they speak to one another. It is important to keep any conclusions the therapist might draw as tentative to avoid getting set in one way of thinking about the family. It is important for the therapist not to prematurely share his/her observations with the family and risk being wrong and/or raising the family members’ defensiveness.

The second phase of the first session is referred to as the *problem phase*. Haley suggests that this phase should be clearly distinguished from the social stage to highlight that this is a therapy situation. Problems can be asked about in different ways. For example, the therapist can ask the family, “What changes do you want?” to frame the therapy situation as one of change. Again, Haley places great emphasis on asking each family member what their perspective is and
respecting the hierarchy of the family in consideration of parents’ authority position. He suggests the use of toys and play items to facilitate children’s communication. Finally, he stresses the importance of not giving advice to the family during this phase.

The next phase of the first session is called the interactive phase. During this phase family members are encouraged to talk about their concerns with one another. This allows the family to communicate directly with one another and the therapist to get a better understanding of how the family discusses their concerns. This is part of the assessment process because the pattern of communication will say something about structure of the family insofar as who talks to whom, what each person emphasizes and how each person expresses him or herself.

The last phase of the session focuses on defining desired changes. In this phase, the therapist asks each family member about the changes they want to see occur as a result of the therapy. During this phase a contract is established with the family. It is important that the therapist focuses on the problem the family wants to see changed as opposed to telling the family what the therapist thinks should change.

Haley states there are several useful guidelines to consider in the first session. For example, the therapist should avoid being too professional and detached from the family. The therapist’s approach should be positive and engender a sense of hope. The therapist should show the family he has something to offer them and help to bring about change.

There are common elements among each of these approaches for the clinician’s first contact with the client. First, each approach emphasizes establishing a positive climate of change. This increases the likelihood of the client returning to treatment and enhances the working relationship with the clinician. Secondly, each approach emphasizes the need to understand from the client what their concerns are as well as their goals for treatment. Finally, the common emphasis is to recognize the unique qualities of each individual and their family in assessing their needs and developing a collaborative plan with them toward the achievement of their goals.

REFERENCES

CHAPTER IX

INDIVIDUALIZED PLANNING

“Goals are dreams with deadlines.”

— DIANA HUNT
CHAPTER IX

INDIVIDUALIZED PLANNING

Everyone has an invisible sign hanging from their neck saying, “Make me feel important.” Never forget this message when working with people.

– Mary Kay Ash

SERVICE PLANNING: AIMING FOR SUCCESS, CREATING PARTNERSHIP

For many youth with emotional difficulties, emerging adulthood is characterized by conflicting needs and emotions within a context of adamant self-righteous surety propelled by vivid visions of the way life should be. Right and wrong are absolutely clear and wrongs are taken as deeply personal affronts. Several developmental issues specific to Transition Age Youth (TAY) that can make life overwhelming include finding a place for oneself in a jumble of belonging, meeting cultural expectations, feeling pressure to conform to a real or perceived norm while simultaneously finding one’s uniqueness, and experiencing confusion about the role of family and impending adult relationships. There are not many ports in the storm and many of the ports that do exist aren’t safe. Adults can be perceived as aggressors trying to keep the young adult a child, yet also protectors trying to create a safe place from which an adult can emerge from the chrysalis of adolescence. Trying to keep up and get ahead while watching oneself fall farther behind is frightening. It gets worse: it’s not safe to admit these feelings to oneself or to anyone else. Is it a wonder that the youth often wants adults and their service systems to just go away?

Thoughtful, comprehensive service plans help sort out issues, priorities, complexities, contradictions, and disagreements while establishing a trusting, safe environment. Focusing on mutually agreed-upon goals that help the individual feel successful and increase the quality of his or her life will help the TAY to feel comfortable participating in treatment.

Lives characterized by rapid change and frequent crisis can benefit from an organized process that takes a seemingly overwhelming task and breaks it into smaller, more manageable units. These smaller units can then be systematically addressed, removing barriers to success one at a time. Successful follow-through is enhanced by systems in which the needs of the youth become the primary driving force behind all actions. This implies the need for flexible bureaucracies, which can be a daunting task, but is essential for success. A “whatever it takes” attitude is welcomed by youth and enhances trust. Timing is another issue addressed by good service planning: life is so immediate for youth that needs are also felt as immediate. Showing TAY that relevant, often times very basic, needs are being planned for in advance can begin to ease the discomfort generated by the perceived urgency.

TAY using mental health services falls into two broad categories based on future eligibility. The two are: 1) youth who will not be eligible for adult services; and 2) those that will be transitioned into adult mental health services. The exact age at which this transition takes place depends on whether the person receives EPSDT and local policy decisions, but the transition issues are the same. A Service Plan for a person not eligible for adult mental health services needs to focus on helping the person attain a stable income, living situation, and natural support network before withdrawal of service supports. These youth need to be linked with Vocational Rehabilitation agencies and other community resources with a gradual withdrawal of services. Since many youth
want providers to “get out of my face” this provides an opportunity for cooperative planning to accomplish exactly what the youth says he or she desires while increasing the chances for success. Some youth will attempt to access services after aging out because of a lack of other options, or when a crisis occurs or because the program is the only safe, supportive place they know. When a youth whose eligibility for services has ended requests assistance, the program should recognize the youth’s needs while considering the program’s resource and staffing limitations. Good planning for community integration can decrease the frequency of this occurrence.

For youth who will transition to adult services, the Service Plan serves to document needs, goals, and interventions that the Adult System of Care (ASOC) will be expected to provide. In systems with separate Children’s and Adult’s System of Care, it is advisable to include representatives of the ASOC in the planning process as transition time approaches. Recovery/Wellness, real world success, and the expectation that the person will not have an unending career as a “mental patient” are hallmarks of the transition process and should be included in the planning process.

Regardless of future eligibility issues, the challenge is to create a relationship in which youth and provider priorities are mutually acceptable and both parties are willing to cooperate on their assigned tasks. Establishing this cooperative relationship is the goal of engagement and beyond the scope of the present chapter, although it is probably the ultimate predictor of success for TAY.

No Service Plan can be better than the assessment. The assessment must cover an analysis of strengths and resources, symptomatology (diagnosis), functional difficulties flowing from the symptoms, and a cultural formulation. The youth is not a passive specimen during this process. She or he is an active participant whose opinions and insights are to be welcomed. Any disagreements need to be negotiated, and a conclusion should be reached that all parties can accept.

Upon completion of the assessment, the provider, youth, and entire team need to stop and think. Is this person eligible for services? Who is this young person? What difficulties does this person experience as a result of his/her psychiatric disability? Who is this person in the context of her/his life and what does the youth need to be successful in an adult world? This formulation must be developed with the youth, and a common interpretation should be agreed to before the planning process begins. Setting a common context establishes the ground from which planning and coordination can proceed. A shared understanding creates a trust among all parties and a commonness of purpose without which success is unlikely. This may not be an easy process in instances where there are serious disagreements. It is preferable to unearth those disagreements early in the process than to find out about them later through “non-compliance” or other behaviors that would lead one to conclude that the proposed plan was not based on consensus.

With a mutually agreed upon foundation, the Service Planning process can move forward. The major components of the Service Plan are as follows:

1. Set the goal
2. Identify the barriers to success
3. Design the objectives
4. Develop the interventions
5. Use a feedback mechanism to gauge success
The goal should be a broad, quality of life, recovery-focused issue, ideally recorded in the youth’s own words. It should be global, describe life changes, address discharge or transition criteria, and serve as the focus of the alliance and collaboration between provider and young adult.

By understanding who the individual is in the context of his or her life, the provider should be able to document how the person’s disability prevented the youth from achieving the identified goal. When a natural maturational experience did not take place, the current plan should address what needs to happen to bring about the delayed experience.

The larger the scope of the goal, the more impact it will have in the person’s life, and the broader the scope of interventions that can be used in achieving its successful completion. For example, compare the two possible goals: “I want an apartment” and “I want a job.” In the former case, there are many things necessary to help a person get and keep an apartment: budgeting skills, health and safety requirements, supports, resources, social skills if a roommate is needed, a source of income, etc. Choosing, getting, and keeping a job may be an integral part of the process, but is only a part of the process. In choosing a goal, all partners need to keep in mind what would have a lasting and beneficial impact on the youth’s life. In either case, medical necessity would need to be documented: how did the disability create the situation in which the youth was unable to get and keep an apartment or a job. The goal needs to address a quality of life issue, and for TAY, the goal should help youth move towards independence from systems of care and facilitate their integration into the community.

The provider must be aware of the cultural issues attendant to a particular goal. Is it consistent with the cultural expectations of the client and the family (where the family is involved)? Will having a particular goal contradict cultural expectations? For example, in some cultures, children (particularly young women) are expected to live with their parents until marriage. In that situation, if the transition age youth wants his or her own apartment, there may be disruptions in the process due to lack of family support or outright antagonism from family members. This is not to imply that this could not be a goal; only that there is a potential barrier to be explored and addressed.

Once a goal is agreed upon, the next step is brainstorming a list of barriers preventing the attainment of the goal. The purpose of the planning process is to help the youth successfully achieve their real world goal so ANY barriers to success must be identified. The following areas comprise the major areas in which barriers fall:

- Presence of distressful symptoms or behaviors
- Culture bound barriers
- Underdeveloped skills, including Activities of Daily Living (ADL)
- Lack of resources
- Need for additional supports
- Safety concerns
- Logistical difficulties (e.g., transportation)
Brainstorming with the youth (and family or personal support system) serves to identify a full range of the barriers. Once the barriers are identified, the most troublesome ones should be prioritized and addressed. Not all barriers will be amenable to reimbursable interventions, but achievement of goals requires alleviation of all barriers. Often other community programs can provide specialized services not reimbursable through county funding, and case management (which is reimbursable) includes identifying these services and connecting youth to them.

After barriers have been prioritized, the essential ones should be turned into objectives. Objectives are the short-term goals that represent the small, achievable steps that lead to the completion of the overall goal. The objective should express the desired changes in symptoms, status, or function, provide a specific time-frame for achieving the change, and identify the removal of a particular barrier(s). It should be written in words that are: behavioral, achievable, measurable, and understandable to the youth. Objectives help the youth understand that completion of small steps leads to achievement of a larger goal. They provide evidence of progress. Care should be taken to ensure that the number and complexity of objectives do not overwhelm the individual youth. If the hill seems too steep, the youth may just give up. The providers need to maintain an attitude that success is not only possible, but probable, if the focus on achieving the small steps is maintained.

After the objectives are developed, the team can begin to identify the intervention(s) needed to achieve the objectives. In the case where the youth is aging out of services, the provider interventions need to be focused on increasing skills and teaching youth to access community resources for themselves. This is where the strengths from the assessment must be incorporated into the process. Be sure to include “homework” so the youth has an investment and that it incorporates things that she or he can successfully accomplish. In subsequent plans, youth tasks can increasingly present challenges, but at initial stages, interventions should be chosen that ensure a high chance of success. These are the stones that pave the road to recovery.

Interventions are actions by: the youth, family/personal support system, peers, community organizations, private organizations, service agency staff, and mental health staff. Over time interventions should increasingly be done by the youth and his/her family or personal support system. In fact, this could be considered a measure of the youth’s Wellness or Recovery. Interventions need to state the following:

- Provider (Clinical Discipline if Agency Staff for reimbursable services especially)
- Person’s name (or job title depending on local need)
- Modality:description of service
- Frequency (e.g., once a week)
- Intensity (e.g., for one hour)
- Duration (e.g., for six months)
- Purpose/intended impact as directed towards the objective

Identifying the purpose ensures the plan is individualized to that particular person. Identifying the timeframe keeps the plan a living document, one that needs to be used on a session by session basis to track progress toward the objectives, coordinate the activities, and make any adjustments. This is part of the feedback mechanism that helps keep everyone on the same page, focused on the goal, and sensitive to the changing needs of the youth.
Interventions need to incorporate cultural considerations. Cultural barriers to service need to be removed through timely and culturally sensitive interventions. Culturally relevant resources such as native healers need to be included on par with the standard service providers. Interventions not consistent with the individual’s cultural values need to be avoided (e.g. representatives from some cultures are very reluctant to speak of their difficulties in front of peers, so sending such a person to group therapy would be ill advised). Typically, younger generations are more acculturated to mainstream culture than their elders. Where intergenerational differences exist, interventions may need to address difficulties resulting from acculturation differences.

A thorough Service Plan helps engage the youth, create a supportive bond, identify emerging difficulties, and place the youth in an empowering position. Young adults need to be as in control of their situation as much as possible. By clarifying everyone’s actions and expectations, the youth is able to see that he or she is the focal point of all activities and that his or her participation in treatment is integral to his or her success. From an administrative perspective, strong service plans document medical necessity and clarify needed resources. Service Plans can identify instances in which coordination between agencies or programs is working well or needs improvement. They can also serve to document the adequacy or lack of resources.

But the bottom line is that Service Plans enhance teamwork and keep everyone’s focus on success and recovery.
CHAPTER X

EDUCATIONAL CONCERNS FOR TRANSITION AGE YOUTH

“You can learn new things at any time in your life if you’re willing to be a beginner. If you actually learn to like being a beginner, the whole world opens up to you.”

—BARBARA SHER
CHAPTER X

EDUCATIONAL CONCERNS FOR TRANSITION AGE YOUTH

INTRODUCTION

“Individuals with psychiatric disabilities increasingly have recognized that education plays a critical role in enhancing their recovery and reintegration process. To assist them with reclaiming the valued role of ‘student’, the concept of supported education has come into being. Supported education for students with psychiatric disabilities can be defined as: education in integrated settings for individuals with psychiatric disabilities for whom post secondary education has been interrupted or intermittent as a result of their disability, and who, because of their disability, need ongoing support services to be successful in the educational environment.” (Adapted from the definition Supported Employment, Rehabilitation Act Amendments, 1986; Unger, 1992.

As the above quotation suggests, it is imperative that youth with psychiatric disabilities receive adequate supports to maximize their success as students. Transition Age Youth (TAY) frequently face disruption to their educational process brought on by the onset or exacerbation of a psychiatric disability. This can impair their ability to think, socialize, and learn in ways that can limit their ascension into adulthood. A major developmental milestone is successfully transitioning into a meaningful role in the community. When youth are left behind as their peers navigate through the educational transition, despair, isolation, and a sense of alienation begin to take hold. In place of hopes, dreams, and aspirations, a sense of futility and meaninglessness can emerge which can undermine the youth’s attempt to find a place in the community.

This chapter will cover the issues and recommended practices for secondary and post-secondary education.

SECONDARY EDUCATION TRANSITION PLANNING

There will always be students who experience symptoms of emotional or behavioral disorders, especially foster care students, who have not qualified for Special Education. These students face intense challenges in planning for college. Many of the entitlements and programs mentioned above may not be available to them as regular education students. These will be clients who may or may not be served by the Adult System of Care, yet, there is a high need for assistance to make this critical transition into a college setting to keep their natural developmental process unfolding. This planning for college should begin well before age 18. Whatever assistance case managers can give this group by referring them to their local community college for a free appointment with an academic counselor for the assessment process will be most beneficial. Another avenue might be to obtain a release to confer with the high school counselor to determine if an application to a state college or university is feasible.

Transitional age youth will benefit from educational opportunities which will help them to reach a successful adult life. Often the TAY can come from a background of involvement in Special Education while in grammar or high school. Both the State (Government Code
Chapter 26.5) and the Federal Government (Individual with Disabilities Education Act or IDEA) have strong mandates that govern Special Education Programs. For youth in the Mental Health System, the qualifying disability will be an emotional disability. Education provides a structured setting for youth as they progress toward independence and creates an excellent opportunity to generate Transition Age Plans.

IDEA requires that the planning for each student’s needs happen at the individual education plan (IEP) meeting. The IEP Team is the school team assisting the student, which includes the parent of the student with the disability, and it is expected that this team will develop a plan that will allow the student to take advantage of his/her educational opportunity in spite of the handicapping condition. Once both the parent and the school sign the plan, the plan becomes binding and potentially can result in legal action if ignored. When the system is working well, it can assist the TAY obtain services or concessions that are critical to graduation.

IDEA also requires that the IEP address the individual’s transition needs. A Transition Plan may be included in the student’s IEP when he/she reaches the age of 14 years. An Individual Transition Plan (ITP) must be developed by age 16, at the latest. The ITP coordinates vocational activities, independent living skills, and other resources to meet the youth’s educational needs. The ITP may address areas for both home and school. Once the student successfully graduates from high school, special education comes to an end. A student can focus on the goal of a high school education until age 22 and still be in Special Education.

“There are many positive outcomes for providing supported education services to people with psychiatric disabilities. A major one is that Mental Health Consumers become college students. The role of college student in our society is highly valued. The role of Mental Health consumer is much devalued. With this change in role and identity, students realize they are not their illness, but a functioning, productive member of the community. Symptoms become something to be taken care of so goals can be accomplished. Although attending college can increase stress, the stress can be managed with support and a symptom management plan.”

**POST-SECONDARY TRANSITION PLANNING AND STRATEGIES FOR SUCCESS**

Effective supported education approaches are rooted in common principles of recovery and rehabilitation and have been carefully documented in a variety of program approaches. Community integration is a major program goal and helps to provide meaning and direction for the educational experience. Various service approaches include both on- and off-campus support strategies and tend to focus on three key areas: *access, retention, and educational outcomes*. Practical experience and research has established that these three domains represent the service context to be considered when constructing a supported education program. This chapter will carefully detail the essential service elements of these three domains and will offer a practical approach to assisting the transition-age youth in completing their educational endeavors successfully.
ACCESS

It is easy to imagine that the young adult who pictures himself or herself in a community college environment can easily make this become a reality. There are numerous ways to gain entry to a community college. With the advent of the Internet, most colleges have online registration that makes it easy to find out about course offerings and enroll. Prospective students can obtain information about major programs and course offerings by physically going to the college and picking up a course schedule and catalogue of major programs. All California community colleges have counseling faculty that can provide academic advising and support to assist students in navigating the maze of the college environment. However, even with a number of access options available, the TAY very often has significant difficulty enrolling in classes.

For students with disabilities, specialized counseling and support services exist in the form of “Disability Program and Services” (DSPS) which offer an array of highly individualized services pertaining to the specific accommodation needs of each student. There is growing evidence that the DSPS service at each college is a pivotal resource in determining the academic success for students with disabilities. In fact, many successful Supported Education programs have established the DSPS resource as the “first point of contact” when assisting individuals with psychiatric disabilities to get started with their college careers.

In addition to California Community Colleges, TAY are often interested in academic or vocational programs offered through a variety of Adult Education settings. An example of such a program can be found in the Regional Occupation Programs which provide training for a variety of occupations. Examples include fork lift operation, electronics assembly, and refrigeration/cooling to name a few. Other training options can be found at the One-Stop career centers and trade guilds. TAY are often referred by their Department of Rehabilitation counselors as part of their Individual Plan for Employment (IPE).

When discussing access, it is also important to be clear that access not only relates to acquiring needed services, course enrollment information, and other critical resources at the educational institution, but it pertains to off-campus resources as well. Examples of such resources are mental health services, Department of Rehabilitation Services, housing services, medical services, etc. Many students may be able to locate these services without assistance, but some may require the help of a case manager to identify and secure the needed resource. TAY are often best helped by a “wraparound” service approach where a case manager knowledgeable in all key domains can help facilitate this process. Listed below are focus areas to consider when addressing access concerns:

- **Recruitment** – Engaging youth in the community and at the educational institution to provide information about courses, services, and available assistance. Recruitment can also include outreach to high school guidance counselors with attention to targeting at-risk youth.
- **Orientation** – Providing hands-on information to introduce prospective students to available support and college programs.
- **Identified Contact Person** – This pertains to the assignment of responsibility for ongoing on- and off-campus support needs.
- **Walk-Throughs, Maps, Bus Routes** – Typically this information is provided as part of the orientation and may include actual transportation training. Often transportation costs are covered by the IPE funded by DOR.
- **Assistance with Registration** – The assigned case manager should assist with this if necessary. Once a student registers for the first time, they may become more comfortable with the process and can handle this on their own.

- **Assistance with Financial Aid Forms** – The case manager may need to assist the youth with this process. College personnel in the DSPS program may also be able to help.

These are but a few of the areas to consider when assisting TAY to access the community college and other educational settings. It cannot be overstated that the circles of support, which make it possible for recovery in the community, also need to extend to include the resources in the educational setting itself. In essence, the college becomes part of the community experience for the TAY and this helps to make the hard work of recovery operational for the TAY. Once the TAY has successfully made the connection to the educational setting, the work of staying connected and becoming a student begins.

**Retention**

As mentioned above, the transition from non-student to student can be an exciting expression of recovery for TAY. A sense of hope and promise begins to replace thoughts of doubt and feelings of despair. The whole educational experience brings TAY into contact with people of all ages and backgrounds and helps to shake loose the shackles of an identity steeped in disability, and in its place a new student identity emerges. At the same time, TAY will often experience increased anxiety resulting from new demands and stressors. There exists a certain level of risk of relapse for TAY as they venture forth on their path of academic pursuit. A solid, immediately accessible plan that identifies and makes available any necessary supports or services can help to mitigate this risk. Often in mental health recovery, TAY develops “Wellness Recovery Action Plans.” (WRAP) (Copeland). These plans identify crucial persons, services, and supports that are essential to help stabilize a burgeoning mental health crisis. These plans have been utilized by a number of individuals with psychiatric disabilities with great success. Many TAY have incorporated the services and supports available at the educational setting into their WRAP plans as well as the services and supports they have identified from other areas of their lives. The list below outlines the **Retention** oriented services that are important for the TAY to remain engaged with their educational program:

- **Identified On-Site Support Staff** – This is made clear during the initial contact and made part of the plan for ongoing support. Often a regular schedule of meetings is arranged with this person or support team. Assessment of learning needs and accommodations should be addressed early as TAY begins their educational experiences. Attention to previously identified learning obstacles, outlined in Individual Education Plans (IEPs) must be reviewed and attended to when developing the educational plan.

- **Transitional Classes** – These are classes designed to assist with the adjustment to the rigors of the educational setting. Time management, use of supports, and study skills are typical areas covered in such classes.

- **Counseling With Someone Who Cares** – This pertains to the identification of a point of contact that can provide the appropriate support. This must be made clear before a crisis occurs.

- **Peer Counseling** – More and more, programs are utilizing peer counselors to provide ongoing contact and support to help with the stresses and strains of college
life. These counselors are being trained in the emerging Human Service Certificate programs that many California Community Colleges are now offering.

- **Priority Registration** – Prior to the beginning of the semester, community colleges offer pre-registration for those students that have special needs. Both college and support staff can assist TAY to take advantage of this opportunity.

- **Book Funds** – Community organizations such as the Alliance for the Mentally Ill and mental health programs may offer book purchasing support. This can help TAY to get started with school while either working on getting financial aid, or getting started with DOR, where their book needs would be covered by their IPE.

- **Tutoring** – The need for academic tutoring needs to be identified as soon as TAY begins their classes.

- **Monitoring** – Case management should focus on the student’s progress and continually review support needs. It may be necessary to provide additional or different supports to meet the student’s needs.

- **Crisis Intervention** – A solid resource for handling a mental health crisis needs to be readily accessible. On occasion, support staff can help the TAY to petition for an accommodation from an instructor in order to resolve the crisis and return to class. An example of a typical accommodation might be an extension of a deadline for turning in an assignment.

- **Social Activities** – On- and off-campus recreational and social outlets are an integral part of the educational experience. TAY needs to review this aspect of their recovery and plan according to their interests.

- **Mentor Programs** – This pertains to setting up a formal structure for utilizing peer counselors who have experience in educational settings in assisting TAY in handling the stresses and strains of going to school. Some successful programs have utilized mentors such as this in helping to teach Transition classes.

- **Safe Place to Meet** – What is meant by this is identifying a place either on or off campus where TAY students can meet to share experiences, or give or receive support without feeling exposed or uncomfortable.

- **Study Labs** – Study labs are the places on campus where reliable help is available to address any ongoing or emergent learning support need. Many schools have learning centers that offer support for computer skills and other assistance.

- **Faculty In-Service Training** – Successful programs have gone to great lengths to provide ongoing consultation and classroom training for college faculty. The goal for this activity is to help promote a campus-wide culture of sensitivity and tolerance for students with disabilities. Some programs have sponsored consumer discussion forums held in high student traffic areas in order to provide information and engage the campus community in dialogue about stigma and other issues.

It is easy to see from this list that there is a need for partnerships between various agencies and services that become part of the circle of support for TAY. These partnerships ensure seamless service delivery and support that helps reduce any delay in response. Another benefit of partnerships between agencies is the creative use of resources in times of financial challenge. An example is the utilization of peer counseling in DSPS services to help extend the reach of professional counseling staff. In many colleges in California, these peer counselors are being trained and placed by Human Services programs, which have been developed in response to the growing need for indigenous or lay helpers. (College of San Mateo, Solano Community College, Riverside Community College, and Merritt College, are a few colleges with this type of program).
EDUCATION OUTCOMES

One of the most critical partnerships for both retention and further progress into the world of work is the collaboration between the community colleges and the State Department of Rehabilitation. This partnership is critical for the support and funding of the academic pursuits of TAY. Thriving supported education programs also involve local county mental health programs in a three-way partnership that provides a potent alliance for the support of TAY. Many successful program initiatives have developed Memorandums of Understanding (MOUs) between county mental health programs and their local community college (e.g., Solano county mental health and Solano College). These MOUs define and describe the overall working relationship between the community college and mental health staff. These MOUs are often referenced and supported by more formal cooperative contracts that exist between county mental health programs and DOR. These cooperative programs are the engines that can drive the educational program for the TAY and are directly tied to the long-term matriculation of the TAY into the work world. Listed below are items that pertain to Outcomes and represent the third domain of focus for successful supported education programs:

- **Service Coordination & Plan Coordination** – Services and supports need to be provided in a planned and purposeful manner. Examples may include Individualized Plans for Employment (IPE) developed with DOR, Service Planning with Mental Health, the “WRAP” plan as described elsewhere in this document, etc.

- **Comprehensive & Coordinated Career Assessment** – This includes the assessment process that TAY goes through with the assistance of the DOR counselor in setting up the IPE. Career counseling and assessment can also be provided through the career center at the college itself.

- **Skilled Academic Counseling** – The focus of this service is to review the catalogue requirements for a particular degree/certificate program to ensure appropriate course enrollment and certificate/degree completion.

- **Assistance With Degree & Certificate Applications** – Effective monitoring as described above will ensure that a schedule of important dates and deadlines are kept in relation to filing the necessary application materials for graduation or program completion.

- **Assistance With Transfer Applications** – This is again a function of ongoing monitoring that is related to the student’s goal of transferring to another educational program if desired. An example of this is a TAY transferring from a 2-year community college program to a 4-year program.

- **Liaison With Transfer & Employment Sites** – The focus here is linking the TAY to the employment service resource for job search and acquisition. One example is a TAY being referred by their DOR counselor to an approved DOR employment service vendor for placement services as specified in the IPE.

- **Assistance With Financial Aid** – This is a support that is both an access issue and a transfer issue, as many TAY move from the community college to the university.

- **Benefits Analysis And Counseling** – Many TAY rely on some form of Social Security Administration (SSA) benefits while they make their way to employment. Counseling support in this area is essential to help TAY students make the transition from student to worker.

- **Ongoing Monitoring And Coaching** – Once TAY finish the educational portion of their plan for employment, it is crucial that their plan include an identified resource for ongoing support and assistance.
RECOMMENDATIONS:

- There is NOT one “right model” of service delivery. Successful programs operate in many different ways.
- Successful Supported Education programs rely on clearly defined agreements that reflect the various roles and responsibilities of participating staff.
- Quality oversight is shared by all partners and constant program review and revision is the norm.
- Resource sharing is pivotal in building the continuum of support for TAY who are pursuing educational goals.
CHAPTER XI

VOCATIONAL AND EMPLOYMENT DEVELOPMENT

“A ship in port is safe, but that’s not what ships are built for.”

— GRACE HOPPER
CHAPTER XI

“The age of emancipation is not the same as the process of emancipation”

— (Davis and Stoep, 1996)

The world of work today changes quickly. The word “vocation” has taken on a totally different meaning than it had in the past. Suppositions are challenged, and the complexity and interrelatedness of the systems in our communities can leave anyone perplexed. Transition Age Youth (TAY), in the midst of this change, often finds themselves lost as they begin the transition from childhood to adulthood. A once familiar world, for many, drastically changes. New rules and survival skills have to be learned as one searches for work, and strives for independence to meet the demands their new life requires of them. Many attempt to do so without the assistance of mentors or other significant guides.

Our expectations are for youth to successfully navigate developmental and programmatic worlds where the ground can shift suddenly under their feet, and yet we still want TAY clients to emerge as independent adults. For youth with all the tools, the transition process can still be perilous. For those youth lacking the tools or given extra challenges, the process of transition becomes infinitely more challenging, and often leaves them snared in hopelessness or among the forgotten.

The first step for TAY is to obtain either a State Identification Card or Driver’s License, and a Social Security Card if they don’t already have one. Along with these documents, a high school diploma or GED certificate is a prerequisite for employment. These will be vital components to independence, and without them, work opportunities will be extremely limited and harder to access. Prior to age 16, which is when a Work Permit becomes available, readiness for employment should have already been started. If a TAY is unable to achieve these milestones, the youth may need an entitlement like Social Security Insurance (SSI) to assist him or her in the initial years of legal independence.

There are specific work programs that offer opportunities for TAY employment. If we view employment as a major stepping stone in successful treatment of a TAY experiencing a disability condition, then counties must establish programs like the ones mentioned in the appendix of this chapter. Remember, work is treatment!

According to Joseph Campbell’s, The Power of Myth78, successful transitions are marked by rites of passage, in which the community acknowledges that a youth has transitioned into adulthood. Many of these rites are undertaken involuntarily in that there is no choice by the youth regarding entering into adulthood. The act of growing up, or becoming adult, occurs no matter how much resistance is put forth. The paths to adulthood are not easy to navigate under ordinary circumstances; the presence of a disability makes the process more problematic. The United States Department of Labor, in a November 2000 report stated, “Despite popular perceptions that youth work more than they did in the past, the proportion of 15 to 17 year olds [in the workforce] has declined over time.”79

Obtaining stable employment could be considered the most important indication in our culture that youth have begun their transition into adulthood. Employment can be a very complex issue for many youth, for it affects many aspects of their lives. Without adequate guidance, frustration and hopelessness can set in very quickly, and from that point a seemingly unbreakable pattern of hopelessness and dependency is established. Traditionally, “three developmental outcomes in particular that are known to have great significance for the adult success of all American adolescents: 1) receipt of high school and postsecondary degrees; 2) the acquisition of employable skills and abilities; and 3) the development of physical and mental health. A host of studies have indicated that the attainment of these outcomes by the end of the teenage years bodes well for the future social and economic integration of youth.”

For youth age 16, or turning age 16, there are at least two significant milestones in our culture. One is the possibility of driving a vehicle, and the other is being able to legally work in the United States, if one has a work permit. We are taught (both at home and in school) that good work habits will not only lead us to desirable employment, but also to independence. For youth with disabilities, the possibility of employment creates fear because they may want to be seen as productive members of the community, but when they work, they worry about having their Social Security Disability benefits terminated or decreased.

One of the strongest deterrents to obtaining employment is the misunderstanding of how Social Security Benefits are impacted. In recognition of this misunderstanding, the Social Security Administration (SSA) asked for interested parties to participate in a 2003 demonstration project. The primary objective of this project was to increase self-sufficiency and decrease dependency on public benefits. This program called for a partnership between the school-based Transition Partnership Program (TPP) with the Department of Rehabilitation. A main component of this program is to educate consumers and families about SS benefits. The call for proposals further states, “This fear and attitude toward working often becomes ingrained at an early age.” It is not simply a concern about the amount of benefit received, but also about losing the medical and other benefits as well.

SSA anticipated this and in their Red Book one can find various programs that will allow social security recipients to pursue work while receiving benefits. One program permits individuals to save money to pursue training or educational goals. The Social Security Administration may also make provisions for a “trial work period”, where benefits continue for a limited period of time while the youth determines if she or he can handle being in the workforce without having to worry about benefits ceasing. What is critical to consider is that the worker on Social Security Insurance will have access to greater resources through working, while developing their job skills and work experience.

The first step for Transitional Age Youth is to obtain either a State Identification Card (which can be obtained at any age) or Driver’s License, and a Social Security Card if they don’t already have one. These will be vital components to independence, and without them, work opportunities will be extremely limited and harder to access. Prior to age 16, which is when a Work Permit becomes available, readiness for employment should have already been started.

---

81 California Department of Rehabilitation (CDOR), *Request for Proposal # 03-02-09*, 2003.
The California State Department of Rehabilitation reports that in the year 2000-2001, there were approximately 14,232 TAY receiving vocational services. Of the TAY with a mental health diagnosis participating in vocational services, 57% worked for 90 days or more over the course of a year (if that’s the period they looked at). Close to 43% of the youth had more difficulty meeting employment objectives, and either dropped out of the program or were unable to work for at least 90 days.\(^{83}\) This information becomes very important in light of the US Department of Labor’s 2000 report, finding that “despite popular perceptions that youth work more than they did in the past, the proportions of 15-17 year-olds have declined over time.”

The above report, while covering TAY in general, underscores the role employment plays in a successful transition to adulthood for challenged youth and calls attention to the need for a smooth transition process from the child to adult systems of care. Vocational classes have been a traditional source of employment training and readiness, but budget reductions and changing dynamics have resulted in limited availability of vocational training.\(^{84}\) The lack of supported employment opportunities for youth sends a mixed message; work is a sign of successful transition into adulthood, but pre-employment preparation is underfunded and not given adequate attention.

The question arises “How can individual communities expand the vision of collaborative employment services and improve local employment for people with disabilities?”

This question was answered in 1992 when the State Departments of Rehabilitation (DR), Mental Health (DMH) and Transportation (CalTrans) formed a partnership to address the workforce needs of CalTrans, which resulted in the formation of California’s “Building Employment Service Teams” (BEST). These teams include major, key stakeholders in local communities, including representatives from Community Colleges, county mental health, and the Social Security Administration. Development and oversight of the BEST networks and the BEST Technicians is through the DMH/DR Cooperative Program Unit.\(^{85}\)

One example of how the BEST networks operate can be seen where one county mental health agency played a key role in the development of a Human Services Curriculum Certificate Program at the local Community College. One of their joint strategies was surveying disabled students to see what is preventing them from enrolling in the program, and then acting to eliminate the barriers identified. The students with disabilities at that community college now have an opportunity to be proactive in the ongoing development of the program, gain an edge in the community job market by earning the certificate, and benefit from the peer support fostered during the program. Encouraging leadership development is another key component of BEST networks, empowering youth to participate in community building efforts. Currently, due to budget cuts, the Department of Mental Health personnel working with this program have been reduced.

One of the most useful resources is the local university, which will provide interns with placements for internships. Some counties may choose to use the interns as BEST Techs, while other counties may utilize the interns in some other capacity. The needs for counties will vary somewhat, as several counties may have housing concerns while other counties may need someone to coordinate the BEST activities, committee membership, etc. Developing a Leadership

---

\(^{83}\) California Department of Rehabilitation (Sacramento), Interview with Marcia Yamamoto 2003.


\(^{85}\) California Department of Mental Health, *California’s Mental Health Cooperative Programs*, July 1996.
Academy for youth is one way to teach leadership skills, while providing an opportunity for youth to network and obtain or sharpen skills they already have acquired. This also expands the number of resources, as student interns and university faculty bring their own knowledge of resources with them to the leadership academy program.

Transportation can also become a challenge for transitional age youth. In rural areas, public transportation may be limited or non-existent. While bus services usually offer discounted bus passes to individuals with disabilities, youth may not know that the passes are available, nor how to effectively access public transportation (reading a bus route map etc.). However, according to the U.S. Department of Health and Human Services, in their October 2001 report, the underutilization of public transit is not necessarily due to lack of knowledge or disability-related issues. Providers should be encouraged to explore the individual’s barriers to using public transit, and alleviating the specific barriers to the extent possible.

Health issues also prevent youth with disabilities from accessing employment. For example, homeless youth are often sleep-deprived as they stay in unsafe, unclean, or overcrowded environments\(^\text{86}\) (Clark & Robertson, 1996). They may eat poorly and have limited job training as well as little opportunity for taking care of personal hygiene. They typically suffer from more frequent traumatic injuries, infectious diseases, and nutritional disorders, and find it difficult to adequately recuperate from even the slightest illness or injury given the lack of safe and restful environments available to them.\(^\text{87}\)

Confidentiality concerns will arise as the youth turns 18, with both the family and youth discovering information once accessible by the family, is no longer obtainable without the youth’s permission. Similarly, with Social Security benefits, a new set of criteria and rules are introduced at age 18. The family may not see this change as positive; this may be even truer in certain cultures whose ideas of family differ from those found in the mainstream culture. Given the developmental and systemic changes occurring as youth transition to adulthood, it is a critical time to insure that family members still feel included in the process, particularly for youth seeking employment.


APPENDIX #11.1

Entitlements and Work Programs as Youth Resources

Youth who are transitioning from school to work and/or moving from a supported living situation to independent living, must make many decisions about school, work, housing, income, and benefits eligibility issues. With advocates and families they can be guided to make informed decisions and develop the skills to research and implement these decisions on an individual basis in the future. For a youth with disabilities this can be a challenge. Youth, who are leaving residential placements, or other disruptive situations, may find it difficult to earn adequate funding to provide shelter and basic needs for themselves, resulting in homelessness. Many are ill-prepared for the workforce and may have multiple barriers to employment. Several studies have documented high rates of emotional and mental health problems among homeless youth. For example, among street youth in California (ages 13-17), 26% met criteria for major depression, (Russell, 1996), with many youth reporting serious psychotic symptoms (Mundy, Robertson, Greenblatt, & Robertson, 1989). Especially troubling are the studies, which indicate a growing trend showing that many homeless adults were also homeless youth. (Susser, Streuning, & Conover, 1987; McChesney, 1987; Zlotnick et al., in press).

As individuals or agencies seek to provide youths with guidance and support in developing a plan for their future, those with special needs and issues can become an exceptional challenge. If a youth exhibits a serious disabling condition or symptoms, an application for disability benefits may need to be considered and determined to be appropriate. Not only will these benefits potentially provide funding for food, shelter and basic needs but will also make the individual eligible for continuing medical benefits.

For those working with transitional age youth, the task, as it pertains to Social Security Benefits, is to translate met criteria for children into meeting the criteria for adult. This is more challenging, as seen by the observations made by Davis and Stoep, 1996. “The age of emancipation is not the same as the process of emancipation. For young adults who have serious emotional disturbance, the disparity between role expectations and developmental status is often very wide. These young people must accomplish the same developmental goals as all adolescents, but they face particular problems in doing so. The very nature of their illness and circumstances often means they have to struggle to catch up emotionally, cognitively, socially and vocationally before they are ready to assume adult roles.”

What are some of the tasks which lay the basis for successful transition into adulthood? One task is obtaining a driver’s license or Identification card (a key component in obtaining employment). Another task, also key, is the completion of school. Both of these are “milestones” in our society for a place in the employment world. However, meeting these two tasks is not an indicator of transitioning successfully and not needing benefits. These are instances, which, if noted properly in a case file, can work toward a youth meeting the criteria for adult benefits. If the youth was unable to independently achieve these milestones, the implication, which needs to be clearly shown, is in the field of work, without the needed support the adult would be unsuccessful as indicated by specific instances.

---

SSA Benefits Categories
It is very important to be able to distinguish between different SSA benefits. Although they have some similarities, the differences between them are important to know, for not only do the rules differ in children and adult benefits, but the funding source for benefits differ as well.

Basic benefits available for children are: 1) Medi-Cal, which is available to most children until age 21 (foster youth should have Medi-Cal until age 21 but their cash benefits are from a different fund set up for foster care youth); 2) Medicare, which is a basic health plan and may be available after a two-year period; and 3) Social Security Administration (SSA) should also make the applicant aware of benefits and related issues such as share of cost Medi-Cal/insurance, work incentives etc. However, the applicant will probably have to ask since once determination for benefits is finished; there is no “debriefing” for recipients other than the basics to get them started.

Social Security Dependents Benefits
Social Security identifies in their literature that there are three ways a child might be eligible for benefits from Social Security or SSI. The first is Social Security Dependents Benefits – these are benefits payable to children under the age of 18 when a parent begins to collect off their work record benefits for retirement or becomes disabled, and are collecting disability payments for their disability or becomes deceased. The payments are determined for dependents of a worker and paid on the work record of a parent. For a deceased parent, their work record is considered to pay survivors benefits to children under the age of 18.

Although children under age 18 who are eligible for these benefits might be disabled, Social Security does not need to consider their disability to qualify them for these benefits. These benefits are based on the child being the dependent of a working adult who has paid into the SSA trust fund. A child can continue receiving dependents or survivors benefits until age 19 if he or she is a full-time student in elementary or high school. There are also Social Security Benefits available for adults disabled in childhood. Typically dependent’s benefits stop when a child reaches age 18 (or 19 if the child is a full-time student). In the case of a child determined to be disabled prior to age 22, those benefits can continue to be paid into adulthood.

The benefit is considered a “child’s or dependents” benefit because it is paid on the basis of a parent’s Social Security earnings record. It is possible for a adult who has received SSI benefits for years to reach their 30’s and have a parent retire or become deceased and as a “dependent” who was determined to be disabled before 22 years of age, they would now become eligible to receive benefits for the parents record. This can be very confusing to families who suddenly receive notification that the SSI benefits are stopping but do not understand that another benefit will begin. Additionally, this non-SSI benefit does not entitle them to automatic Medi-Cal and they will receive notification that the SSI Medi-Cal is being terminated. Although still eligible for Medi-Cal there will be additional paperwork that the beneficiary must complete.

Supplemental Security Benefits (SSI)
Another benefit available for children is Supplemental Security Benefits (SSI). These are benefits payable to disabled children under age 18 who have limited income and resources, or who come from homes with limited income and resources. A parent’s income is applied towards the child’s financial eligibility until they reach age 18. The child’s disability is considered and determined for SSI eligibility. Children can qualify for SSI benefits if they meet Social Security’s definition

---

89 Social Security Administration, SSA Publication No. 05-10026.
90 Social Security Act, Title VIII
of disability. In addition, the income and assets accessible to the child must fall within the eligibility limits. Supplemental Security Income supplements a person’s income up to a certain income level, as SSI is a needs-based income. The level varies from one state to another and can go up every year based on cost-of-living increases. The federal SSI for adults is generally $579.00 in the year 2005. California can provide a supplement amount of up to $226.00. For the children’s SSI, the child’s income and assets, family income and assets as well as living situation can affect the SSI amount. Social Security refers to this as “deeming” of income and “assets.” This applies to children who live at home, or who are away at school but return home occasionally and are subject to parental control. Foster care youth typically receive specific foster care funding and would not be eligible for SSI until emancipation or age 18.91

**Social Security Determining That A Child Is Disabled**

Social Security determines that a child is disabled after the local Social Security office determines if a child’s income and assets are within the SSI limits. All documents and evidence pertaining to the disability are sent to a State office contracted to determine if the disability criteria is met. A team of disability evaluation specialists and a medical or psychological consultant reviews the child’s case. Records are requested by this agency from all the treating sources listed. If the information is not enough, a second independent opinion may be requested from an outside source. The child may be asked to be taken to a special examination that Social Security will pay for. Failure to attend the examination usually results in a negative or “denial” decision.92

The disability criterion for a child is the physical or mental condition or a combination of conditions, results in “marked and severe functional limitations.” The condition must last or be expected to last at least 12 months or be expected to result in the child’s death. To make this decision, the disability evaluation specialist first checks to see if the child’s disability can be found in a special listing of impairments that is contained in Social Security’s regulations. These listings are descriptions of symptoms and signs of physical and mental problems.

According to SSA, as of December 2000, 82,012 children were receiving SSI in California. While the child’s condition does not have to be one on the list, if the symptoms, signs of the child’s condition are the same as, or medically equal in severity to the listing, the child is considered disabled. If the impairment does not meet or medically equal a listing, the evaluation division then decides whether it “functionally equals” the listings. Utilizing the outline and criteria the law provides and detailed in “The Blue Book” (Disability Evaluation Under Social Security), evaluators assess the effects of the condition on the child’s ability to perform daily activities by comparing your child’s functioning to that of children the same age who do not have impairments.93

**The Social Security Rules Change For Children 18 And Older**

Anyone planning for a youth’s transition from school to work and self-sufficiency must consider that Social Security rules change for children 18 and older. For children receiving survivors income and Social Security Dependent Income (SSDI), at 18 years of age (19 if in school) these

---

91 Foster Care Independence Act 1999.
93 Social Security Administration, *Disability Evaluation Under Social Security*. 
benefits cease, unless the child is determined to be disabled. As the child is now considered an adult, they must meet the adult criteria for disability.

“We must re-determine the eligibility of individuals who were eligible for SSI based on disability in the month before the month in which they attained age 18. This age-18 re-determination must use the initial adult eligibility rules and must occur during the 1-year period beginning on the individual’s 18th birthday (The Medical Improvement Review).”

A complicating issue is that any spouse, who received benefits for caring for this child, will also lose their benefits. As families are preparing for these decisions in low-income household situations, there could be concern that families are rushing to a disability decision in order to protect benefits not only for the youth, but for family members as well. Those assisting youth in this process must take this into consideration when interacting with family members and directing youth decisions.

Of special interest to those planning for transition age youth who are or will have to make decisions regarding self-support, is the fact that a child who was not eligible for SSI before the 18th birthday because the parent’s income or assets were above the SSA limits or was in foster care, may become eligible at age 18. When a child turns age 18 years of age, Social Security no longer considers the children’s guidelines for SSI. Foster care funding ends, parent’s income and assets are not considered, and disability criteria change to the adult criteria. Even if the youth remains in the parent home, eligibility is based on the youth income only. SSI amounts may be adjusted based on living in the home of another without the cost of rent. Utilizing this knowledge can assist a youth, family or his advocates in planning for self-sufficiency. As the SSA disability determination process can be lengthy, typically three months for an initial application, it is possible to avoid a delay in funding by applying for benefits in the two to three months prior to the youths 18th birthday (Social Security Handbook Section 0342, Social Security Administration Program).

It is important to note each office may address this issue differently. By incorporating this process in the Transition IEP and treatment plan well in advance, the youth, families and staff can compile the information needed, such as birth certificate, financial information, and treating sources and begin to ensure that the appropriate documentation of disability is available. Provision for adults and children applying for SSI disability whose condition is so severe that they can be initially presumed as disabled has been established. In these cases, SSI benefits are paid for up to six months while the formal disability decision is being made. These payments can be made only if the financial eligibility factors apply. If at a later date SSA decides the disability is not severe enough to qualify for SSI, the benefits do not have to be paid back. (Appendix 11.2)

CONTINUING DISABILITY REVIEWS

After a child starts receiving SSI, the law requires that SSA review the child’s disability to verify that he or she is still disabled. As stated by law, “Not less frequently than once every three years, we must conduct a Continuing Disability Review (CDR) for any childhood disability recipient eligible by reason of an impairment(s) that is likely to improve. At the option of the Commissioner, we may also perform a CDR with respect to those individuals under age 18 whose

---

94 Social Security Administration, Social Security Administration Handbook section 2140.
impairments are unlikely to improve. The (CDR) must be done at least every three years for children under 18 whose conditions are expected to improve, and not later than 12 months after birth for babies whose disability is based on their low birth weight; unless it is determined that the condition is not expected to improve by the child’s first birthday, then it may be scheduled for a later date.”

At the time of a CDR, the representative or parent must present evidence that the child is and has been receiving treatment that is considered medically necessary and available for the child’s disabling condition. Children who are eligible for SSI benefits in the month before they turn age 18 must have their eligibility re-determined and will receive a notification. The evaluation of disability will be according to the criteria and the rules for adults filing new claims.

**GUIDELINES FOR THE APPLICATION PROCESS FOR SSI**

The process for application of SSDI and SSI are basically the same. SSDI has more focus on the past job history and will require more detailed work history, therefore making application for SSI more applicable for most transition age youth. The application for both are accepted at the local Social Security office, but can also be initiated through the SSA toll free number 800-772-1213. When the case is determined to be eligible for either benefit, it is sent to the disability evaluation division which contracts with Social Security to determine whether there is a disabling condition, which entitles the client to benefits. After disability is determined, as approved or denied, the case is then sent back to the local office. The local office then processes the decision and forwards the decision to the client. If denied, the client is sent a notice (notice of action) with detailed information as to why the disability was denied. There are three levels for appeal and it is not uncommon for cases to only be approved at the administration law judge level, which is the just before the final level of appeal. All approved benefits will then be paid to client based on the original date of application.

According to Social Security data more then 850, 000 children were receiving SSI payments. They made up 12.8% of the over 6.6 million SSI recipients at that time receiving SSI funding and the corresponding Medicaid benefits. The important focus on work objectives for transitional age youth can be supported for youths receiving SSI or SSDI, with the realization that benefits can mean increased independence and opportunities for youth within the correct context and framework. Many youth with mental health or medical issues may find it difficult to earn adequate funding to provide shelter and basic needs for themselves, resulting in homelessness. Applications for financial aid and health coverage through Social Security’s disability benefits (such as SSI and SSDI) may be applicable for these youths. For some cases, there may be concern that benefits receipt can undermine a focus on achieving work objectives, as well as develop barriers to employment. There is often a misguided fear that by pursuing work objectives the individual’s health care benefits or the funding dollars will be halted when work begins. In 1999, The Ticket to Work and Work Incentives Improvement Act was signed as a law. This law includes several important new opportunities for people who receive Social Security disability

---

96 Social Security Administration, Pub. L. 104-193, section 212(a); section 1614(a)(3)(H)(ii) of the Social Security Act.


benefits. This law allows an individual to pursue work objectives and still receive cash funding as well as valuable health care coverage. One program (PASS Plan) can even allow an individual to set aside money to pursue training or educational goals.99

For a youth on benefits prior to their 18th birthday, at age 18 they will undergo a disability review (CDR) to determine if they continue to meet the disability criteria based on the adult criteria for disability. Once an adult (over age 18) is on SSI or SSDI, most will receive Tickets from the Social Security. (Appendix 11.4)

Best practices in transition planning for youth includes active involvement by the youth in the planning process. For a youth already on SSI or SSDI benefit, or those considering applying as they are unable to currently work and may need additional options and time to develop their work abilities and meet the employment objectives, utilizing the SSA work incentives invites that necessary active involvement. It is required for the youth to be active in the application for disability and SSA will insist on interaction with the youth, as well as on strict confidentiality requirements to be met once a youth is 18 years of age. The SSA Employment and Self Sufficiency plans also require the individual to meet specific regular outcomes with the Employment Network (EN), to be actively involved and take a lead role from the assignment of their ‘Ticket’ to an EN, to the completion of their employment objective.

What is critical to consider is that the worker on SSI will have more available funding through working then not working, as well as developing their job skills and work experience. The new law also allows for rapid reinstatement of benefits once a worker has experienced a set back and is unable to work for a period. This allows for continuity of income and provision for the basic needs of food, shelter and clothing in addition to health care coverage. For many youth, having experienced a life of residential placements, or disruptive, abusive and neglectful family situations and are poorly prepared for the workforce, this fear of homelessness may be a substantial barrier to employment. Knowledge and understanding of the employment provisions, such as rapid reinstatement of benefits, can remove such barriers to employment.

APPENDIX 11.2

BASIC STEPS IN AN APPLICATION PROCESS FOR SSI

Social Security Administration
24-Hour Telephone Service
SSA Publication No. 05-10082
August 2001

1. Call the SSA toll free number (800-772-1213) and request to file a disability application. The SSA operator will take the information down and mail an application. This is generally preferable, as this provides an immediate record of the application for SSI in the event documentation is lost and also provides you with a more verifiable date of application. This call can be made with the youth as part of the transition plan process. If the youth is unable to make this call on his or her own, utilize this opportunity to walk the youth through the process and make the call to Social Security with the youth. They will need to provide Social Security with permission to allow you to speak with the SSA worker.

2. Providing individuals with a basic monthly calendar in a file folder in an envelope style with a closing flap can be very useful in promoting and modeling basic record keeping skills. This allows organization of pertinent correspondence, a format to track the process and keep a detailed written log of who the youth spoke with and when.

3. As SSA shifts its programming to include a focus on computer based records archiving system, some of the offices will take your application directly during an interview and enter it into the computerized data system. SSA will schedule either a phone appointment with the youth and family, or will arrange an in-office visit. It is important to advise SSA immediately of any changes in address or phone number.

4. Allow the youth to complete as much of the application as needed on their own. If the youth is unable to complete, then you may assist, but note this on the back of the application – write in the comments section that the client was unable to complete the form without assistance and document the reason. This is an opportunity to demonstrate the level of functioning. (Such as unable to read, unable to understand, unable to focus or concentrate, paranoia affected ability to remain in office and complete form, etc.) Be as specific and thorough as possible when you answer. This means that you should give us the dates of visits to doctors or hospitals, the account numbers and any other information that will help us to get your child’s medical records as soon as possible. If you do not have all of the information, list as much as you know.

5. Allow the client to go into the Social Security office for a face-to-face interview appointment if possible. A face-to-face meeting with the SSA worker rather than a phone interview application allows the worker to see the level of functioning first hand and make comments regarding this on the case note.

6. Have all the additional forms ready to submit including copies of any additional records or information (be sure to get a release form signed by client for your agency to release documentation).

7. You will need to have youth sign one release of information authorization for each medical or hospital source listed in the application and sign at least two additional copies. Social Security generally requests that this form be signed only, do not date or add any other information.

8. On the initial application be sure to provide names, addresses and telephone numbers of all doctors, hospitals, clinics and others specialists visited. Include the names of teachers, day care providers and family members who can give information. School records and IEPs can also be useful. You can bring them with you to the interview, but it is not necessary to wait to apply before you gather all this information. Having the records available at application time expedites the case.

9. Include any inpatient admission and discharge information, as this is instrumental in the disability decision. Most agencies require a specific release for Mental Health inpatient records.

10. Include a narrative letter if possible from a family member, teacher or friend, who is a witness to the level of functioning and the manner in which symptoms affect the client’s daily lifestyle, as well as ability to work at simple tasks. If not available at the initial application time, it may be submitted at a later time. The evaluation division will ask for a third party form to be completed, but any individual can submit a simple narrative letter detailing the condition, its affects and the changes in the lifestyle of the individual over the years.

11. If there is a psychiatrist or treating physician involved, consult with the doctor. Chances are you see this person more often then the doctor does and your input may mean the difference between benefits or denial as well as providing health providers with a bigger picture of the child. Talk to any person invested in the child’s well being.
12. Typical SSA forms used in this process will be: (All of these forms are available for downloading from the Social Security web-site at www.ssa.gov):

- SSA 3368 BK disability report (green application form)
- SSA 3369 BK work history (beige form)
- SSA-827’s records request: This is the authorization to release information form. This form states that an agency can release all pertinent information to Social Security and that they may also fax the information.

It should be noted, the disability analyst must contact any agency that provided care for the child, that is listed on the form, or appears in a narrative, would be contacted by the disability division.

SOME EXAMPLES

SSA provides in their handbook for children with SSI some of the following disability categories in which they can choose to presume disability and make immediate SSI payments:

- HIV infection
- Total Blindness
- Total Deafness (in some cases)
- Cerebral palsy (in some cases)

APPENDIX 11.3

CONFIDENTIALITY LAWS AND THE 18 YEAR OLD

Included with the major changes in how SSA views individuals at age 18 as opposed to children, is that prior to age 18, the youth parent or legal guardian typically interact with SSA on behalf of the youth. When age 18 is reached SSA will refuse to interact in many instances with the parent due to confidentiality laws.\(^{100}\) This can be especially difficult for many parents who have interacted for years on behalf of their child and are suddenly told that they cannot have access to the youth’s case or information. If the youth is unable to interact or chooses to, a representative form is available for the youth to sign stating and assigning the right for this representative to interact with SSA on their behalf. This is not necessarily a payee.

Subsequent to being determined to be disabled and eligible for SSI a youth is then determined to be capable of handling their funds. If determined unable to or in most cases with substance abuse issues, a payee will be assigned. This individual will receive the benefits funds and be responsible for the appropriate disbursement of those funds on the youth’s behalf for food shelter and clothing, as well as providing SSA with an annual accounting of expenditures. A youth will be able to select an individual of his choice to act in the role of payee. SSA will interview this individual and determine if they are appropriate. In the case of a conservator, the conservator will act as representative and payee. The Social Security Process for applying for benefits can be confusing even for those well versed in its workings. Because of its complexity, one should start the planning process for benefits at about age 14, or when an Independent Treatment Plan is

\(^{100}\) Social Security Administration, *Social Security Handbook*, Section 0118.
developed. It should be here the detailed, specific record keeping starts. Independent Living skills, educational skills, vocational planning, etc., should be put into motion and developed along the way to transitioning into adulthood. The disparities or gaps in these skills are what will be looked for in determining benefits. Early on in the process, one should start asking the question “How do my observations and case notes translate into the language of this youth functioning in the field of employment or school?”

Any seemingly unimportant change in work or school has the potential of reducing benefits, as does meeting deadlines. Keeping SSA apprised of any changes in circumstances, work, school, etc. needs to be a top priority and may need your staff intervention on behalf of the youth in contacting SSA. One should also have started developing relationships with not just other agencies, but with the Adult system(s) as well (both in and outside of your agency), so the transition can go as smoothly as possible and the youth is not lost in the transition.

APPENDIX 11.4

EMPLOYMENT OPPORTUNITIES FOR YOUTH

CALIFORNIA’S WORK OPPORTUNITY AND RESPONSIBILITY TO KIDS (CAL WORKS)
(DEPARTMENT OF SOCIAL SERVICES)

OVERVIEW

CalWorks is a welfare program that gives cash aid and services to eligible needy California families. The program serves all 58 counties in the state and is operated locally by county welfare departments. If a family has little or no cash and needs housing, food, utilities, clothing or medical care; they may be eligible to receive immediate short-term help. Families that apply and qualify for ongoing assistance receive money each month to help pay for housing, food and other necessary expenses.

ELIGIBILITY

A person’s eligibility is based on a number of components including citizenship, age, income, resources, assets and other factors. Generally, services are available to:

- Families that have a child(ren) in the home who has been deprived of parental support or care because of the absence, disability or death of either parent.
- Families with a child(ren) when both parents are in the home but the principal earner is unemployed.
- Needy caretaker relatives of a foster child(ren).

Persons who are first time applicants to the CalWorks program receive aid for 18 months with a county option to extend aid for an additional 6 months. If the recipient is not employed when the time limit is reached, the recipient begins to participate in community service provided the county certifies that “no job was available.”
DESCRIPTION OF SERVICES

CalWORK’s payments are issued in the form of a check. The amount of a family’s monthly assistance payment depends on a number of factors, including the number of people who are eligible and the special needs of any of those family members. The income of the family is considered in calculating the amount of cash aid the family receives.

For additional information:
http://www.dss.ca.gov/calworks.html

CALWORK’S WELFARE TO WORK PROGRAM (DEPARTMENT OF SOCIAL SERVICES)

Current welfare rules ensure that individuals who work are better off financially than if they do not work. California’s Welfare To Work (WTW) program is designed to assist welfare recipients to obtain or prepare for employment. The Welfare To Work program serves all 58 counties in the state and is operated locally by each county Department of Social Services or its contractors.

ELIGIBILITY

Persons who are receiving financial aid (welfare) and are required to participate in welfare to work activities as a condition of receiving aid. Others not required to participate may volunteer to take part in the program.

DESCRIPTION OF SERVICES

- All Welfare To Work participants receives an orientation to the program and an appraisal of their education and employment background.
- Initially, most individuals receive job search services (assistance in finding a job).

Additional employment-related services are provided based on an individual’s education and work history. Individuals may be assigned to:

- Unpaid work experience/preparation.
- Vocational training placements.
- Adult education or community college programs.

In addition, program participants may be eligible for help with childcare, transportation, and work-related or training-related expenses. Moreover, participants who find a job and are no longer eligible for welfare may continue to receive help with medical care and child care expenses.

For additional information:
http://www.dss.ca.gov/getser/calworks.html
http://www.dss.ca.gov/wtw/default.htm

Publication Information:
http://www.dss.ca.gov/getinfo/pubintro.html
http://www.dss.ca.gov/getser/afdc.html
DEPARTMENT OF REHABILITATION SERVICES

OVERVIEW

The California State Department of Rehabilitation (DR) offers services to Transition Age Youth. Some counties have developed a cooperative agreement between the Department of Rehabilitation and the Department of Mental Health. These programs have combined funds to strengthen the ability of DR and Mental Health to deliver services to shared clients. These cooperatives have focused on services for job placement, supported employment, and job development.

ELIGIBILITY

All SSI and SSDI beneficiaries who want to work are eligible to apply for Department of Rehabilitation services. If an individual does not receive SSI or SSDI, eligibility is based on the following factors:

1. physical or mental impairment;
2. the impairment constitutes or results in an impediment to employment; and
3. vocational rehabilitation services are required to prepare the individual to secure, retain, or regain employment.

DESCRIPTION OF SERVICES

The mission of the Department of Rehabilitation is to assist Californians with disabilities in obtaining and retaining employment and maximizing their ability to live independently in their communities. Goals include:

- Increasing the quality and quantity of employment outcomes;
- Increasing the quality and availability of independent living services;
- Increasing employer knowledge of the Department of Rehabilitation (DR);
- Developing methods to improve internal and external communications;
- Increasing participation of people with disabilities, and all stakeholders, in the DR’s planning process;
- Improving administrative processes and the quality of DR services;
- Increasing consumer involvement in development of their IPE (Individualized Plan for Employment);
- Providing a comprehensive system of personnel development; and
- Maximizing the availability and use of assistive technology.

For additional information:
http://www.rehab.cahwnet.gov/
http://www.dor.ca.gov
TRANSLATION PARTNERSHIP PROJECT (TPP)

OVERVIEW

The Transition Partnership Program (TPP) is a statewide vocational education and work placement program which was established in 1987. TPP is a contract partnership with the California Department of Rehabilitation and the local education agencies. TPP services secondary and post-secondary students with disabilities the tools and support necessary to effectively transition from school to competitive employment. TPP contracts are located throughout the state of California in local high schools.

ELIGIBILITY

Persons who are enrolled in a secondary school and who meet Department of Rehabilitation eligibility:

1. physical or mental impairment;
2. the impairment constitutes or results in an impediment to employment; and
3. vocational rehabilitation services are required to prepare the individual to secure, retain, or regain employment.

DESCRIPTION OF SERVICES

The TPP provides enhanced vocational rehabilitation services for at least one year prior to the student leaving high school. Services include training and enhanced programming to enable students to obtain employment. This may include community based instruction, vocational and work-site training, job placement, work incentive wages, and follow-up services.

For additional information:
http://www.rehab.cahwnet.gov/

DESCRIPTION OF SERVICES

Workability I Program (WAI) is a statewide work placement program through the California Department of Education and the Department of Rehabilitation. It specifically targets special education students and places them in work training or actual work situations. WAI may assist employers in providing appropriate employees as well as offer funds to pay for initial wages.

The Workability I program provides comprehensive pre-employment training, employment placement and follow-up for high school students in special education who are making the transition from school to work, independent living, and post secondary education or training.

The Workability I Program is coordinated and administered between the California Department of Education, Special Education Division, and the Department of Rehabilitation. Program services are appropriate to individual student needs, abilities and interests. Local program sites coordinate state and local service providers to offer comprehensive services tailored to local economic, social and geographic needs and abilities. The Workability I Program provides secondary students with an understanding of job seeking and job keeping skills. The employability of students improves through occupational class training and on-the-job subsidized or unsubsidized work experience. A two-year follow-along support service provided by local program staff helps to improve the potential for successful student employment.
For additional information:
http://www.cde.ca.gov/spbranch/sed/worka_i/wkaindex.htm

**Workability II** serves adults and out of school youth with disabilities. Workability II programs provide vocational rehabilitation services, including vocational and basic skills assessment, specific job skills training, pre-employment preparation, worksite evaluation, job placement, job coaching, and ongoing follow-up after vocational placement.

**Workability III** is designed to assist college students with disabilities as they prepare to become members of the work force. The following services are among those available to participants:

- College Coursework
- Career Counseling & Guidance
- Job search seminars
- Videotaped interview simulation
- Resume and application preparation
- Job Club
- Disability management strategies
- Workplace accommodations
- Interest and aptitude assessment
- Individualized Job placement & follow-up
- Liaison with employers

Services provided through Workability III include:

- Vocational counseling and guidance
- Employee placement assistance
- Job coaches and on-the-job training
- On-the-job support

Skills provided through Workability III include:

- Job seeking skills
- Resume development
- Individual job development and follow-up services
- Information about federal and state tax credits available to employers who hire people with disabilities
- Job placement and transition assistance
- Suggestions of job accommodations
- Coping strategies and job retention skills

**Workability IV** is a transition program designed to create career options and opportunities. Students with disabilities can complete their degrees at California State University campuses. This program establishes and meets student/consumer career development, psychological and educational needs. It provides disability management and accommodation training, and wellness training. It creates job readiness and job search skills, help secure internships and jobs, and educate communities to ensure successful transition of consumers into the employment market.

Students at the university who are also clients of the California State Department of Rehabilitation have the opportunity to participate in this job placement program. The goal of
Workability IV (WAIV) is to prepare and place students in appropriate career employment positions after graduation. This program may offer the following services:

- Training to use assistive technology specific to a disability to help prepare for success in the work environment. This may include individual and classroom instruction of computer assistive technology.
- Education for the employment community to ensure successful transition into the employment market.
- Disability management and accommodation training.
- Coaching for job readiness and job search skills to secure employment.
- Work experience during the academic year including internships and volunteer job placements.
- Coaching and job search skills.

Teaching students to understand the Americans with Disabilities Act, become aware of their rights, and develop an enhanced sense of self-esteem.

**Ticket to Work and Self-Sufficiency Program.** This voluntary program provides opportunities for the beneficiaries to receive rehabilitation and vocational services to set and obtain their employment goals, therefore lessening the dependence on public assistance. These incentives actually can increase the choices a youth can consider as a transitional plan is developed. As the Ticket to Work Plan expands in California, there will be more selections in educational and rehabilitation services available. As schools and rehab service providers realize that they may be eligible for funding that can aid in offsetting cost of services for providers, more providers will apply to be a part of the Ticket to Work as an Employment Network (EN). These ENs can receive funding for providing outcome-based employment and support services to beneficiaries individually or as a collaborative partner splitting the EN payments. Barriers to employment will be found to be reduced as individuals realize that health care benefits will continue once they start employment, that they will not have to undergo another disability review for medical criteria as long as they use their ticket and it is assigned to a Employment Network and that SSA, in some circumstances also makes provisions for what is called a “trial work period.” At the time of employment, the dollar amount of the financial benefit may fall, but it will be in proportion to what is earned.
CHAPTER XII

FISCAL RESOURCES

“Money isn’t everything – but it ranks right up there with oxygen.”

— RITA DAVENPORT
CHAPTER XII

FISCAL RESOURCES

This chapter is an attempt to organize in one location information about funding streams that might be helpful in supporting Transitional Age Youth (TAY) programming. An important concept to bear in mind is that counties that have successfully created transitional programs first did “vision building” to determine what kind of programming would be most useful. When a county collaborative generates a vision statement and maps out the existing resources, it becomes far easier to identify both the gaps in services and the potential funding streams. The principle here is that money does indeed follow a good program idea. When a group of individuals is eager to serve the needs of the TAY population and is brainstorming together, the probability is quite high that creativity in blending resources will ultimately accomplish the task.

Chapter XV of this resource guide will discuss some best program design strategies. You will find three examples of current TAY programming around the State that has each used a different funding stream to fulfill their vision. For example, The TAY program associated with the “Village” in Long Beach uses AB2034 funds to pay for their innovative ideas. On the other hand, Santa Clara county in their Young Adult Transition Team (YATT) uses medical necessity and Medi-Cal funds to provide services. Mendocino county has garnered Establishment Grant Funds from the Department of Rehabilitation to piece together an employment opportunity for the TAY population that may be a new emerging practice.

There are a variety of program and financing possibilities available. There is general agreement however, that some assistance needs to be provided for youth in their transition to adulthood. Poor planning for transition from youth to adult almost guarantee a county that there will be many fiscal risks that lie ahead, since high-end service needs will result. There will be considerable cost avoidance in setting up a sensible continuum of care that helps young people find their way into independence. When two different divisions within the same organization, such as Children’s and Adult Services, or when Mental Health (MH) and Alcohol and Other Drugs Program (AODP), or MH and Department of Social Services (DSS) team up, barriers are reduced, and the spirit of cooperation allows for new ideas to come to fruition that seemed impossible at an earlier time.

The funding streams listed in this chapter are in no particular order. Each has its own unique criteria and uses. A combination of funding sometimes referred to as “braided funding,” can be used to provide comprehensive services.

FORMAL RECOMMENDATIONS FROM FISCAL CHAPTER

1. County Administrators should plan to develop transitional age programming if for no other reason than future cost avoidance. There is a wealth of evidence to suggest that intervention by county mental health departments for this age group is a wise investment in times of limited resources. County staff has noticed that this age group can make dramatic changes when offered the kinds of programs they need.

2. Vision building is an important first step to identify gaps in service and to hear from the youth themselves what kinds of services they need the most. We know from experience that once a solid idea is formulated that has a group consensus; it can more quickly become realized by exploring the possible funding streams noted below.
3. Brainstorming about how to fund new programs with partner agencies has surprising success. When barriers begin to fall away, possible plans of funding innovative ideas become much more feasible.

4. California’s Mental Health Services Act (Proposition 63) is an example that requires that the resources be used on new programming. This is an ideal time to set in motion ideas concerning TAY Programming that counties may have had for a long time that were set aside and not realized due to budget issues.

5. Counties must leave no stone unturned to discover possible funding streams to support TAY Programs. Administrators must put aside traditional viewpoints of categorical and silo funding in order to create new models for system development.
## Funding Streams

### Table of Contents for Funding Chart

<table>
<thead>
<tr>
<th>Page</th>
<th>Funding Stream</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Federal Financial Participation (FFP)</td>
</tr>
<tr>
<td>7-8</td>
<td>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</td>
</tr>
<tr>
<td>8</td>
<td>Assembly Bill (AB) 34/2034</td>
</tr>
<tr>
<td>8-9</td>
<td>Independent Living Skills Funds</td>
</tr>
<tr>
<td>9-10</td>
<td>Specialized Care Incentives and Assistance Program (SCIAP)</td>
</tr>
<tr>
<td>10</td>
<td>Senate Bill (SB) 163</td>
</tr>
<tr>
<td>10-11</td>
<td>Mental Health Substance Abuse Allocation from California Work Opportunity &amp; Responsibility to Kids (CalWORKs)</td>
</tr>
<tr>
<td>11-12</td>
<td>Adolescent Family Life Program (AFLP) Allocation</td>
</tr>
<tr>
<td>12</td>
<td>AB 1784, Adolescent Treatment Program</td>
</tr>
<tr>
<td>13-15</td>
<td>California Access to Recovery Effort (CARE)</td>
</tr>
<tr>
<td>15</td>
<td>Children’s System of Care (CSOC)</td>
</tr>
<tr>
<td>15</td>
<td>Proposition 63 (The Mental Health Services Act)</td>
</tr>
<tr>
<td>16</td>
<td>Intensive Services Waiver</td>
</tr>
<tr>
<td>16</td>
<td>Projects for Assistance in Transition From Homelessness (PATH)</td>
</tr>
<tr>
<td>16-17</td>
<td>Child Welfare Services (CWS) Redesign</td>
</tr>
<tr>
<td>17</td>
<td>Supportive Housing Initiative Act (SHIA)</td>
</tr>
<tr>
<td>18</td>
<td>Department of Rehabilitation Establishment Grant Opportunities</td>
</tr>
<tr>
<td>18</td>
<td>Substance Abuse &amp; Mental Health Services Administration (SAMHSA)</td>
</tr>
<tr>
<td>18-19</td>
<td>Juvenile Justice Crime Prevention Act (JJCPA)</td>
</tr>
<tr>
<td>19</td>
<td>Temporary Assistance for Needy Families (TANF) Probation Fund</td>
</tr>
<tr>
<td>19-20</td>
<td>Realignment</td>
</tr>
<tr>
<td>20</td>
<td>Foster Children and Parent Training Funds (AB 2129)</td>
</tr>
<tr>
<td>20-21</td>
<td>AB 3632</td>
</tr>
<tr>
<td>21</td>
<td>Minor Consent</td>
</tr>
<tr>
<td>21</td>
<td>County General Funds</td>
</tr>
</tbody>
</table>

The column categories in the chart are:

- **Funding Stream** – The type of funding available
- **Age of Recipient** – Age of clients eligible to receive service(s) under a particular funding stream

- **Scope of Service** – The services the funding stream funds for a particular age group

- **Method for Accessing** – Explains how a county or individual can access services through a particular funding stream for a certain age group.

- **Agency Lead** – The agency primarily responsible for providing services for a particular age group utilizing a particular funding source

- **Other** – Notes or government codes where information about such funding streams can be accessed
<table>
<thead>
<tr>
<th>Funding Stream</th>
<th>Age of Recipient</th>
<th>Scope of Service</th>
<th>Method for Accessing</th>
<th>Agency Lead</th>
<th>Other</th>
</tr>
</thead>
</table>
| Federal Financial Participation (FFP)  | 0-100            | Medi-Cal specialty mental health services provided through county mental health programs. | Medi-Cal FFP is available for Medi-Cal specialty mental health services provided through county mental health programs. | Federal – CMS has primary federal policy and oversight responsibility. | Title 42, United States Code, Chapter 7, Subchapter XIX (also known as Title XIX of the Social Security Act)  
Title 42, Code of Federal Regulations, Chapter IV, Subchapter C, especially parts 433,438 and 447  
W&IC, Divisions 5, Chapter 3, Part 2 (commencing with Section 5700)  
W&IC, Division 5, Chapter 4, Part 2.5 (commencing with Section 5775)  
W&IC, Division 9, Chapter 8.8, Article 5 (commencing with Section 14680)  
Title 9, California Code of Regulations, Division 1, Chapter 11, especially Subchapter 4, “Federal Financial Participation”  
Additional cites/references may be found in the Performance and Mental Health Plan contracts between DMH and counties, and DMH letters and information Notices (available on the DMH web site: [http://www.dmh.ca.gov](http://www.dmh.ca.gov)) |
<table>
<thead>
<tr>
<th>Funding Stream</th>
<th>Age of Recipient</th>
<th>Scope of Service</th>
<th>Method for Accessing</th>
<th>Agency Lead</th>
<th>Other</th>
</tr>
</thead>
</table>
| Early and Periodic Screening, Diagnosis and Treatment (EPSDT) State Funding  | 0-21             | EPSDT is a federally-mandated Medicaid program for full-scope Medi-Cal beneficiaries under age 21. Under this program, the State pays for any medically necessary procedure or treatment to correct or ameliorate a defect, physical illness, mental illness, or a condition even if the service or item is not otherwise included in the State’s Medicaid program. Services include all covered specialty MH Medi-Cal services except inpatient hospital services. Therapeutic Behavioral Services (TBS), a supplemental EPSDT service, is included under EPSDT. Drug Medi-Cal (DMC) Services youth commonly receive include:  
  - Outpatient Drug Free counseling (group)  
  - Individual counseling that is limited to intake, crisis intervention, collateral services | State GF available to MH Plans.  
  Originally, the State agreed to provide the state funds to match the FFP beyond the baseline funding that counties had previously provided. The state/county share of the matching funds has been adjusted to include:  
    1.) the Phase II consolidation amount that the state provides the counties through the managed care allocation,  
    2.) cost of living increases for some years,  
    3.) a 10% county match of the state’s share of growth over the FY 2001-02 baseline. A minor can receive EPSDT services from a DMC certified provider. | Federal – CMS  
  State- DMH develops policy and provides oversight under the direction/approval of the DHS, the single state Medicaid agency. ADP | Federal definitions and requirements for EPSDT are outlined under Section 1905 of the Social Security Act and Part 05 of the CMS State Medicaid Manual (available at: [http://cms.hhs.gov](http://cms.hhs.gov)).  
  Additional cites/references for EPSDT and TBS may be found in the contract between DMH and the MH Plans, DMH Letters and Information Notices (available at [http://www.dmh.ca.gov/](http://www.dmh.ca.gov/)) and the California Code of Regulations, Title 9 Chapter 11.  
  Title 22, CCR, Sections 51188, 51340, 51532, 51132. |
<table>
<thead>
<tr>
<th><strong>FUNDING STREAM</strong></th>
<th><strong>AGE OF RECIPIENT</strong></th>
<th><strong>SCOPE OF SERVICE</strong></th>
<th><strong>METHOD FOR ACCESSING</strong></th>
<th><strong>AGENCY LEAD</strong></th>
<th><strong>OTHER</strong></th>
</tr>
</thead>
</table>
| Assembly Bill (AB) 34/2034 | 18-100 | Comprehensive, integrated services.  
- Full complement of psycho-social rehab.  
- Local programs to move the homeless to housing, with use of their grant funds can provide subsidized housing, purchase food, clothing and other necessary items. | State GF, State allocations are capped. Federal funds for any Medi-Cal services provided are uncapped. Local programs are not required to match grant funding. | State DMH | General guidelines for ASOC grant programs: W&IC Sections 5800-5811.2.  
Specific guidelines for AB 34/2034 grant programs: W&IC Section 5814.5 |
| Independent Living Skills | 16-21 (Counties also have the option to provide services to youth as young as 14) | Services provided to wards and dependents that are emancipating from foster care. On a case by case basis, some 2034 youth can receive ILS funds and also keep their MediCal.  
IV-E funds are allocated to counties by CDSS to provide life skills education and services. Counties can either | County welfare departments get funds from CDSS | State CDSS | All County Letter 02-54: [http://www.dss.cahwnet.gov/getinfo/ac102/pdf/02-53.pdf](http://www.dss.cahwnet.gov/getinfo/ac102/pdf/02-53.pdf)  
All County Letter 02-45: Modifications to the Aid to Families with Dependent Children-Foster Care Program (AFDC-FC) [http://www.dss.cahwnet.gov/getinfo/ac102/pdf/02-45.pdf](http://www.dss.cahwnet.gov/getinfo/ac102/pdf/02-45.pdf) |
<table>
<thead>
<tr>
<th><strong>FUNDING STREAM</strong></th>
<th><strong>AGE OF RECIPIENT</strong></th>
<th><strong>SCOPE OF SERVICE</strong></th>
<th><strong>METHOD FOR ACCESSING</strong></th>
<th><strong>AGENCY LEAD</strong></th>
<th><strong>OTHER</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialized Care Incentives and Assistance Program (SCIAP)</td>
<td>0-18</td>
<td>Specialized care allows a county to supplement the family home basic rate on behalf of children who require additional care and supervision because of a health or behavior problem. This program places the youth into a family-like setting.</td>
<td>County DSS administer the program with approval from State DSS.</td>
<td>State DSS</td>
<td>All County Information Notice 1-133-00: Specialized Care Rate System and Specialized Care Incentives and Assistance Program <a href="http://www.dss.cahwnet.gov/getinfo/acin00/pdf/1-133_00.pdf">http://www.dss.cahwnet.gov/getinfo/acin00/pdf/1-133_00.pdf</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Operate their own ILP, contract for the services, or both.</td>
<td></td>
<td></td>
<td>All County Letter 00-84: Applying Non-Specific John H. Chafee Foster Care Independence Program Amendments to the Independent Living Program Allowable Expenditures for Emancipated Youth Stipends <a href="http://www.dss.cahwnet.gov/getinfo/ac100/pdf/00-45.pdf">http://www.dss.cahwnet.gov/getinfo/ac100/pdf/00-45.pdf</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Supportive Transitional Emancipation Program Transitional Independent Living Plan (STEP-TILP). This program allows ongoing financial support for emancipated foster/probation youth who pursue a plan for educational and career and other goals.</td>
<td></td>
<td></td>
<td>All County Information Notice No. 1-62-02: Independent Living Program <a href="http://www.dss.cahwnet.gov/getinfo/acin02/pdf/1-61_02.pdf">http://www.dss.cahwnet.gov/getinfo/acin02/pdf/1-61_02.pdf</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>The court must consider services necessary and available for a child to transition to adulthood.</td>
<td></td>
<td></td>
<td>County Fiscal Letter No. 02/03-01: Planning Allocation Fiscal Year (FY) 2002/03 Independent Living Program (ILP) <a href="http://www.diss.cahwnet.gov/getinfo/cf102/pdf/02-03_01.pdf">http://www.diss.cahwnet.gov/getinfo/cf102/pdf/02-03_01.pdf</a></td>
</tr>
<tr>
<td>Funding Stream</td>
<td>Age of Recipient</td>
<td>Scope of Service</td>
<td>Method for Accessing</td>
<td>Agency Lead</td>
<td>Other</td>
</tr>
<tr>
<td>---------------</td>
<td>------------------</td>
<td>------------------</td>
<td>---------------------</td>
<td>-------------</td>
<td>-------</td>
</tr>
<tr>
<td>Senate Bill (SB) 163</td>
<td>0-18</td>
<td>This program provides localized Wraparound. Serves children who are currently residing or risk being placed in an RCL 10 or above</td>
<td>Counties can apply for this program through DSS. These funds are not just meant to bring kids home, but also to reinforce care for kids in the community.</td>
<td>State DSS</td>
<td>All County Information Notice 1-28-99: Children: Senate Bill 163 Wraparound Services Pilot <a href="http://www.dss.cahwnet.gov/getinfo/acin99/1-28_99.pdf">http://www.dss.cahwnet.gov/getinfo/acin99/1-28_99.pdf</a> All County Letter 12-01: “Expansion of Rate Classification Levels for Wraparound Program through Senate Bill 163 or Title IV-E Child Welfare Wavier Demonstration Projects Wraparound Sub-Study. <a href="http://www.dss.cahwnet.gov/getinfo/ac101/pdf/12-01.pdf">http://www.dss.cahwnet.gov/getinfo/ac101/pdf/12-01.pdf</a></td>
</tr>
<tr>
<td>Mental Health Substance Abuse Allocation from California Work Opportunity &amp; Responsibility to Kids (CalWORKs)</td>
<td></td>
<td>Counties are required to provide substance abuse and mental health services as a part of their CalWORKs programs.</td>
<td>There are times when these funds can be redirected to child and family services. Counties receive CalWORKs funds from the State’s General Fund to provide mental health and substance abuse services. Counties can receive additional funds for providing mental health and substance abuse services under Cal WORKs.</td>
<td>State DSS ADP or DMH provide the service, and the claims are submitted to the County Welfare Department.</td>
<td>All County information Notice 1-82-99: Mental Health and Substance Abuse Services <a href="http://www.dss.cahwnet.gov/getinfo/acin99/1-82_99.pdf">http://www.dss.cahwnet.gov/getinfo/acin99/1-82_99.pdf</a> All County Information Notice 10-16-00: Guidelines for Serving Individuals with Mental Health and/or Substance Abuse Problems that Create Barriers to</td>
</tr>
<tr>
<td><strong>Funding Stream</strong></td>
<td><strong>Age Of Recipient</strong></td>
<td><strong>Scope Of Service</strong></td>
<td><strong>Method For Accessing</strong></td>
<td><strong>Agency Lead</strong></td>
<td><strong>Other</strong></td>
</tr>
<tr>
<td>--------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Adolescent Family Life Program (AFLP) Allocation | Females and their children are eligible up through age 18 and males and their children are eligible up through age 20. | The goals of AFLP are:  
- Ensure healthy pregnancy outcomes for mothers and infants, including a reduction of low birth weight babies.  
- Help teens complete educational or vocational programs and become emotionally, socially and economically self-sufficient.  
- Promote healthy family relationships.  
- Reduce the incidence of subsequent teenage pregnancies.  
- Promote the development of collaborative and integrated systems of care that support pregnant and parenting adolescents and their children.  

There is a provision of case management services including assessment of adolescents’ strengths and needs, and development of individualized service plans. | $250-$300,000 allocation which comes from Department of Health  
There are 43 Adolescent Family Life Programs in 40 counties of the State. These programs are located in county health departments, county departments of social services, hospitals, schools, and community-based organizations.  
Funded by State General Funds, Federal Title V MCH Block Grant Funds, and Federal Title XIX (Medicaid) Funds. | Department of Health and Human Services. | Employment  
http://www.dss.rahwnet.gov/getinfo/acin00/pdf/1-16_00.pdf  
Section 2008 of the Public Health Service (PHS) Act. |
<table>
<thead>
<tr>
<th><strong>FUNDING STREAM</strong></th>
<th><strong>AGE OF RECIPIENT</strong></th>
<th><strong>SCOPE OF SERVICE</strong></th>
<th><strong>METHOD FOR ACCESSING</strong></th>
<th><strong>AGENCY LEAD</strong></th>
<th><strong>OTHER</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>AB 1784, Adolescent Treatment Program</td>
<td></td>
<td>There are monthly contacts that include home visitation support the teens’ educational and career goals and strengthen their self-sufficiency skills. Promotion of health and safety practices. Assisting teens and their children to access appropriate services.</td>
<td>In Fiscal Year (FY) 1998-99, twenty California counties determined to have the greatest need for adolescent substance abuse treatment were allocated $4.7 million of Substance Abuse Prevention and Treatment (SAPT) Block Grant funds to provide comprehensive, age-specific services to substance abusing adolescents. In FY 2001-02, an additional $2.666 million SAPT funds was allocated to all counties.</td>
<td>ADP</td>
<td></td>
</tr>
</tbody>
</table>

There are monthly contacts that include home visitation support the teens’ educational and career goals and strengthen their self-sufficiency skills.

Promotion of health and safety practices.

Assisting teens and their children to access appropriate services.

**AB 1784, Adolescent Treatment Program**

Assembly Bill 1784 (Baca, Chapter 866, Statutes of 1998), provides authority for the Adolescent Treatment Program.

The focus of the services varies depending on local needs and priorities. Generally, services include residential treatment for adolescents in group home settings and juvenile detention facilities, services for youth transitioning into the community after discharge from such facilities, and additional adolescent-specific services at school sites and other outpatient settings. These funds must follow the Youth Treatment Guidelines.
<table>
<thead>
<tr>
<th>FUNDING STREAM</th>
<th>AGE OF RECIPIENT</th>
<th>SCOPE OF SERVICE</th>
<th>METHOD FOR ACCESSING</th>
<th>AGENCY LEAD</th>
<th>OTHER</th>
</tr>
</thead>
<tbody>
<tr>
<td>California Access to Recovery Effort (CARE)</td>
<td>12-20 years old</td>
<td>The California Access to Recovery Effort (CARE) Program is part of the President’s Access to Recovery grant created to allow people in need of substance abuse treatment to make individual choices for recovery that reflect personal values. The CARE program is open to substance using youth from ages 12 through 20 years old who live in either Los Angeles County or Sacramento County. Youth demonstrating symptoms of substance use or substance related problems may enter the CARE program a variety of ways. They can be self-referred, or they can be referred by an individual or organization, such as a parent or other family member, school, medical professional, probation officer, or clergy. Participating counties (Los Angeles and Sacramento) will have designated assessment centers that can be located by either calling the CARE toll-free number, logging on to the CARE website, or from a directory that will be available at many youth</td>
<td>ADP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FUNDING STREAM</td>
<td>AGE OF RECIPIENT</td>
<td>SCOPE OF SERVICE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------</td>
<td>----------------</td>
<td>----------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>service organizations. Youth referred to the CARE Program may choose one of these locations to receive an eligibility determination. Assessment centers will make every effort to immediately accept any youth, either by appointment or walk-in. If the assessment center determines that the youth is eligible and appropriate for the CARE Program, the youth will be issued a voucher for a comprehensive assessment. The comprehensive assessment will identify the youth’s strengths and needs, the level of treatment services needed, and the support services the youth may need to address problems and help build competencies. The assessor will match the youth’s needs with at least two appropriate providers with available space for each of the service types needed. The assessor will explain the options to ensure that the youth can make an informed, independent choice about the service provider(s) that will best meet their needs.</td>
<td>METHOD FOR ACCESSING</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AGENCY LEAD</th>
<th>OTHER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Funding Stream</td>
<td>Age Of Recipient</td>
</tr>
<tr>
<td>----------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Children’s System of Care (CSOC)</td>
<td>0-18</td>
</tr>
<tr>
<td>Proposition 63 (The Mental Health Services Act)</td>
<td>0-100</td>
</tr>
<tr>
<td>Funding Stream</td>
<td>Age of Recipient</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Intensive Services Waiver</td>
<td>0-21</td>
</tr>
<tr>
<td>Projects for Assistance in Transition from Homelessness (PATH)</td>
<td>18-100</td>
</tr>
<tr>
<td>Child Welfare Services (CWS) Redesign</td>
<td>0-18</td>
</tr>
<tr>
<td><strong>FUNDING STREAM</strong></td>
<td><strong>AGE OF RECIPIENT</strong></td>
</tr>
<tr>
<td>-------------------</td>
<td>----------------------</td>
</tr>
</tbody>
</table>
| **Supportive Housing Initiative Act (SHIA)** | 18–100 | Low-income adults with one or more disabilities, including mental illness, HIV/AIDS, substance abuse or other chronic health conditions and individuals with developmental disabilities, and may include families with children, elderly persons, young adults aging out of the foster care system, individuals exiting institutional settings, homeless people and veterans. | State GF  
Local government, non-profit service or housing agencies, or groups of local non-profit and/or local government agencies were eligible to apply for SHIA funding.  
Each grantee was required to match its SHIA grant award with fifty cents for each one dollar awarded in the first year, one dollar for each one dollar awarded in the second year, and one dollar and fifty cents for each one dollar in the third year and all subsequent years.  
Services funding is available for 3 years. Rental subsidy funding is available for up to 15 years.  
The SHIA legislation remains intact, but currently no funding is available. | California Department of Mental Health for services.  
<table>
<thead>
<tr>
<th>FUNDING STREAM</th>
<th>AGE OF RECIPIENT</th>
<th>SCOPE OF SERVICE</th>
<th>METHOD FOR ACCESSING</th>
<th>AGENCY LEAD</th>
<th>OTHER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Rehabilitation Establishment Grant Opportunities</td>
<td>Working age; 16 or older</td>
<td>Services include employment training opportunities for members of MH/DR Cooperatives in more than 20 counties across California. Generally the Establishment Grant will be an opportunity for a start-up program to begin offering training to clients by a job coach in a business that will eventually become a stand alone without DOR direct support.</td>
<td>Cooperatives can use the standard grant application as provided by DOR. Applications will be submitted during the window of time when they are being accepted.</td>
<td>California Department of Rehabilitation</td>
<td>Mendocino County used the Establishment Grant to begin a delicatessen where high school students work in a privately owned shop and are paid out of TPP Funds and the Establishment Grant pays for the job coach who is a MH employee.</td>
</tr>
<tr>
<td>Substance Abuse Mental Health Services Administration (SAMHSA)</td>
<td>0-100</td>
<td>The Substance Abuse Mental Health Services Administration (SAMHSA) is an agency of the U.S. Department of Health and Human Services. SAMHSA was developed to focus attention, services and funding on improving the lives of individuals with or at risk of substance abuse or mental illness.</td>
<td>SAMHSA has several funding opportunities available through grants. The States, Counties or non-profit organizations can apply for grants, depending on the rules for each grant.</td>
<td>SAMHSA</td>
<td><a href="http://www.samhsa.gov">www.samhsa.gov</a></td>
</tr>
<tr>
<td>Juvenile Justice Crime Prevention Act (JJCPA)</td>
<td>0-18</td>
<td>Funding source for juvenile justice programs that have proven to be effective in reducing crime and delinquency among offenders and at-risk youth. There are 193 collaborative programs in 56 counties</td>
<td>The Legislature decides each year how much to allocate to the JJCPA. The initial allocation was $121.3 million and in 2001-02 the allocation was $116.3 million. To be eligible for funds, each County must develop a comprehensive plan that includes</td>
<td>California Board of Corrections</td>
<td><a href="http://www.bdcorr.ca.gov/cp">http://www.bdcorr.ca.gov/cp</a> pd/cpa_2000/cpa_2000_page.htm</td>
</tr>
<tr>
<td>FUNDING STREAM</td>
<td>AGE OF RECIPIENT</td>
<td>SCOPE OF SERVICE</td>
<td>METHOD FOR ACCESSING</td>
<td>AGENCY LEAD</td>
<td>OTHER</td>
</tr>
<tr>
<td>---------------</td>
<td>-----------------</td>
<td>-----------------</td>
<td>---------------------</td>
<td>------------</td>
<td>-------</td>
</tr>
<tr>
<td>Temporary Assistance for Needy Families (TANF) Probation Fund</td>
<td>0-18</td>
<td>The TANF probation funds provide for juvenile probation services, including anger management, family mentoring, and mental health assessment, among others. A 2003 RAND Report indicated that most of the funding is probably used for services provided to youth detained in juvenile halls, camps, and ranches.</td>
<td>An assessment of existing resources targeting at-risk youth, offenders and their families. The plan needs to be developed by the county’s Juvenile Justice coordinating Council. Each funded program must report annually expenditures and outcomes for the program.</td>
<td>California Department of Social Services.</td>
<td></td>
</tr>
<tr>
<td>Realignment</td>
<td>0-100</td>
<td>Funding comes from the Vehicle License Fees and a portion of sales tax. Funding responsibility is transferred to counties for health, mental health and social service programs. The counties control the following mental health programs: community-based programs, IMDs, State hospitals. Increase in county share of foster care and child welfare. IHSS</td>
<td>Sub-allocation of CalWORKs allocation, carve out based upon capped amount. Has historically provided $200 million to juvenile probation activities. The Governor can determine what the VLF should be. Counties receive this funding automatically.</td>
<td>The Governor’s Administration.</td>
<td></td>
</tr>
<tr>
<td>FUNDING STREAM</td>
<td>AGE OF RECIPIENT</td>
<td>SCOPE OF SERVICE</td>
<td>METHOD FOR ACCESSING</td>
<td>AGENCY LEAD</td>
<td>OTHER</td>
</tr>
<tr>
<td>----------------</td>
<td>-----------------</td>
<td>------------------</td>
<td>---------------------</td>
<td>------------</td>
<td>-------</td>
</tr>
<tr>
<td>Foster Children and Parent Training Funds (AB 2129)</td>
<td></td>
<td>And county services block grants. This requires one or more home interviews prior to the issuance of any foster family home license. The Foster Children and Parent Training Fund requires the allocation of up to $1,000,000 for the support of foster parent training programs conducted in community colleges. Law requires foster family agencies to supplement the community college training by providing a program of training for their certified foster families.</td>
<td>State DSS is allocated funds for the training and the funds are transferred to county welfare departments.</td>
<td>California Department of Social Services</td>
<td>AB 2129</td>
</tr>
<tr>
<td>AB 3632</td>
<td>0-23</td>
<td>The State is mandated by the federal government to provide services to SED children. If the counties do not provide the services to SED children that are mandated by the federal government to be provided in every state, then the State of California would have to find some other way to comply with the federal mandate, such as require the public schools to provide the services directly. AB 3632 services are an entitlement and children can receive all mental health related, medically necessary services for kids who are SED. The necessary services would be identified on the child’s IEP.</td>
<td>California County Mental Health Departments and County Departments of Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Funding Stream</td>
<td>Age of Recipient</td>
<td>Scope of Service</td>
<td>Method for Accessing</td>
<td>Agency Lead</td>
<td>Other</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
<td>-------------</td>
<td>--------</td>
</tr>
<tr>
<td>Minor Consent (100% State General Fund)</td>
<td>12-21</td>
<td>A minor between 12 and 21 years of age can receive the following services:</td>
<td>Minor Consent is a State-only program which excludes parental income and resources from consideration of Medi-Cal eligibility for certain, limited services to youth under 21 who is living with his/her parents or guardians.</td>
<td>State ADP</td>
<td>Title 22, CR. Sections 50147.1, 50167(a)(6)(D)(4), 50063.5, 50157(f)(3), 50703(d); Family Code Section 6929; Welfare and Institutions Code Section 14010.</td>
</tr>
<tr>
<td>County General Funds</td>
<td></td>
<td>Some counties give match funds for maintenance of effort for mental health and child welfare.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CHAPTER XIII

HOUSING

“Always assume your guest is tired, cold, and hungry, and act accordingly.”

—NAVAHO TRIBE
CHAPTER XIII

HOUSING

Transitional Age Youth (TAY) moving into the world of independence has many challenges to endure, but none may be as great as securing adequate, affordable, stable and safe housing. The lack of affordable housing, coupled with extreme poverty, is the underlying cause of homelessness in the United States. Consider the following facts gathered by the Child Welfare League of America.

IN CALIFORNIA

- According to the National Low Income Housing Coalition (2000), the Fair Market Rent for a two-bedroom unit is 265% of the minimum wage. This is based upon the formula that 30% of an income is spent upon housing. It is estimated that this amount has increased by 12% in most communities in 2003 and is expected to increase in 2004 as well. In 2003 the fair market rent for a two-bedroom unit was 312% of the minimum wage.
- In 2003, in order to afford a two-bedroom apartment, a person’s wage would need to be at least $21.18 per hour.
- There is generally a shortage of housing for persons of all ages in California.

NATIONALLY

- In no town, city, or state in our nation can an individual or family working full time at minimum wage, or receiving Social Security Insurance (SSI) or Temporary Assistance for Needy Families (TANF) income, afford a one or two bedroom apartment at fair market rate.
- It costs the community and the government approximately $20,000 per year to support a homeless person, and it is less costly to provide them with supportive housing. Providing a mentally ill homeless person with permanent housing and supportive services costs virtually the same as letting them remain homeless.
- There are between 1.3 and 2 million homeless or runaway youth in America (youthnoise.com). (This estimate is based on a definition of youth as being 12 to 24 years old.)
- Homeless youth are at a much higher risk for too-early parenthood, substance abuse, HIV/AIDS, brushes with the criminal justice system, physical and sexual abuse, and even violent death.
- Young people, with limited education or job experience, are at more of a disadvantage in a difficult housing market. Landlords are less inclined to rent to very young single people than to young families.
- It is estimated that 38% of homeless youth have been in the foster care system at some point in time. Each year, thousands of youth age out of the foster care system and enter young adulthood without sufficient supports. Too often youth are discharged without realistic formal plans for housing, employment, or continued school.
The average age of emancipation for the typical youth in America, disabled or not, is 26 years old. Although many factors will impede a TAY person from obtaining independent housing, the reality is that youth generally are developmentally drawn to live with peers in congregate living situations like college dormitories. For youth, living in a semi-structured environment with paid peer oversight is an extremely successful housing model. Generally speaking, TAY will tend to flourish in a healthy group living situation of peers who are motivated to participate in constructive activities that lead to educational or vocational goals that foster independence.

Homeless youth become homeless for a variety of reasons, as do homeless adults and families. But some of the common avenues into homelessness for youth include:

- Separating from her or his already homeless family
- Leaving home to escape physical or sexual abuse
- Being thrown out of home by parents/guardians
- Emancipating from the foster care system
- Leaving an intolerable placement in an institution after having been placed there from her or his family
- Immigrating unaccompanied to the United States
- Unsuccessful experience in public school, which can lead to withdrawal from both home and academic life
- Difficulty coping with the symptoms of mental illness
- A TAY who has not developed sound financial skills, but lacks access to a payee, may be left homeless when impulsive decisions are made
- Often a combination of above factors may develop

The reason that youth do not emancipate fully until 28 is that youth are dependent on the relationships and support that families can provide. Youth need to know that they can leave home, but that the emotional and financial support is still available in times of need. If a TAY has been disappointed in relationships or if personal interruptions happen, and the TAY needs to forge ahead in life alone, the chances for becoming homeless dramatically increase. When a TAY is in a congregate living situation, negative events can happen when roommates transition too quickly, or when the TAY finds him or herself bouncing from residence to residence without consolidating gains. Adults who want to assist a TAY in securing a living situation may be wise to promote environments where youth can live together with a mature youth in a leadership role to provide oversight. In summary, the significant barriers to a TAY finding a successful rental situation include:

1. There will be an economic barrier. The TAY will not have the work history or the income to qualify for fair rate market housing stock. They will not pass the credit check.
2. They will not have the references from successful past rental experiences.
3. The TAY will not have clear information about what “sheltered” or “subsidized” housing programs are available. Once they discover a resource, they will need assistance to comply with all requirements.
4. Once they are successfully housed, they will need assistance and support to stay in the house.
5. If the youth is accepted into a subsidized housing program, they will need intensive support so they do not become overly reliant on the resource and continue to work towards increasing independence.

---

6. Individuals or agencies supporting youth don’t always have knowledge about each other’s programs. They do not always collaborate.

7. The TAY with a disability of mental illness will have all the above stated challenges with the additional burden of dealing with the disability that may have contributed to the condition of homelessness in the first place.

8. There are few Board and Care Facilities that accept youth, and often the facility will also accept older adults who may not be compatible with the TAY lifestyle and needs.

9. On an emotional and financial level, if the TAY perceives that he or she has a severed relationship with the adults in his or her life; it will be far more difficult to feel secure in living in an independent setting.

10. Congregate living situations, though the most desirable housing setting for the TAY, may not be available in the community where the TAY actually wants to live.

11. Youth without financial or emotional support of family will find entering into the independent world far more difficult than youth who have this safety net to fall back on. Youth transitioning out of the foster care system are most vulnerable to setbacks in finding a successful place to live.

12.

RECOMMENDATIONS FOR COUNTY ADMINISTRATORS REGARDING TAY HOUSING RESOURCES

1. TAY with mental illnesses needs intensive case management beyond high school graduation. Since this is 90% reimbursable under EPSDT Medi-Cal, providing case management is a good investment in the TAY will make a tremendous difference. The County Administrator must realize that even if the diagnosis is less serious than for other adults, as long as medical necessity exists for Medi-Cal, it is advantageous to both the youth and the department to provide specific mental health supports for this population. By giving the TAY population support in the early years of emancipation, the youth is more likely to be successful in his or her living situation.

2. As county mental health departments identify housing resources for their clients, they must carve out stock that will be used for youth who will need subsidized assistance. Housing options must be thought of in the context of what is developmentally appropriate for this age. As discussed above, congregate supervised living arrangements that allow for sufficient privacy reflect most clearly the needs of the TAY population. The less a TAY congregate living situation looks like a residential treatment facility, the more likely the TAY will see it as a place they want to be.

3. Every county should have a housing collaboration that meets regularly to review the resources and attend to the needs of homeless youth, those aging out of foster care, and TAY with mental illness for referral into the “sheltered” or “subsidized” housing stock.

4. TAY should not be placed in board and care facilities with older adults. TAY needs to have an environment of hope and recovery and a home environment that is developmentally and culturally appropriate. If the home is licensed as a Board and Care, there should be a transitional theme that encourages youth to expand boundaries in a safe context.

5. In supported housing programs, the ideal TAY climate can be fostered. There should be social support from peers and the service coordination necessary to assist with life’s important decisions. The youth needs to be simultaneously involved in an educational or vocational program that will promote further independence. In such a setting, the symptoms of mental illness can be stabilized and TAY have the opportunity to self-
monitor symptoms and balance activities in the outer world using the valuable experience of learning to live with a disability successfully.

6. When TAY are still in a CSOC Program, it will take intensive collaboration with agencies involved as well as interested family members to create a service plan that will address the many needs that will develop after the “Freedom Birthday” of age 18. Only after a strengths-based assessment is completed, will the client and a clinician have established a trusting relationship in order to actually generate a client-driven culturally competent service plan.

7. County Administrators need to be aware of family systems theory so that in the development and organization of programs, there is sensitivity to family members. Youth do not emotionally grow and thrive outside the context of the family system. The natural resources that the family and community can provide cannot be duplicated by an agency.

RESOURCES

Child Welfare League of America; Laura Steward M.A.; Youth Housing Program Manager; lblock66@aol.com (949) 388-3264.
CHAPTER XIV

SOCIAL ACTIVITIES

“A gossip is someone who talks to you about others, a bore is someone who talks to you about himself, and a brilliant conversationalist is one who talks to you about yourself.”

—Lisa Kirk
Youth who have been involved in the Children’s Mental Health System of Care and are transitioning into adulthood often have many challenges to meet to negotiate an independent life successfully. Issues such as housing, employment, education, or health concerns are often priority items for discussion – but what about social and recreational activities? What do youth like to do with their leisure time and how can a youth with a mental illness feel “normal?” Socializing with peers or acquaintances is an important aspect of recovery. In this chapter, we share the thoughts of three young persons, ages 18, 20 and 21 who spoke with us about the kinds of social activities they enjoy.

We encourage clients to participate in work or education as a rehabilitative intervention, but frequently we fail to comprehend just how vital a constructive social life may be to a youth in transition. Youth who have a supportive peer network report to case managers and family members that they feel better about themselves and their future when they feel successful in the social arena. Isolation can breed feelings of low self worth and decreases overall quality of life. Generally, instruments used to measure quality of life in young people show more satisfaction with youth who are engaged in positive activities than youth who are feeling alone and alienated. The stigma of being mentally ill fades in the face of participation in developmentally appropriate activities. A strengths-based initial assessment should try to identify the leisure and social activities that will lead the youth to take the next step in his or her emotional development.

Activities that are tailored to an individual youth may be more desired than “group sponsored” outings and events. The youth we spoke with told the subcommittee that they prefer to integrate with all other members of the community rather than be isolated with peers who also have a disability. Activities that include music, dancing and karaoke are high on the list of desired things to do. The ideal is to promote such activities in a substance-free environment. The cost of many typical teen-age activities like movies, bowling, and golf are simply not available to TAY who lack resources, so the TAY population must be inventive in finding social activities that are inexpensive.

Case managers should foster activities that allow youth to develop relationships within the community in which they live. The goal is to facilitate opportunities for activities without actually sponsoring the activity. This encourages a sense of belonging, and hence, a firmer sense of security and ease. This approach also puts the success in the hands of the TAY clients. Case managers need to look to the natural resources in the community. The rewards of hiking, swimming, and playing sports, even though “free,” can bring as much pleasure and bonding as more expensive pursuits that can leave the youth feeling lonely or isolated.

Rusty Clark refers to this concept as building “Community Life Functioning.” A case manager should have focused on helping TAY build social networks whenever possible. Natural opportunities for TAY to be with similar age peers where they can explore age appropriate cultural norms and receive valuable reality-based feedback are essential. In Chapter XIII, on housing for TAY, congregate housing such as dormitories is cited as most being most appropriate for this age group. What makes congregate living so desirable is the opportunity for natural social contact and interaction. Again, every effort to include social opportunities in the environment of TAY is healthy and useful.
Case managers can make social activities rehabilitative by assisting a youth in planning an activity and then participating in the activity with the youth. Rehabilitative activities are Medi-Cal reimbursable activities if the treatment goals include overcoming life impairments and barriers that are linked to the current Axis I diagnosis. The progress note should include an assessment statement, as well as comments about barriers to progress. More information is available on this topic by reviewing the material in Chapter VII of this resource document, “Individualized Planning.” Generally, when the case manager participates in a leisure activity as a rehabilitative effort, care must be taken to integrate the youth as quickly as possible into the social activity so the youth does not come to depend on the case manager and ultimately still feel a sense of isolation from peers.

The more TAY associate with peers who are disability free, the more they will develop a sense of identification with youth who do not have the challenge of experiencing mental illness. By not focusing on the illness, youth may be able to set the disability aside and enjoy the activity at hand. In the long run, this is one beneficial aspect to recreation. In fact, it is a common belief that social participation often decreases symptoms of mental illness. It is therapeutic to have fun!

Another area that youth mentioned as helpful to them is a support group for young parents. Not only does this afford an opportunity to meet and socialize with other TAY who are rearing children, but also it gives the children a chance to participate in a structured social environment where positive modeling occurs. The “Mommy and Me” type program parenting series can be a dynamic resource. Potlucks can also be an informal way of being together that affords the opportunity to get to know others better while building the foundation for friendships that will be future resources for overcoming mental illness.

Another valuable way for TAY to spend time is mentoring other youth who may be disabled or younger. This is a positive strategy to assist TAY in consolidating gains made by sharing their positive experiences and strategies with others who may be struggling with a disability themselves. We all know that focusing on another human being permits us to “forget” about ourselves, and it is in this forgetfulness that some of the best growth spurts occur. Similarly, volunteering is an excellent opportunity for TAY to have a positive impact on the community. The more TAY give, the more their self-esteem can be built up. Youth can mentor others by signing up at the local high school in programs that read to younger students, or as college students, the TAY may participate in volunteer activities at a homeless shelter, soup kitchen, and community garden or clothes closet. When tutoring a younger child in a structured setting, the TAY has an advantage in that the younger student may have no knowledge or awareness that the TAY is experiencing mental illness. This can be a successful experience for both youth.

Social activities can also provide an outlet for creative or artistic expression. One TAY mentioned she would like to be able to do art or music projects with other youth her own age. This type of socializing can involve young adults getting together to do the same activity, such as making pottery, writing poetry or creating music. It could also involve youth sharing their various skills and interests with one another and providing feedback and acknowledgement for each person’s perspective. A group could get together to work on a project, such as a theatrical play, a musical composition, or a wall mural. These types of activities would raise self-esteem in the participants because each person would feel recognized for his or her talents and efforts.

Many transition age youth love computers. With the Internet, TAY may access information that is of interest as well as join “chat rooms” and participate in e-mail exchanges. The computer has its downside, though, in that TAY can become isolated and withdrawn from the real world. Another
is that TAY can be exploited by others or addicted to the lure of the computer. On the other hand, many youth will use a computer to look up information about the illness they are experiencing or a medication that they are taking.

Another area of focus for the case managers working with TAY is the shaping of social behavior. When the youth is practicing “community life functioning” while interacting with peers, it is important to give feedback to the youth. This is indeed a balancing act for the case manager. While some behaviors may be appropriate for a youth to display around other youth, these same behaviors are inappropriate when in the presence of adults. When a youth is behaving in a manner that is socially unacceptable, crude, obnoxious, or distasteful, the case manager should address these as behaviors to be “shaped” and ultimately controlled or eliminated. Although some behaviors may be just part of the developmental phase, unless youth get honest feedback from the case managers, TAY may not realize that their behavior is sabotaging their efforts to build a social network. TAY may also get this feedback from their peer group. It is important for TAY to learn social graces, etiquette, and manners, as these skills that will serve them well into the future. A discussion about socially unacceptable behavior can be a rehabilitative moment if it links the shaping of behaviors to the individual’s goals.

In Maslow’s scale of actualization, the areas of safety and basic human needs are addressed first. Housing, food and physical health treatment are generally addressed in an individual’s life before an emotional disability is focused upon. Once basic needs are met, recreation and social activities represent an opportunity for the youth to reach beyond accepted notions of which he or she is and to migrate into realms where hidden talents and gifts will be uncovered and explored with the help of others.

In conclusion, we know that even self-help activities such as Alcoholics Anonymous (AA) value the necessity of social involvement. What we have found is that TAY clients are interested in activities that they can do in the community with other youth who may or may not have disabilities where substance use is not the focus. Primary recommendations coming out of this chapter are:

1. The case manager should carefully look at the life impairments that are articulated in the service plan of the TAY client, and if appropriate, add a goal with specific objectives that are measurable and observable that address social activities as a rehabilitation activity.

2. Case managers should attempt to integrate TAY into the community by supporting TAY in participating in youth-oriented activities sponsored by the community rather than encouraging the mental health department to develop their own menu of disability-based activities.

3. The case manager should bring to the attention of the TAY those visions, hopes and dreams of the TAY that were explored in the strength-based assessment and treatment process. Youth possess natural talents that, in the correct atmosphere, can be fostered. The expression of these strengths and interests can be quite therapeutic.

4. People can gain considerable internal resources from volunteering. This is a vital activity for youth that the case manager can address as a means to improve self esteem and build new skills in the TAY.
CHAPTER XV

PROGRAM DESIGN

“A well adjusted person is one who makes the same mistake twice without getting nervous.”

— JANE HEARD
INTRODUCTION

Efforts dedicated to the development of programs and the provision of services for youth around ages 14 to 25 with emotional and behavioral difficulties who are in transition, either from the children's system to the adult system, the children’s system to the community, or the community to the adult system, are relatively recent. Policies which have provided for Transition Age Youth (TAY) programs and services have been primarily the result of advocacy from family members, researchers, and service providers who demanded that social policies address the under-serving of the transition needs of youth with emotional and behavioral difficulties (Clark and Davis, 2000). Government agencies have only minimally led the charge in developing TAY policy. Clark and Davis (2000) offer five legislative efforts which have produced this response, namely: 1) the Individuals with Disabilities Education Act of 1990 and the Individuals with Disabilities Education Act Amendments of 1997; 2) the Comprehensive Community Mental Health Services for Children and Their Families Act (Section 119 [amended] of the ADAMHA Reorganization Act of 1992); 3) the John H. Chafee Foster Care Independence Program (formerly known as the Independent Living Program, the Consolidated Omnibus Budget Reconciliation Act of 1985, reauthorized, COBRA 1993, and Foster Care Independence Act of 1999); 4) Section 504 of the Rehabilitation Act of 1973 and the Rehabilitation Act Amendments of 1992; and 5) the School-to-Work Opportunities Act of 1994.

The reality is that much of this policy drive has mainly come from education, individuals with disabilities, family members, and advocacy groups. This TAY Resource Guide is a response from the California Mental Health Directors Association (CMHDA) to address California’s ability to understand and meet the needs of young people with emotional and behavioral difficulties who are in transition as described above. This chapter will present a comprehensive description of the TAY population. Then the focus will move to the implications of culture and socioeconomic status on the TAY population. Next will be a brief primer on evidence-based practice to introduce the importance of a greater science base for TAY programs and practices; followed by a section covering three programmatic efforts (promising practices) presently occurring in California. These efforts are presented to better understand some of the programmatic components necessary in order to help meet the needs of young people in transition. The chapter ends with a series of recommendations for mental health systems and other human service agencies serving TAY.

TRANSITION AGE YOUTH (TAY)\textsuperscript{102}

Transition periods are a natural part of human development. What children, youth, and young adults with emotional and behavioral difficulties experience, along with their families, during any of the three forms of transition mentioned earlier are critical to understand when designing programs and services to mitigate potential systemic and organizational barriers? It is often the abilities critical to a successful transition that are compromised in these young individuals (Clark and Davis, 2000). Further, they have gone through adolescence with conditions which have affected their natural development; they have struggled with emotional, cognitive, social, and

\textsuperscript{102} Much of the information in this section and some of the proceeding sections were adapted from Rusty B. Clark and Maryann Davis’ book, Transition to Adulthood: A Resource for Assisting Young People with Emotional or Behavioral Difficulties (Paul H. Brookes Publishing, Baltimore, MD: 2000).
moral growth; and they have missed important social, community, and school functions because of hospitalizations, therapy sessions, or involvement with juvenile justice. In addition, rites of passage, developmental milestones, family dynamics, and community life are important factors for the transitioning young person (Clark and Davis, 2000). These areas are determined to a large extent by one’s cultural experiences, which include environmental influences, and should influence the design of programs and provision of services. Spindler (1996) suggests that any intervention which disrupts or interferes with the natural learning process and development of human beings are in effect, cultural interruptions. These interruptions are generally in the form of systemic or institutional environments (e.g., schools, mental health systems, child welfare systems, etc.) and substantially effect transitioning young people.

CULTURE AND SOCIOECONOMIC STATUS

The prevalence of emotional and behavioral difficulties in young people cuts across all racial and ethnic groups, and socioeconomic levels. The United States Surgeon General (DHHS, 2001) set forth a report which focused on the provision of mental health services to culturally diverse communities, with a focus on the four primary racial and ethnic minority groups in the U.S. (African Americans, American Indians and Alaskan Natives, Hispanic/Latino Americans, and Asian Americans and Pacific Islanders); and which was intended to be a supplement to its landmark mental health report in 1999. Some emerging themes were set forth: culture mattered; diverse communities had less access and availability to mental health services; diverse communities were less likely to receive mental health services; diverse communities in treatment often received a poorer quality of mental health care when accessing services; and diverse communities were underrepresented in the mental health profession and in research, both as researchers and subjects. Additionally, the supplement reported that since 1986 nearly 10,000 participants had been included in randomized clinical trials evaluating the effectiveness of treatments for bipolar disorder, major depression, schizophrenia, and attention-deficit/hyperactivity disorder. However, only in half of the studies was race or ethnicity reported. Furthermore, of those that reported data on race or ethnicity, few minorities were included; and not one of the studies analyzed the effectiveness of treatment by race or ethnicity.

Recent research reports on mental health have demonstrated that individuals who come from families living in poverty are more likely to experience emotional and behavioral difficulties (Clark and Davis, 2000). This is not to say that families from middle and higher incomes do not have individuals who experience emotional and behavioral difficulties — they do — but that the prevalence for those living in poverty is simply higher. Davis and Vander Stoep (1997) reviewed six studies on outcomes for TAY, including three based on nationally representative samples. Across these studies, the authors found that youth with Severe Emotional Disturbance (SED) were more likely to come from families from lower Socio-Economic Status (SES). It has been common knowledge for many years that people living in poverty, whatever their race or ethnicity, have the poorest overall health and quality of life (Krieger, 1993; Adler et al., 1994; Yen and Syme, 1999). Studies have consistently demonstrated that people in the lowest strata of income, education, and occupation are about two to three times more likely than those in the highest strata to have a mental health disorder (Holzer et al., 1986; Regier et al., 1993; Muntaner et al., 1998; Adler et al., 1994; DHHS, 2001). These individuals are also more likely to have higher levels of psychological distress (Eaton and Muntaner, 1999). People who live in poverty are more likely to be exposed to stressful social environments (e.g., violence, unemployment, academic failure, etc.) and to be cushioned less by social or material resources (Dohrenwend, 1973; McLeod and Kessler, 1990). The presence of a mental health disorder takes such a toll on individual functioning and productivity that it can also lead to poverty (Dohrenwend et al., 1992).
The fact that racial and ethnic minority populations have higher percentages of young individuals living in poverty puts them at a higher vulnerability (DHHS, 1999 and 2001). This is especially significant in California given the diversity of the young people in this state. The fact is that diverse populations bear a greater burden from unmet mental health needs and subsequently suffer a greater loss of their overall health and productivity (DHHS, 2001). The programmatic implication is that when designing and implementing programs or practices for TAY efforts should be included to understand the effects and impacts of services in relation to cultural competence and SES.

**ENVIRONMENTAL FACTORS**

There are other factors important to explore regarding TAY notably familial roles, prevalence of specific types of emotional and behavioral difficulties, and multi-system impacts. Families are the front line for many young people in transition. They have lovingly raised and supported their children who have struggled with emotional and behavioral difficulties and sought the support of systems which have only minimally addressed their needs. The transition period for these young people is further complicated by the lack of coordinated services among children’s mental health, child welfare, educational, adult mental health, drug and alcohol treatment, juvenile justice, and rehabilitation sectors (Clark, 1998). In addition, having parents actively involved in the planning process is highly beneficial in including important familial priorities. Clark and Davis (2000) stated that families with TAY may actually reduce their extra-familial contacts and roles. This is significant in that many policies and legislative acts designed to address the needs of TAY focus on the provision of services to individuals, rather than the familial systems in which they live and the cultural characteristics that comprise their social and self-identities. Sometimes caregivers of young adults with emotional and behavior difficulties understandably attempt to hold these young people back from adult activities to protect them, as they may not be ready for adulthood (Clark and Davis, 2000). However, this inevitably leads to conflicts, acting out, and often destructive acts such as running away or homelessness. It is important to note that programs which provide services to TAY are limited by funding sources that limit eligibility and in many cases ends or changes eligibility when young people reach certain ages, placing a further strain of families.

Research on young people has demonstrated that in general about 18% to 21% of children and their families living in communities meet the diagnostic criteria for a psychiatric disorder and the prevalence increases with a child’s age (Clark and Davis, 2000). The prevalence of SED has been estimated to be at least 5% to 9% nationally. In 1997, it was estimated that 6.5 million individuals of transition age had a psychiatric disorder (Clark and Davis, 2000). In one study, less than 33% of youth who had both a psychiatric disorder and a significant functional impairment received mental health services. Other studies have found that less than 20% of children and adolescents who need mental health treatment actually receive such treatment (See Clark and Davis, 2000). Another study found that the most common forms of mental illness for 16 to 17 year olds with psychiatric disorders living in households in communities was disruptive behavior disorders (12%), substance-related disorders (9%), anxiety disorders (6%), and depressive disorders (4%). Still another study found that for 17 to 25 year olds with SED who received treatment as children.

---

found their most common diagnosis to be substance-related disorders (43% to 49%), anxiety disorders (34% to 36%), and depressive disorders (10% to 18%). Additionally, another study found that half of all adolescents who met the criteria for any psychiatric disorder met the criteria for two or more disorders.

Males and individuals from racial and ethnic minorities are overrepresented in special education classrooms, residential treatment facilities, psychiatric hospitals, and juvenile correction centers. Youth who are African American, Asian American, Hispanic/Latino American, and Native American are underrepresented in receiving mental health services in general. Middle and lower-income youth with emotional and behavioral difficulties and those living in rural areas are less likely than other youth to receive mental health treatment. Various surveys have demonstrated that TAY with emotional and behavioral difficulties when compared to the general same-age population were: 14 times more likely not to complete school; 4 times more likely at age 18 to 21 not to be in college, in vocational school, or employed; 3 times more likely to engage in criminal activity; and 6 times more likely to be involved in a pregnancy (Clark and Davis, 2000).

TAY experience cultural, socioeconomic, and environmental factors that greatly affect their experience in mental health programs and services. They often come from loving families struggling to deal with their child’s emotional and behavioral difficulties. These mental health difficulties may or may not be lifelong conditions and do not necessarily end when someone reach’s a particular age. In fact, many programs that provide services to TAY are limited by funding sources which limit eligibility when these young people reach the ages of 18 to 22. Our systems, especially children’s systems, are limited by these types of fiscal policies and mandates. Inevitably, some other entity has to pick up the ball and the bill. Transition is an ongoing need, which is determined and defined by young people and their families; and should be mitigated by the systems that serve them, programmatically and fiscally.

**Evidence-based Practice**

Evidence-based practices are gaining in popularity. Proponents of various treatment approaches understand that practices can be promoted by describing them as evidence-based. As a result, the term has been used to describe an expansive and increasing number of practices with very different levels of scientific evidence. The National Institute of Medicine (2003) defined evidence-based practices as the integration of the best research evidence with clinical expertise and patient values. The definition makes it clear that evidence-based practices involve the incorporation of research with, and not in lieu of, clinical expertise and experience and the values of TAY and their families. Evidence-based practices are based on the application of proven approaches, as demonstrated through controlled research. However, these practices rely on clinical practices and TAY and family choices in their selection and use with any individual TAY. There are two important implications associated with the definition above. First, the strength of a program or practice to predictably achieve positive outcomes for TAY varies with the strength of the research on which it is based. Second, evidence-based practices do not replace clinical expertise or experience, or limit TAY choice, but build upon this expertise and offer a variety of alternative proven approaches. An example of an evidence-based practice for TAY is Clark’s (1998) *Transition to Independence Process (TIP) system*, which prepares and supports young people as they transition into adult roles through an individualized process that teaches

---

104 Much of this information was adapted from the California Institute for Mental Health report: Toward Effective Mental Health Practices: A Strategic Work Plan to Develop Organizational Capacity for Incorporating Values and Science Into Mental Health Practices. (2003).
community-relevant skills, encourages completion of secondary education, provides exposure to community life experiences, promotes movements into post-school employment, educational opportunities, living situation, and community life; and transcends the age barriers typical of child versus adult services, and respects the self-determination of young persons.

In general, the level of research which supports a practice can vary. The strongest research involves controlled experimental designs that are replicated by independent researchers across diverse groups of individuals and families. Controlled experimental designs would include such features as random assignment of individuals into treatment and control groups, reliable application of the treatment approach, application of the appropriate statistical analysis, and a comprehensive analysis of the results. However, there are other less rigorous, but credible research levels including quasi-experimental research, case studies, and anecdotal observations, to name a few. Evidence-based practices can be classified by the level of research that has been used to establish the practice’s efficacy or effectiveness. Higher levels of research evidence support greater confidence in the treatments efficacy or effectiveness and greater likelihood that if replicated in a similar manner with a similar group of individuals, that good outcomes would result. Not all practices are equally effective for treatment of all mental health conditions. There is growing evidence for the support of treatment specificity (DHHS, 2001; Sue and Sue, 2003). Research on efficacy and effectiveness of various mental health treatments has found that some practices predictably result in improved outcomes, some promote minimal change, and some practices result in bad outcomes. A hierarchy of scientific evidence can be used to describe important levels of effectiveness. The following hierarchy is useful in better understanding the next section in this chapter of efforts in California for TAY.  

- **Effective** — refers to a program or practice, applied in a usual care setting that has been evaluated using a strong research design, including random assignment into treatment and no treatment/control group(s), and found to achieve positive outcomes. This level of research supports high confidence that the practice will be effective when used with fidelity in a similar usual care setting.
- **Efficacious** — refers to a program or practice, applied in a controlled setting that has been evaluated using a strong research design, including random assignment into treatment and no treatment/control group(s), and found to achieve positive outcomes. This level of research supports high confidence in the effectiveness of the practice, but has not yet been tested in usual care settings. The effectiveness of the practice may be diminished when transported to a usual care setting.
- **Promising** — refers to a practice that has been evaluated using less rigorous quasi-experimental designs or case studies and found to achieve positive outcomes. Alternatively, the strength of the practice may be based on strong theory and expert consensus. In either case, this level of research supports optimism, but not high confidence.
- **Emerging** — refers to a practice that has distinguishing characteristics that can be defined and appear reasonable or has face validity. This level of research supports cautious optimism. Additional research is needed to verify the practice’s merit.
- **Not Effective** — refers to a practice, applied in either a usual care or controlled setting using a strong research design and found to result in no or adverse outcomes. This level of research supports high confidence in the lack of effectiveness of the practice when used in a similar manner with similar targeted populations.

---

105 This information was adapted from the California Institute for Mental Health 2003 report, Toward Effective Mental Health Practices: A Strategic Work Plan to Develop Organizational Capacity for Incorporating Values and Science into Mental Health Practices.
It is important to note that early applications of efficacious practices in usual care settings revealed challenges around conducting the practice with strong adherence to its model and in achieving comparable outcomes. Effectiveness research focuses on the outcomes achieved in usual care settings with typical diverse clientele. Related to the issue of effectiveness is fidelity. The high level of confidence associated with evidence-based practice assumes that the practice is being implemented with strong fidelity, meaning the implementation strongly follows the practice’s defining features as determined by the developers of the treatment approach. Moving away from the practice’s defining characteristics could jeopardize or even negate the effectiveness of the practice when applied. However, cultural evaluation will be a necessary element to this process, and resulting adaptations will allow the practice to be more fully scrutinized when implemented with targeted populations different from those in the original research design. The U.S. Surgeon General (DHHS, 1999) found that despite strong and consistent evidence of effectiveness, evidence-based treatments were not being translated into community settings and were not being provided to everyone who came in for services. In addition, it was suggested that there were many reasons which explained the gap between research and practice. The most significant explanations were service provider’s lack of knowledge of research results, the lag time between reporting of results and translating them into practice, and the cost of introducing innovative services into existing systems.

TAY Promising Practices In California

As we now present three efforts currently underway in California, we are reminded that the best work for TAY is still only in its infancy and that much is owed to the committed and caring individuals, families, and organizations in California and across the country who strive on a daily basis to meet the needs of TAY. The first effort is a promising practice called The Village Transitional Age Youth Program which is administered by the National Mental Health Association of Greater Los Angeles and is nationally recognized practice. The second effort is another promising practice called The Young Adult Transition Team (YATT) run by the Santa Clara County Mental Health Department and which continues to demonstrate good outcomes for TAY. The third effort is an emerging program in one of California’s small counties, Mendocino County Mental Health, which is significant because of the collaborations involved and the good outcomes achieved for TAY. We are hopeful that these efforts will provide practical information that could be applied or learned from across mental health and other human services systems.
INTRODUCTION

In 1999, the California Legislature passed AB34 (Steinberg) which targeted people who have a severe mental illness and are homeless and/or incarcerated. AB34 programs were required to provide intensive supports and services designed to achieve such outcomes as reduced homelessness, incarceration and hospitalization, as well as increased employment and education.

In 2000, Steinberg sought to capitalize on the very positive outcomes demonstrated in AB34 programs (Pilon) and passed follow-up legislation (AB2034) that significantly expanded the number of homeless mentally ill served on a state-wide basis. In addition, AB2034 specified sub-populations to be served by these newly funded programs. One of these targeted sub-populations was identified as “severely mentally ill young adults 25 years of age or younger who are homeless.” Most AB34 service-providers elected to blend this group in with the general AB34 population by offering the same programming, while a few, including The Village, chose to focus on developing a more specialized approach. This decision was based on the expectation that effective services to this emerging population of Transition Age Youth (TAY) would require significant adaptations to the established, adult-oriented Village recovery model.

MEMBER STORY

In 2001, “Edward” was referred to the Village by the Department of Family and Children’s Services when he was 19 and had “aged out” of the foster care system. He had been in multiple, out-of-home placements since the age of 4 when he had been removed due to physical and sexual abuse. Edward had also been diagnosed with bi-polar disorder and mild mental retardation.

Edward was initially housed in a Board and Care facility in Long Beach where the process of engagement (building a relationship) was first begun. This period of time proved to be quite difficult as Edward stayed in bed, was mostly non-responsive to staff’s daily visits and invitations to go out, and refused to shower or brush his teeth. His eyes seemed lifeless, as he appeared to struggle with a crushing depression and hopelessness.

After about six months of routine, relentless encouragement, behavior modification techniques and medication therapy, Edward began to stir. He made his first ventures out into the community and began dropping in at The Village. But then something very disturbing happened.

Edward was reported by a neighbor for coming over to their front porch and killing their pet canaries. It was also noted that during this time, Edward had been reading a book on serial murderers. Staff was alarmed; staff was worried; some staff was frightened. We immediately began identifying and calling experts in the field who could hopefully give us guidance on what kinds of treatment would be indicated, how the risks could be best managed. One expert gave us very stark and sobering advice: “Discharge him immediately, he’ll do something terrible and bring your whole program down.”

We didn’t discharge him. First of all, it is counter to our no-fail, unconditional commitment philosophy and secondly there were no acceptable alternatives. We increased our support and tried to keep a closer eye on Edward’s activities.
In the next two years, Edward tried work three times. His first job in maintenance lasted three hours; he felt it was too demanding. Edward tried again several weeks later and was able to work for over two weeks with intensive support and cheerleading. The Village practices an approach we call “continuous opportunity” and Edward was hired for a third time and has kept the job for the last several months.

Edward has been determined to get his GED and was connected to the local community college. He was making good progress but was kicked out for staring at campus co-eds for uncomfortable lengths of time. Another adult school was located and Edward has attended sporadically but has yet to achieve this goal.

For housing, Edward eventually chose to go into the Village’s “TAY House,” a transitional residential option specifically designed to teach independent living skills to this population. Edward didn’t know how to operate a can opener or washing machine, was unfamiliar with public transportation, and resisted the concept of paying rent on a monthly basis. He was evicted twice from the house for refusing or being unable to meet the requirement of being active in the community (school, work, groups, volunteering etc.) for at least 20 hours per week or completing his assigned chores. When he returned to the Board and Care settings where his meals and laundry were done for him, he soon complained of being bored and asked to return to the TAY House. He graduated from TAY House last month into his own apartment.

In April 2004, something amazing took place. Edward was selected for special honors at the “Golden Ducky Awards” – an annual Academy Awards style celebration that recognizes Village member’s many accomplishments. He bounded onto the stage in his rented Zoot Suit, while basking in the applause of over 400 supporters. He spoke to the audience excitedly about his plans to go to college, get his apartment and get a higher paying job. Edward’s eyes sparkled with promise and possibilities.

But the road of discovery is seldom a smooth one. Edward is currently struggling. He interpreted the goal of graduation as requiring him to go off his medications, despite staff’s attempts to educate him otherwise. His work hours have been reduced to one hour per day. The light has dulled in his eyes again. We will continue to stand by Edward and await the next breakthrough.

**TARGET POPULATION**

The TAY member (clients are referred to as members) probably differs from other non-AB34 mental health consumers in the same age range (18-25). The AB34 TAY member frequently presents to the mental health providers with an overwhelming array of needs such as no established income, no family or natural supports, no housing and no clue on how to get basic, survival needs met. Due to the inclusion of homelessness and/or incarceration (jail referred) as eligibility criteria, the typical AB34 TAY member likely has a higher incidence of:

- Background of foster care and out-of-home placements
- Involvement with juvenile justice
- Extreme poverty and no insurance
- Non-completion of secondary education
- Exposure to multiple traumas including abuse, abandonment, violence and homelessness
- Unclear psychiatric diagnoses. A large percentage does not probably have neurochemically based brain disorders such as schizophrenia and bi-polar disease.
- Non-involvement of family members and other supportive adults
PROGRAM DESCRIPTION

The MHA/Village TAY program offers a comprehensive array of integrated services and supports including:

- Supported housing continuum
- Supported education
- Supported employment
- Income/benefits advocacy – money management
- Social programming/outdoor adventures
- Dual diagnosis services
- Psychiatric/medication counseling and education
- Life-coaching

The MHA/Village TAY program adopts a no-fail approach and conceptualizes its mission as a “diversion” of members away from the mental health system whenever possible. The program serves 50 young adults and is staffed with 1 Director, 3 service-coordinators (case-managers), ½ psychiatrist, 1 education/employment coordinator and 1 ½ “TAY House” managers.

METHODOLOGY

As with all AB34 programs, outcomes are collected in nine quality of life domains. The outcome tracking system is designed to provide programs with data regarding their effectiveness in helping members to make significant changes in the objective quality of their lives. It does this by documenting “real-time” changes in the member’s objective status in a number of different quality of life domains. These include:

1. Residential (What is the member’s living situation?)
2. Employment (What is the member’s involvement in paid and unpaid work?)
3. Educational (What is the member’s involvement in school or training?)
4. Legal (What is the extent of the member’s contact with criminal justice, i.e. citations, arrests, etc?)
5. Income (What are member’s financial assets?)
6. Conservatorship (Does the member have control over basic life decisions?)
7. Payeeship (Does the member have control over his/her money?)
8. Incarceration (To what extent has the member been incarcerated?)
9. Hospitalization (To what extent has the member been hospitalized?)

The evaluation methodology for these programs employs a “before and after” approach to analyzing both client and system outcomes including cost effectiveness. The AB34 programs collect twelve months of pre-enrollment historical data on every consumer enrolled in the program. The comparison of the consumer’s pre-enrollment data to the data generated after the member’s enrollment in the program is the primary means used to evaluate program effectiveness. For example, if a consumer had 4 hospitalizations averaging 15 days per hospitalization in the year prior to enrollment, she would have a total of 4 hospitalizations and a total of 60 hospital days prior to enrollment. If in the first year following enrollment in the AB34 program the same member had 2 hospitalizations and each hospitalization lasted 10 days, she would have 2 hospitalizations for a total of 20 days. In this example, this would be reported as a 50% decrease in the number of hospitalizations (from 4 to 2) and a 67% decrease in the number of hospital days used by the consumer (from 60 to 20).
Of course, few members have been in the program for exactly one year. They may have been in the program anywhere from 1 day to more than 4 years, depending on their date of admission. To complicate things even more, on a program level this is changing with every new enrollment and disenrollment and with every passing day. This fact of varying lengths of program tenure requires that post-enrollment data be corrected by “annualizing” the data to make them comparable to the standard 1 year of pre-enrollment data.

GUIDING PRINCIPLES

The MHA/Village TAY program has struggled since its inception to transform its well established adult-oriented recovery services to reflect a more developmentally appropriate “discovery” model. The recovery model focuses attention on adults regaining lost roles, lost relationships and lost functioning. A discovery paradigm emphasizes the initial teaching, habilitation and exposure of TAY members to more normative learning environments.

The 1990 census reports that the average age when young adults leave home for the last time is 28. This statistic provided a helpful context to The Village/TAY program in developing its services. It suggests a prolonged period of transition that, in optimum conditions, requires intensive levels of financial and emotional support for even non-disabled American youth to successfully establish self-sufficient lives. This was comforting to harried staff hoping to produce results within a six month service plan. This statistic may also be indicative of the period of time that Erik Erikson described as a “psychosocial moratorium,” when young adults experiment with different roles and activities in their quest to form a viable, adult identity. For the evolving Village/TAY program this promoted the inclusion of continual exposures that support explorations and avoid pathologizing normative behaviors or stigmatize failures.

Hewitt B. “Rusty” Clark has developed a comprehensive framework to guide efforts to serve this population. The Transition to Independence Process: TIP System Development and Operations Manual (1995, Revised February 2003) has proven to be an invaluable resource in shaping the NMHA/Village TAY program. The following TIP System Guidelines are presented with related commentary on how these guidelines have been interpreted in the program. (TIP web site:http://tip.fmhi.usf.edu)

1. Engage young people through relationship development, person-centered planning and a focus on their futures.

The emphasis on building relationships has always been a central tenet of the Village recovery philosophy and is described as forming adult to adult relationships. Expecting transitional age youth to respond as adults may be unreasonable and unfair, as they have not yet matured into adult roles in many instances. This recognition has caused Village TAY staff to modify the traditional adult to adult stance and consider the roles of mentor, teacher and, at times, parent. At the same time, staff needs to be prepared to assume the role of learner, as young adults have much to teach. Awareness of developmental delays in skills, social responsibilities and emotional competencies is essential.

This engagement effort is also facilitated by our efforts to understand and interact in ways that are sensitive to the cultural differences and orientations of our young people (e.g., ethnicity, sexual orientation, alienation from years of homelessness, poverty and/or out-of-home placements). Most of our young people do not have family members that our staff is able to locate and/or involve with the young adult. However, our staff
understands, as Clark emphasizes, that we need to respect and nurture relationships that a young person might have with family and other natural and community supports that are valued and positive in the life of the individual.

2. **Tailor services and supports to be accessible coordinated, developmentally appropriate, and built on strengths to enable the young people to pursue their goals in all transition domains.**

The concept of developmentally appropriate services has been an important guide in recognizing that while the chronological age range of TAY members is 18 – 25, developmentally most of the Village TAY members seem 12 – 18. Understanding the common backgrounds of most of these members coming from the foster care system with horrific experiences of abandonment and abuse; as well as the lack of consistent, caring adults indicates the need for more specialized interventions. More age appropriate outcome measures will need to be developed that are better attuned to the incremental learning and normative benchmarks that are reflective of this transitional period. Other challenges include: performing meaningful, trauma sensitive, developmental assessments and recognizing implicit, adult oriented assumptions (e.g., the making and keeping of appointments).

3. **Acknowledge and develop personal choice and social responsibility with young people.**

The importance of choice is seen as a key element of the Village recovery model and a helpful empowerment strategy. However, for many TAY members, especially those “aging-out” from the foster care system, the idea of choice presumes that they have had sufficient life experience on which to base meaningful choices. The Boston University approach to supported employment of choose/get/keep has been modified accordingly to include: expose/choose/get/keep. This approach can also be applied fruitfully to education, housing and community/recreational activities.

4. **Ensure that a safety-net of support is provided by a young person’s team, parents and other natural supports.**

Clark discusses the art of striking a balance between maximizing the chances for member success while allowing for the potent learning of natural consequences to take place. Finding this balance is as difficult as it is often gut-wrenching. Should a 19 year-old youth go homeless because he fails to pay rent? Should a 20 year-old youth go hungry because she quits her job? The Village recovery model espouses a “high-risk – high support” position, it acknowledges that true growth and success is not possible in an environment that protects people from trying and failing. But when is it more appropriate to shield and buffer this more vulnerable age group from some of life’s harsher realities? A consistent message of unconditional commitment and caring, accessible relationships seems imperative to promote resiliency in young adults.

5. **Enhance young person’s competencies to assist them in achieving greater self-sufficiency and confidence.**

Village TAY staff have recognized that case-managing is not the same as teaching and coaching basic life-skills. The emphasis on teaching requires staff to be ever alert for teachable moments and to be prepared to train members in the natural environment where the competency is needed. This “side-by-side” style of teaching necessitates staff to ride
buses, go grocery shopping and give flirting tips at the coffee-house. Overall, the teaching/coaching approach is more time-intensive than a case-management orientation.

Continuous efforts to uncover and discover strengths and interests are also important. One process that has been found useful is known as the “core-gift” approach. The member is engaged in an interview designed to elicit enthusiasms and passions, questions such as “when do you feel most alive,” and “If we invited people from all parts of your life into the same room together, what is one thing they would all agree you were good at?” Annual outdoor, camping activities and rope courses have also been beneficial in building confidence.

6. **Maintain an outcome focus in the TIP system at the young person, program, and system levels.**

See previous description of NMHA/Village outcome tracking system in section V.

1. **Involve young people, parents, and other natural and community partners in the system at the practice, program, and system levels.**

One of the most challenging and least developed areas in the Village TAY program has been in sustaining community involvement. Efforts to locate and nurture “places of belonging” for TAY members have produced discouraging results thus far. The pervasive stigmas against disabilities, youth and poverty have combined to limit opportunities for TAY members to meet others and form relationships. There is a growing recognition, however, that for the Village TAY program to fulfill its mission of diverting members from the adult mental health system, we cannot retreat from the goal of community integration.

**PROMISING PRACTICES**

According to the National Registry of Effective Practices and Programs (NREPP) a promising practice is defined as “programs that have been implemented and evaluated so as to be scientifically defensible and produce positive outcomes – but lack sufficient support to meet effective or model program status.” Three discovery-oriented, developmentally appropriate Village TAY practices will be described and their respective outcomes shared. These three promising practices are supported housing, supported education and supported employment.

1. **Supported Housing**

   Through many trials and much error the Village TAY program has learned that most TAY members (especially 18 –21) are not prepared to live by themselves in their own apartments. Independent apartments don’t appear to be developmentally appropriate, and it is unlikely that this is where most 18 to 25 year olds reside in California.

   However, adult residential facilities (Board and Care homes) do not seem to be acceptable alternatives for young adults because large groups of severely mentally ill adults congregate there with little sense of support or direction. Most Village TAY members have not yet had sufficient life experience to learn how to manage the many visitors that often besiege their new place or how to budget and take on the demanding new responsibility of paying rent. Responsible adult supervision is essential to try to
assure basic safety and to teach the many complex, independent living skills that are new to most of them.

Taking these issues into account has required the Village TAY program to develop a transitional “teaching” facility with high levels of staff support. A college dorm setting has been suggested as the appropriate, normative learning environment where many young adults engage in high-risk, experimental behaviors and learn from the experiences. While possession of drugs and alcohol are prohibited on the premises, those members who choose to use elsewhere are held accountable solely on the basis of their behaviors (no violence, threats or destruction of property), not on the basis of whether they’re under the influence. Members are routinely exposed to the natural consequences of rule violations (i.e., “exited” from the facility), but in accordance with the no fail approach, they are offered the opportunity to return with a plan to address the problem behaviors.

Housing appears to be one of the program’s greatest successes, with fully 95.8% of the program’s members (46 of 48 consumers) maintaining some form of housing as of April 30, 2004 and 23 of these members living independently (47.9%).

Chapter 2 HOMELESSNESS*

<table>
<thead>
<tr>
<th>NUMBER OF CONSUMERS HOMELESS AT ENROLLMENT</th>
<th>NUMBER OF CONSUMERS CURRENTLY NOT MAINTAINING HOUSING</th>
<th>PERCENT CHANGE</th>
<th>NUMBER OF HOMELESS DAYS IN THE 12 MONTHS PRIOR TO ENROLLMENT</th>
<th>NUMBER OF HOMELESS DAYS SINCE ENROLLMENT</th>
<th>PERCENT CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>2</td>
<td>-86.7%</td>
<td>4,084</td>
<td>1,686</td>
<td>-83.2%</td>
</tr>
</tbody>
</table>

2. Supported Education

Supported education should probably be the centerpiece of any effective TAY program. The role of student is often the most developmentally appropriate one. A vigorous and relentless effort to engage and expose TAY members to educational opportunities is seen as imperative. Most Village TAY members have had interrupted and discouraging experiences with the educational system and have had multiple failures.

Several strategies have been employed in attempt to overcome the pervasive sense of disconnect and hopelessness commonly expressed by TAY members. Establishing a relationship with our local community college’s (Long Beach City College) Disabled Students Programs and Services (DSPS) has been a significant step forward in the evolving Village TAY program. This crucial partnership has enabled the TAY program to provide on-campus support, welcoming, and navigational assistance to its members. The accurate assessment of learning disabilities, as well as various learning styles has enhanced chances for success and retention. TAY staff and members becoming familiar with the many educational options including self-contained classrooms; brief 3-class introductions to various subjects; for credit “transitional classes” (i.e., Transition to College), are some examples of less daunting ways to re-connect with the member’s educational goals. In addition, Village TAY members are offered housing subsidies called “scholarships” based on maintaining their educational status.
The TAY program appears to be successful in helping members to access educational opportunities. There has been a 55.6% increase in the number of members attending school from pre- to post enrollment. As of April 30, 2004, fully 13 of the 48 program members were currently enrolled in some type of educational activity (27.1%).

Chapter 3 **EDUCATION**

<table>
<thead>
<tr>
<th>NUMBER OF CONSUMERS IN SCHOOL IN 12 MONTHS PRIOR TO ENROLLMENT</th>
<th>NUMBER OF CONSUMERS IN SCHOOL SINCE ENROLLMENT</th>
<th>PERCENT CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>14</td>
<td>+55.6%</td>
</tr>
</tbody>
</table>

3. Supported Employment

A large number of TAY members have benefited from the availability of an impressive “menu” of employment options. However, even the effective application of the robust Village employment services has demanded some innovations when dealing with the TAY members. Strategies that incorporate ways for TAY members to visit job sites and learn about qualifications and conditions are proving useful. Before many TAY members choose, let alone get a job, we attempt to expose them to as a wide variety of job settings as possible. Day labor services that offer paid work opportunities in the community provide immediate, accessible ways for TAY members to “try work for a day.” Apprenticeships have been developed as an additional employment menu option for TAY members. This arrangement usually entails the Village paying the member’s wages for a contracted period of time to gain valuable experience in a career related field.

Helping program members to find and maintain employment of program is another strength of the program, which has demonstrated a 122.2% increase in the number of members working from pre- to post-enrollment and a 52.5% increase in the number of days they worked. Not only are more members working, but they are working longer.

**EMPLOYMENT**

<table>
<thead>
<tr>
<th>NUMBER OF CONSUMERS EMPLOYED IN 12 MONTHS PRIOR TO ENROLLMENT</th>
<th>NUMBER OF CONSUMERS CURRENTLY EMPLOYED</th>
<th>PERCENT CHANGE</th>
<th>NUMBER OF DAYS EMPLOYED IN THE 12 MONTHS PRIOR TO ENROLLMENT</th>
<th>NUMBER OF DAYS EMPLOYED SINCE ENROLLMENT</th>
<th>PERCENT CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>20</td>
<td>+122.2%</td>
<td>1,668</td>
<td>3,508</td>
<td>+52.5%</td>
</tr>
</tbody>
</table>

*The preceding tables reflect the outcomes for the 48 consumers enrolled in the Village ISA TAY program as of April 30, 200. All post-enrollment data are “annualized” to take into account the average length of tenure for the 48 program participants.*
INTRODUCTION

In 1998, Santa Clara County Department of Mental Health began providing mental health services which were specifically targeted toward young adults who had problems with daily functioning as a result of mental illness. The concept behind this program was two fold. First, the Young Adult Transition Team was developed to help children who were already involved in the mental health system to make the transition to adult mental health services with as little disruption in services as possible. Secondly, this team was also designed to serve the needs of young adults who required these services as a result of the recent emergence or identification of symptoms of mental illness. Whether the clients mental health service needs were of a more chronic or acute nature, the Young Adult Transition Team’s purpose was to provide the level and type of services that were necessary to help their clients achieve a high level of satisfaction with their lives and in their relationships with others, to function effectively in all domains of living and to be able respond to the challenges associated with the young adult phase of development.

MEMBER STORY

One of the clients of our YATT service team, “George” was first referred to our team in April 2003, at the age of 18 years. At that time, George was in a residential treatment program through the provisions of Chapter 26.5 (aka3632). This meant George had an emotional disturbance that was serious enough to warrant this level of intervention in order for him to benefit from his education. George was subsequently diagnosed with Major Depression with Psychotic features. He was previously hospitalized three times because of suicide attempts he had made. He said he was depressed about his family and living at home “was hell.” He reported that he had run away from home on several occasions. George indicated he was also physically abused at the time. Finally, he added that he was behind in school and his grades “weren’t that good.”

Our Family and Children Intensive Services Unit referred George to the YATT. He needed an adult residential facility because he could not return home and had nowhere else to live. He could no longer continue his placement at the residential facility because it was an adolescent treatment center and he was now legally an adult.

The YATT staff assigned to assist George was Ernie Schmidt, LCSW. He helped George transition from the adolescent facility to the Young Adult program at the Riviera facility. He also took on the role of Rep Payee to assist George with managing his Social Security Insurance (SSI) monies.

George wanted to stay out of the hospital. He still felt depressed and was living on his own for the first time in his life. He stayed at the Riviera for eight months. He felt a lot of good things happened while he was there. He was able to become more accustomed to living on his own. He had a girlfriend for a few months. However, he had difficulty with some of the program rules and received warning notices for his behavior.
During the course of this placement, George received weekly individual counseling from Ernie. George felt it was helpful to have someone to talk to at the time and he wanted to reduce his depression. He focused on this goal during his therapy with Ernie and gradually began to feel better.

George moved from the Riviera program to a rented room as part of his desire for greater independence. His therapist, Ernie, disagreed with the timing of the move but supported George’s right to make that decision. The first four months went well and George continued to attend high school classes. Unfortunately, he also decided to discontinue his medication and subsequently began to hear voices and developed suicidal ideation. He was eventually hospitalized for a short period of time and began taking his medications again.

At this point, Ernie assisted George in eventually returning to the Riviera program. George participated in group and individual therapy. He continued to struggle with depression and hallucinations but gradually improved in both areas and he was ultimately successful in graduating from the Riviera program and left the program in April 2004.

He reported he completed the program in record time and this fits with his self-described tendency to be a “competitive person.” He was student president of the program at one time and participated in developing the program rules.

George currently resides in a studio apartment. He completed his high school education program and hopes to take classes at a local community college. One of his academic goals is to study courses in counseling.

To assist George in his occupational goals, Ernie referred him to a Vocational Rehabilitation program. He got a job at a local shop as a food server in February 2004 and currently works 28 hours a week. He likes his job and hopes to work full time so he can get benefits. He doesn’t know what he would like to pursue as a career but is considering options such as a security guard, probation officer or peer counselor. His long term goals include marriage, home ownership and a college degree.

In terms of relationships, George reported his communication with his family has improved. The family focuses on their present relations and chooses to not dwell on the past. George reports he has positive relations with his parents. Socially, George mentioned he has a small circle of friends that he met at his residential and educational placements. He recently broke up with his girlfriend through mutual agreement.

George stated that overall he is doing well, “The best I have done in my life.” The YATT psychiatrist worked with George to reduce and eventually discontinue his medications. George still gets angry at times and sometimes feels lonely on the weekends. During the week “There is no time to be bored.” George has not been hospitalized for almost two years now. He will soon graduate from the YATT. He will continue to receive support from his friends and family. George knows he can call us if he needs our help again.
**TARGET POPULATION**

The Young Adult Transition Team provides mental health services to young adults who meet the criteria for medical necessity for mental health services. That is, these individuals have been diagnosed with a mental health disorder included in the Diagnostic and Statistical Manual (DSM IV) and have significant difficulty with functioning in basic areas of life, such as social and/or occupational domains. In terms of mental health disorders, the two most frequent diagnoses of our approximate 100 current clients fall under the general classification of a mood (37) or psychotic disorders (41). Of the mood disorders, the most common diagnoses are Bipolar Disorder (16) and Major Depression (12). Of the psychotic disorders, the three most prevalent diagnoses are Schizophrenia (16), Psychotic Disorder NOS (15) and Schizoaffective Disorder (10). Several of our clients have also been diagnosed as having different types of anxiety disorders, including Post Traumatic Stress Disorder (PTSD), Obsessive Compulsive Disorder (OCD), and Social Phobia. Finally, our clients often have co-morbid disorders, such as a personality and depressive disorder. It is also not uncommon for our clients to have a dual diagnosis. For example, Bipolar Disorder and substance dependence frequently co-occur as has been indicated in research in this area.

In terms of referral sources, some of our clients come to us through other mental health clinics throughout the county. Often, these youth require more intensive case management and therapeutic services than the referring parties can provide. For example, we often work with youth who have basic needs in multiple areas, such as housing, education, and vocational rehabilitation, social and emotional adjustment. When these youth have been served through the Family and Children Division of the mental health system, there is typically a high level of care provided to that child and their family prior to being referred to the YATT. For instance, these youth have often been placed in out of home settings through Chapter 26.5 or other programs. Other youth have been receiving wraparound services (intensive community based programs). These youth “age out” of the children’s system when they turn twenty-two years old or graduate from high school, whichever occurs first. These same youth often continue to need mental health support due to the difficulties they have associated with their mental illness. These difficulties are compounded by the stress that has already been placed on their families and primary support system. Moreover, young adults typically have the desire (and the encouragement of their family) to leave home and begin independent living as an adult. This is difficult enough for most young adults; it is a monumental undertaking for young adults with serious mental illness. These are the youth we serve. We continue to provide assistance until they are able to navigate the demands that are a part of young adulthood without an intensive level of support.

**PROGRAM DESCRIPTION**

A helpful way to look at the program description of the YATT is to first describe the disciplines of the various members who comprise the core team. This team is located at Las Plumas Mental Health (LPMH) Center on the East Side of San Jose, California. Currently, the YATT consists of 2 Licensed Clinical Social Workers (LCSW’s), 2 Licensed Marriage and Family Therapists (LMFT’s), 1 Occupational Therapist (OT), and 1 adult psychiatrist (MD). In addition, each clinician supervises one to four interns who are students or graduates from the local state and private universities. These interns are an invaluable resource for increasing our capacity to provide more frequent contact and assistance for our clients.
The Occupational Therapy component of our program helps our clients’ transition from adolescence to young adulthood utilizing multiple resources and treatment modalities to assist them thru this process. The OT provides 1:1 sessions, groups, home and site visits to obtain a more comprehensive evaluation of our clients’ needs, skills and goals. Structured and measurable assessment tools are incorporated. Examples include Allen’s Cognitive Level (ACL) evaluation through task analysis, and the Kohlman’s Evaluation of Living Skills (KELS), and community re-entry training. Treatment interventions and modalities that are unique but yet common to the Team is the use of the Occupational Therapy Dog (OTD) with communication/socialization skill training, we developed our OT program in collaboration with San Jose State University Occupational Therapy Department, contract agencies and housing programs. As a result, we offer multiple mini-clinics and additional treatment groups/activities for our clients to graduate in an upward motion toward increased independence. A client who would never leave home can advance to attending a group at the clinic, receiving OT services in a residential setting, to living independently and attending a group with other young adults at the university site.

In addition to the core member team described above, each Santa Clara County Mental Health (SCCMH) Clinic has a designated staff that serves as a YATT Specialist. These staff participates in training seminars, which are designed to provide information about various community resources that can be of benefit to our clients, such as housing and vocational rehabilitation programs. As a result, the YATT Specialist is able to serve as a consultant for that particular clinic who can assist YATT clients to access resources in the local community. This type of design is helpful for clients in a number of different ways. First, Santa Clara County is a relatively large county with a significant amount of traffic congestion. Clients are sometimes unable to travel across county or may not have the means to do so. Mental Health Services at a local site can serve as a tremendous convenience to our clients. Secondly, there are two divisions in Santa Clara County – Adult Division and Family and Children Division (F&C). Youth who have been served in the F&C Division as children can sometimes continue to be seen as young adults for a period of time by the same clinical staff that worked with the individual as a child. This allows for greater continuity of care, especially at a time often associated with multiple changes in the youth’s life, such as graduating from school. The transition to the core YATT can be made when more intensive case management services are required, such as the location of housing programs. The role of the YATT Specialist thereby serves a crucial function in helping the youth to make the transition to young adult services in as smooth and coordinated fashion as possible.

In addition to the YATT Specialist in the SCCMH system, several of the local agencies that contract with the county also have YATT Specialists on their teams. These Specialists attend the same training meetings and participate in our System of Care model toward coordinating services for clients that are seen at the different agencies. Some of these agencies have their own service teams that specifically serve young adults. For example, ALLIANCE for Community Care (ALLIANCE) has such a team and offers comprehensive mental health services similar to the level provided by SCCMH. This is helpful in that clients can be transferred to a team at ALLIANCE if LPMH clinician’s caseloads are full. This way, clients are less inclined to have to wait for services once they are referred to the YATT.

When clients are transferred to the YATT from other agencies, the referring person completes a brief screening form that provides basic information regarding the client’s needs and status (see addendum). This information is helpful in determining the specific reason for the clinician referral and whether the client is eligible for YATT services. The LPMH team is interested in client strengths and resources as well as some basic historical data regarding education, health,
and so on. Also, insurance information is necessary because only Medi-cal and uninsured clients can qualify for YATT services.

If the referred client is deemed eligible for YATT services, the assigned clinician meets with the client to conduct the initial assessment. This is a very comprehensive process that helps the clinician understand the client’s current needs and concerns and the goals they wish to work toward as part of their involvement with the YATT. The mental health assessment also helps the clinician gather information that pertains to basic background and current relevant areas such as family history, medications, previous treatment, cultural factors, and developmental history and so on (see appendix). Also, clinicians will conduct a traditional mental status exam, which includes inquiry regarding how areas the client identifies as their strengths.

Once the assessment process is complete, the clinician will develop a treatment plan with the client that consists of the client’s current concerns or identified problems, goals, and objectives. The clinician also indicates what basic interventions and treatment modalities will be involved in helping the client achieve their goals. Treatment modalities can include individual, family and or group therapy. (Also, occupational therapy is routinely offered to LPMH clients. LPMH’s OT program is described in detail in the appendix.) Finally, clients are routinely evaluated for medication needs and subsequently monitored for medication efficacy by the team psychiatrist. The entire treatment team meets at least once a week to discuss client program and adjust goals and interventions as needed.

**GUIDING PRINCIPLES**

Guiding principles for the YATT were defined and disseminated at the inception of the program in 1998. At that time, the YATT Specialist was initially informed what the mission statement and general goals would be for the program. These principles were established through a collaborative process involving the YATT, administrative staff, stakeholders and advocacy groups. After careful consideration of what the foundations of the program should consist of, the group established the following premises:

*The Goal*

The goal of the Young Adult Transition System of Care is to help young adults who are severely mentally ill to develop skills and competencies so they can graduate to a greater degree of independence in adulthood.

**Core Values:**

- *Young Adult Consumer Centered.* This value implies that the focus of treatment is consistent with needs, which are associated with the young adult phase of development. Youth at this age often need help with basic areas of life, such as housing and finding employment. They are generally transitioning from institutions of childhood – such as being a child in a family or a student in high school – to institutions of adulthood-which can involve college, adult education, being an adult in a family and so forth. Therefore, the clinician can be of the greatest assistance if they have knowledge and commitment to helping the young adult to make these transitions by providing the necessary type and amount of information and support in these areas.

- *Community based.* This value involves working with the youth in their setting as opposed to always meeting in the clinician’s office. Community-based work allows for the clinician to visit the youth at home or out in the community, to go with the youth to help make connections, such as social and occupational linkages, and to be flexible in general in terms of setting and time.
- **Family friendly.** The clinicians work with the youth and their families to the degree that it is beneficial to the clients and to the extent that it is possible. If the clients give consent to do so, family members are invited to meetings to discuss ways to improve communication when necessary and coordinate efforts to help youth and the transitions noted above.

- **Cultural Competence.** A central aspect of the values is to provide services, which are consistent with the cultural values and practices of the clients. Through the system of care, LPMH offer Spanish and Vietnamese speaking clinical mental health services. The team assesses client cultural beliefs and needs in the provision of psychotherapy and the coordination with other community agencies.

**Core Principles:**

- **Early Intervention.** We try to assist youth at the earliest point of their transition to adulthood. In many instances, the consultation and intervention occurs prior to this phase.

- **Individualized.** All the services are designed to meet the individual needs of each of the youth referred to the program. This process begins at assessment and is reflected in the youth’s treatment plan.

- **Comprehensiveness.** We focus on each of the primary domains of the youth’s life, including social, occupational, education, and housing needs.

- **Smooth Transition.** As stated, the focus is on helping adolescence make a smooth transition to young adulthood. In addition, we assist young adult to transition from one level of care to another with as much support as possible.

**Supported Housing**

As Maslow indicated in his concept regarding the need for hierarchy, food and shelter are basic needs, which must be addressed before one can start to focus on growth needs. As such, we place a great deal of emphasis on identifying the type and level of housing needs of each of our clients and then providing referral and linkage to the designated program. Established YATT core principals regarding housing are this service promotes stability, learning of life skills and enhancement of consumer safety.

There are two basic set of circumstances which apply to our clients regarding housing when they enter our program- either they are transitioning from living with their families or they have already made this transition. In the former case, we will assess the youth and their family’s level of satisfaction regarding their relationship and their plan regarding the timing of the youth’s transition from home. Since housing in the Santa Clara County is quite limited, we try to plan in advance regarding housing needs whenever possible. It is not uncommon for youth to be placed on a waiting list in order to get into a Board and Care home or Transitional Housing program. Sometimes, you can continue to reside with their parents or other family members for a period of time before they transition from the home. We can provide family therapy as needed to help work out agreements between the youth and their family regarding rules and responsibilities in the home that the youth and their family members can agree to during this final phase of living together and to assist in a smooth transition of “leaving home.”

Some of the clients transition from residential treatment centers or group home where they resided as adolescence. When this occurs we work with the providers and the youth to identify the type and level of adult placement that will be needed once the youth leaves their current placement. For example, we have ongoing meetings with our local Community Treatment...
Facility (CTF) to coordinate efforts to help the involved youth transition successfully from this facility to an adult placement.

There are instances where young adults require hospitalization and subsequent placement in one of our IMD’s. When this occurs, our clinicians work with the staff of the IMD, the Public Guardian, when applicable, the client and our 24-Hour Care team to transition the youth to a Crisis Residential facility when the client is ready for this change. This process often occurs when youth have a “first break” due to an emerging psychosis or a relapse attributable to mental illness.

The level of care of housing varies according to the youth’s level of functioning, the development of their independent living skills and any other individual needs or abilities, which will affect the level of support, they will require. When they are placed at higher levels of care we will identify what skills they need to acquire to transition to less restrictive placements. We then provide mental health services, medication support and occupational therapy and case management in concert with the services they receive at the facility to help the youth make the transition to lower levels of care and greater independence as so as they are ready to take this step.

One of the key components regarding housing for young adults who have been emphasized by the CMHDA and young adults pertains to the opportunity to live with other consumers who are of the same or similar age. This grouping according to developmental age provides a peer support network, positive peer mentoring and the chance to associate with peers with who are more likely to share similar interests and experiences.

To achieve this optimal condition in the area of housing, Santa Clara County partnered with one of our local adult housing programs to provide a live-in program for YATT clients. This program is called the Riviera Young Adults Program. It provides up to eight beds for our clients along with a comprehensive array of mental health services. The program goals are to help teach young adults skills toward obtaining employment, to help clients with future housing assistance and to teach clients skills to help them become more independent in basic areas of their lives (e.g., medication management, managing finances, etc). The program provides an area for young adults to room together, paid work experience on site, staff able to assist clients in the development of independent living skills, dual diagnosis groups, 24-hour supervision and security, careful monitoring for medication compliance and hygiene maintenance on a daily basis. The YATT routinely coordinates services with the Riviera program by visiting the site to provide individual, group and occupational therapy to clients as well as case management and consultation. The Riviera program has a well-established behavioral therapy approach to assist clients in achieving the above stated goals.

**SUPPORTED EDUCATION**

The YATT is committed to assisting youth to achieve higher education as adults when it is identified as a goal they would like to pursue. Staff encourage all youth to pursue some form of education beyond high school, whether it is enrolling in classes at a local community college or just signing up to take a course at a nearby adult education or community center. The timing of a youth’s readiness to continue this pursuit also varies considerably during the young adult phase of development. Sometimes, young adults need to prioritize work over education when their living situation necessitates earning an income. In these situations, education takes the form of learning a new job skill.

As previously mentioned, young adults who enter the YATT program have a range of strengths and needs. This range also pertains to their academic ability and performance. For example, some
of our clients participated in Special Education during the course of high school. These students were frequently qualified for this form of support due to being classified by their local district school psychologist as Emotionally Disturbed. Some of these youth also received counseling support from our Family and Children team through eligibility under Chapter 26.5. When this occurs, we work with the F&C providers and the local school districts to provide the most recent school records to the youth and the local community college. Than, the college disability counselor can review the student Individualized Education Plan (IEP) and work with the student to design a program to include the appropriate accommodations and supports to provide for the student. This procedure is also applicable for Special Education students with other types of disabilities.

**SUPPORTED EMPLOYMENT**

One of the primary goals of the YATT is to assist young adults in the process toward greater independence. Nowhere is the opportunity for this accomplishment greater that in the attainment of a job. Our staff work diligently with youth to help them identify the type of work they would like to pursue and to help connect them to a vocational rehabilitation program as needed. Typically, our clients have limited job experience due to their age, their circumstances and the mitigating effects of their mental illness.

The YATT frequently refers our clients to community vocational rehabilitation programs whenever such services are need to assist you in acquiring job training skills and connection with potential employers. SCC provides matching funds to state and federal funding which enables the voc rehab programs to fund staffing, clothing, books supplies and training. Three of our local agencies that provide voc rehab services include Focus for Work, ALLIANCE for Community Care and the local branch of the Department of Rehabilitation.

Generally speaking, the criteria for eligibility for these programs include a referral from our staff with the indication of the client’s disability and need for services. There is an initial orientation and linkage with a Mental Health counseling specialist. At this point, an assessment is conducted to determine the client’s individualized needs (job training, placement, etc.) This process usually consists of a three week class where the client is assessed to see if they can be on time, are dressed appropriately, and can practice the job skills training they are taught. Once the assessment is complete, the provider will establish with the client what services they can provide. Providers will work in the community to help connect clients to potential employers and to provide on site job coaching as needed.

**Outcomes**

There are a variety of ways to measure client outcomes that will help to reflect the degree to which they benefiting from their participation in the treatment program. With respect to the YATT program, our guiding principles and client needs are the cornerstones on which we build our treatment plans and related client goals and interventions. Typically, clients are seeking assistance in very basic areas of living, such as obtaining stable housing and/or getting a job. As such, we will than prioritize these needs and begin our work with our clients to help them have their basic needs met in as timely a fashion as available resources will allow.

Based on the above-mentioned guidelines for measuring outcomes, the YATT compiled gathered clinical data pertaining to the approximately one hundred clients referred to in the target population section (Section III). As indicated, the majority of our clients (est. 78%) have been diagnosed with a mood disorder or psychosis. The team provides the level of service, which is
necessary to help the client be successful in their life domains. The results of our work are included in the following sections and pertain to a one-year period of time from April 2003 to the same time the following year. This is not meant to be a research design since the YATT is not set up to do research at this time but rather a pre-post type of measurement regarding the distinction of how many clients were assisted in each domain and the success of that assistance.

**Housing** – The YATT was able to locate and secure appropriate housing for 23 of the clients referenced above. Not all of our clients needed housing over this time period. Of those who required housing, virtually all clients were provided a placement at the level of care that he or she required. At times, some clients had to be placed on waiting list for a short period of time until an opening was available at the designated placement.

A second consideration with respect to housing is to be able to assist clients to transition to the level of care, which they need at any given point in time. The YATT was able to facilitate the transition of 29 clients to lower levels of care that were deemed appropriate by the client and their support system. In many instances, this involved helping clients to transition from a locked hospital facility (IMD) to a Board and Care level of care or higher-level placement. Of those clients who were previously hospitalized, 17 were able to function without a readmission to a psychiatric hospital for the one-year period included in this report.

**Employment** – There is also a great deal of variance in the area of interest in getting a job. Since employment is not a necessary requirement for receiving YATT services, clients identified when they wanted assistance in this area as well. Approximately 20% of the 100 clients were able to obtain and maintain employment over the year time period referenced above. YATT staff assisted clients in receiving vocational rehabilitation when indicated. Other times, clients were connected to private providers in the community. Case management was provided to assist clients in maintaining employment.

**Education** – Some of our young adult clients indicated an interest in returning to school. This usually meant a community college or adult education program. When clients indicated an interest in education, they were given the level and type of support necessary to make a connection with designated program. Of the 100 clients in the target group, 20 were linked to academic programs and maintained class enrollment.

**Supportive Programs and Independent Living Skills** – As previously mentioned, many of our clients require supportive day programs to help them learn independent living skills, prevocational training and other basic skills such as socializing with others. Of the 100 clients referenced above, 17 were connected to Day Treatment programs, which assisted our clients in acquiring these abilities. An example of an important area of focus pertained to money management. Some of our clients are conserved and require Rep Payee services to help them plan how to budget their money. Of the target population of this group, eight clients were able to acquire the necessary money management skills to act as their own Rep Payee within the year time period of this report. In addition, as part of learning increased independence, we assisted our client to learn how to be responsible for taking their prescribed medications. This compliance is also linked to other outcomes. For example, medication compliance decreases the likelihood of recurrent hospitalizations. Of our clients who were prescribed medications, 29 were compliant for the year period of time of this report.

**Program Completion** – One of the best indicators of program efficacy can be see in the area of program completion. One of our goals is to assist clients to successfully complete the program and to move from our support to support in the community. Clients are always
welcome to return if their need and circumstances warrant our services. Of the clients in this report, 17 were able to successfully complete our YATT program.

The above-mentioned outcomes provide some indication of program efficacy in helping our clients to live more independent and satisfactory lives. Yet, these figures are not meant to convey outcomes that subscribe to good research methodology. Clearly, for this to occur, such basic practices as random assignment to control and treatment groups and other controls for extraneous variables are needed.

Currently, our program is in the process of developing a best practice approach to providing mental health services to young adults. Through a generous grant from our local Health Trust, we have contracted with Dr. Robert Reiser and his team from Pacific Graduate School of Psychology to develop a treatment manual that will allow us to adopt a standardized approach to treatment our young adult clients in Santa Clara County. So far, the team has conducted an extensive review of the literature for best practice treatment outcomes for young adults who meet the diagnostic criteria described in our target population section. One consistent finding was the successful use of Cognitive Behavior Therapy (CBT) for treatment of mood disorders, psychosis and anxiety disorders in adult populations. We are currently being trained in the use of this method of treatment for our clients. Subsequently, we will also be uniformly trained in family therapy and engagement strategies. Once our training is complete, we will utilize a research design including random assignment to treatment and control groups and update our outcomes section to include the results of this study.

MENDOCINO COUNTY MENTAL HEALTH

INTRODUCTION

In Spring of 2003, Mendocino County Mental Health and Department of Rehabilitation made a decision to apply to the State Department of Rehabilitation for an Establishment Grant to create a new Work Adjustment Program within the Cooperative. After ample consideration, the decision was made to partner with the local high school, the local Workability Program through the Special Education Local Plan Area (SELPA), and attempt to create a transitional age youth work program in a vacant delicatessen on the county campus. Several private food vendors had attempted to provide a food business in the now vacant space, but for various reasons, were unsuccessful. A grant was written while team members searched in the community for a business that was interested in both an expansion into the county campus and was willing to employ TAY clients with a stated disability of mental illness. Such a company was identified, called the “Bottle Shop Delicatessen” that also had a history of employing Regional Center Clients. An agreement was reached that allowed the Bottle Shop Delicatessen to enter into a contract with Mendocino County to utilize the commercial restaurant space and a MOU with Mental Health was generated spelling out the terms of how youth would work in the business and what each partner would do to insure a positive work experience for participants.

MEMBER STORY
Lorenzo was nearly 17 years old when he was referred to work in the Bottle Shop by his teacher from his special education 10th grade class room at Ukiah High School. Lorenzo was eager for the opportunity to work, and a closer look at his checkered background illustrates why he identified so well with the world of employment.

Lorenzo was born to an agricultural family in Fresno and experienced poor health as a child and was often sick with a fever and diarrhea. His family was monolingual Spanish Speakers and only the father was somewhat literate. He was often absent from the home while he migrated looking for work. As a young boy Lorenzo had a poor appetite and did not appreciate being away from his mother at school or the babysitters. Lorenzo was initially placed into special education at age 7 because he showed language difficulties in English and Spanish and had learning disabilities, especially in processing verbal information. In addition to his academic challenges, behavioral and emotional difficulties were becoming more pronounced and he was referred for counseling.

By the time Lorenzo reached high school, his difficulties seemed to worsen. However, a goal began to develop that he wanted to become a mechanic, and the school directed him toward shop classes. He also got a job in a local appliance shop, which Lorenzo reports as being one of the high points in his life. The job sparked his motivation to learn to read, which was currently at about a first grade level. This seemed to lift him out of feelings of depression he was experiencing that were a result of his failures at academics and the hardships he felt in the world of his peers. However, some months later when he lost his job, Lorenzo began to feel so depressed he doubted that he wanted to go on living. Over the course of the next couple of months he made several visits to the community mental health crisis center and eventually was detained as a danger to himself and hospitalized in San Francisco. His diagnosis was Major Depression with Psychotic features. He was started on a course of Paxil. Because his family did not view the counseling and medication as being consistent with their cultural values, they chose instead to try herbs from a family resource. Lorenzo was referred for a 26.5 assessment by his school.

Since his job had been an important part of his daily life, his teacher referred him to the new work adjustment program at the Bottle Shop. Since Lorenzo was a Workability Student, and the return of his symptoms was worrisome, the team believed a new job experience might be the key to a better life. Since Lorenzo qualified as a student with a disability who had an IEP, he could have an opportunity to work in the Bottle Shop as part of his curriculum. He would be allowed to work ten hours per week at a rate of $5.75 per hour. He began the program and within weeks his family revealed that they were quite pleased with how he was doing in the work adjustment program and that he was getting along much better at home. He agreed with his teacher to begin a reading program that would accelerate his skills. Although Lorenzo was tempted to participate in local gang activities and had threatened during discouraging times to “steal a car,” because he had the “know-how to do it and get away with it,” he made healthy choices.

Lorenzo successfully finished his semester and went on work in the county garage as a mechanic’s helper. While working in the delicatessen, one of his jobs was to deliver orders to go to local county workers. In the course of taking coffee specialty drinks to the county garage, the shop manager befriended Lorenzo and organized a work placement for him the following semester. Lorenzo now works in a restaurant as a dishwasher and bus boy, still, he sees himself becoming prepared for the future when he will work as a mechanic in a garage. For the past year, no serious symptoms of mental illness have manifested. In this case, work turned out to be the best form of treatment.

TARGET POPULATION
High School students in this program need to be at least 16 years of age, but not older than 24, have an Individual Education Plan (IEP) with a stated disability, be enrolled in the SELPA Transition Partnership Program (TPP) as a Workability participant, or as a Department of Rehabilitation Cooperative Client and have a teacher willing to make the referral to the Mental Health Job Coach for a suitability assessment. Clients do not need to have an open Mental Health Clinical Chart, although most participants are receiving clinic services upon entry into the program.

The target group is individuals who have a psychiatric disability and are 16-24 years of age, Transition Age Youth (TAY). They are clients of Transition Partnership Program (TPP) and/or the Mental Health Cooperative Program (MH Coop). They will have a current IEP with an identified psychiatric or emotional disability and/or a client of MCMH Children’s or Adult System of Care. Both TPP and the MH Coop have found it difficult to adequately serve youth who have psychiatric disabilities. TPP has found that the students with psychiatric disabilities or emotional disturbances need more supervision and guidance than the majority of the students they serve. Most would benefit from a more sheltered work environment than is available through existing resources. This group of individuals seem to have a history of dropping out of “the system” when they graduate from school. They seem to reappear later in the Adult Mental Health system needing services.

**Program Description**

Mendocino County Mental Health (MCMH) will provide Work Adjustment (WA) training for clients of the Department of Rehabilitation (DOR). MCMH currently operates Work Adjustment services. This new component targets the Transition Age Youth individuals. It proposes to meet the need for more supervision and intensive training by providing a direct Coach at a 1 Coach to 2 trainees ratio. This service is provided in the Ukiah area of Mendocino County which is in the Santa Rosa District of DOR.

The goal of Work Adjustment Training is to overcome employment barriers, which improves an individual’s employability. Individuals successfully completing the training will be ready to move on to the next phase of services as outlined in their DOR Individual Plan for Employment. This next phase may be referral to Employment Services (i.e., employment preparation, job development, placement and follow-along and/or job coaching) or other training services (i.e., occupational skills training, college, vocational training program, etc.). In the WA Program, trainees develop work safety skills, customer service and communication skills, punctuality, soft work skills, and work related academic skills in a positive work setting. In addition they may also learn cashier skills, cooking and food preparation skills, as well as cleaning skills.

DOR will refer transitional age clients of the MH Coop and/or TPP by issuing an authorization for services. A multi-disciplinary team (DOR Counselor, MH Case Manager, Work Adjustment Coach, TPP staff and/or the MH Coop staff and client) meet to develop the client’s work adjustment plan, focusing on identified barriers that inhibit the client from obtaining competitive employment. The WA Coach reports progress to the team monthly and, as needed, at meetings. Written records are maintained for all clients. Additionally, the WA Coach makes recommendations for referrals to the appropriate services when an individual’s training is nearing the end.
Trainees work 2 to 6 hours per day for a maximum of 20 hours per week. They can be in the program for 3 to 6 months. There are a maximum of two trainees working at one time. It is expected that 20 will be served in a year’s time. The Clinical Services Associate (Work Adjustment Coach) provides the Work Adjustment training. This is a grant-funded position. This element of the program proposes to meet this population’s need for more supervision and intensive training by providing a direct Coach at a 1 Coach to 2 trainees ratio. The job coach transports or arranges the transportation.

Trainees learn time and money management, transportation, grooming, and work related academic skills. For many of these clients, this is their first work experience. The Work Adjustment Coach helps the trainees to overcome barriers to employment. This is done mostly through work-based training. The WA Coach also uses vocational training curriculums, computer and internet resources, videos, and other resources from the local One Stop Office. Included in this is training in safe food handling using the curriculum offered by the County Environmental Health Department and Work Safe (a curriculum on safe work habits for youth). Assistive technology and reasonable accommodation needs are identified. At the conclusion of Work Adjustment, the DOR counselor refers the client on to the next appropriate service such as, placement services, or additional training or educational experiences.

The WA Job Coach is already in the position and this will continue. Clients are already receiving services and will continue to do so. New referrals are being received on a regular basis. Outreach to the schools, case managers, DOR, the MH Coop and TPP is to be conducted on an on going basis.

GUIDING PRINCIPLES

We believe it is useful to develop employment opportunities for the high school age student who is experiencing symptoms of mental illness for a variety of reasons. Some of our guiding principles that have served this project well are noted below:

- Begin assisted employment by age 16 as this activity is normalizing to the TAY and boosts self confidence. Some TAY may have academic barriers, but may find success in the arena of employment and this promotes new motivation in standard classroom learning.
- In order to serve the TAY high school student who has an IEP, it is critical to gather the entire group of individuals working with the TAY including the teacher, the parent, the Special Education school case carrier, the MH job coach, the Department of Rehab Counselor, and the TTP or Workability Program Specialist. Without all providers on the same team, confusion results and there is little hope for success.
- Similar to the recovery model with adults, plans should be client driven and involve the family whenever possible. By being strength focused, the TAY can experience new successes. While the money earned on the job is a reward, the contacts made while in the program can lead to bridges for the future.
- The nature of the disability that the TAY bring to the workplace requires a job coach who posses a variety of skills in rehabilitative treatment. The youth needs the full attention of the job coach who must be willing to begin with basics and patiently build on skills acquired, so the TAY can become prepared a non-assisted job.

OUTCOMES
We had planned to serve a minimum of 20 individuals the first year. We expected that at the end of the first year, a minimum of 6 individuals would have successfully completed their training. We have served 13 unduplicated DOR clients with 6 individuals successfully completing their training and moving on to the next step in their IPE. Successful completion of the Work Adjustment Program is when the barriers outlined in the Work Adjustment Plan have been addressed and/or removed. This is documented in progress notes and monthly progress reports. The outcomes are measured by the number of WA plans completed successfully (all goals met) and the number of referrals to either job placement services and/or vocational training.

The outcome for the restaurant is a real success story! Because of the Cooperative effort to find a business willing to employ TAY workers, and the willingness of General Services of the County to create a business friendly lease, the restaurant is open from 7:30 a.m. until 3:30 p.m. and is well frequented by county employees, local students from both the high school and middle school and other community residents. This has become a gathering place for informal meetings, lunch time bridge games and a waiting place for timed agenda items for citizens attending the Board of Supervisors meetings.

**EMERGING PRACTICE**

The Mendocino County Cooperative has long wanted to establish a service delivery system that would help target the TAY group more effectively. It is anticipated that this Establishment Grant Program will improve services to the TAY population. The primary promising practice discovered in this project has been the success of supported employment for high school students. When identified barriers are addressed, the individual will be more employable and better equipped to succeed on the job and in life. Success on the job in a sheltered environment with a sensitive but professional job coach leads to gains in self confidence and motivation that allow the student to return to the classroom setting with increased focus.

**CONCLUSION**

The truth is that much of the programmatic policy efforts on behalf of TAY have come from family members, advocacy groups, researchers, and other human services agencies. We hope that the information within this chapter will express the California mental health system’s desire to contribute to the growing body of knowledge about TAY. This was a direct result of the California Mental Health Directors Association’s desire to address California’s ability to better understand and address the varying needs of young people with emotional and behavioral difficulties who are in transition. We hope that the information presented will assist mental health systems, program designers, individual providers, advocates, family members, other human service agencies, and most importantly TAY, in helping to create a better mental health system; whether TAY are transitioning from the children's system to the adult system, the children's system to the community, or the community to the adult system.


**RECOMMENDATIONS**

The following recommendations regarding TAY are offered to guide mental health systems in promoting improved design and implementation of programs and practices for TAY, as well as better outcomes for young people with emotional and behavioral disturbances and their families. These recommendations were derived from a multitude of sources including the members of the committee, the literature on TAY, and the good work in practice occurring across California.

1. Mental health systems must conduct new or review existing system and system component assessments to adequately measure their readiness to adopt, implement, and evaluate evidence-based, promising, or emerging TAY programs and practices.
2. Science-to-practice and practice-to-science initiatives, including evidence-based practices, implementation projects, and performance improvement projects for TAY need to be enhanced and adequately funded to improve their level of science and value to the target population.
3. Evidence-based practices which have been proven to be effective with TAY populations, as well as promising practices which demonstrate positive outcomes for TAY, if implemented, must track their implementation with fidelity, effectiveness, and value to the target population.
4. Evidence-based practices or promising practices for TAY which have been proven to be effective with non-ethnic minority populations must track any modifications and/or adaptations made, to collect and generate new information to enhance the effectiveness of these practices to diverse populations.
5. The use of TAY educational curricula should be mandated in clinical training programs, county technical assistance efforts, and continuing education strategies.
6. Better tools for assessing language abilities in clinical assessment and linguistic and cultural issues in the diagnostic process for TAY are needed.
7. The selection of a treatment practice for TAY needs to be based on mutual decision-making between informed young people, their family members or caregivers, and their providers.
8. Efforts to eliminate barriers to accessing mental health care for TAY including stigma, discrimination, bias, and costs need to be continued and expanded.
9. Efforts to eliminate disparities in access to and quality of mental health care for TAY need to be continued and expanded.

**TAY RECOMMENDATIONS**

**TAY PRINCIPLES**

1. Be passionate about working with young adults or stay home.
2. One of the primary goals of TAY services should be the diversion of young adults with emotional and behavioral disorders from the mental health and criminal justice systems.
3. Young adults with EBD are at a psychosocial stage when they are exploring and forming new, adult roles (identity formation) that will probably influence behavior more than any other factor. Providers would get the biggest bang for their service buck if they first and foremost offered an array of age appropriate, normalized experiences (“exposures”) unrelated to mental health.
4. Seek not just to educate and inform, but to inspire.
5. If young adults with emotional and behavioral difficulties are to transcend the confining boundaries of disability and the mental health system; providers must transcend the
boundaries of disability and the mental health system. Partnerships must be established with institutions of education, job training and youth development.

6. Most young adults avoid the mental health system for good reasons; it is rarely welcoming, tolerant or cool. Effective TAY services must adopt more youth friendly approaches and environments.

7. If the “average” American young adult does not fully “emancipate” from their families until age 28; it is not reasonable to expect young adults with EBD, many with little or no family support, to emancipate successfully at age 18.

8. Early “upstream” interventions (by age 14) are imperative and will result in better outcomes and substantial cost avoidance later.

9. Know that today you will be ignored, dismissed and cursed at for things that you will be thanked for profusely years later. (Unless you’re wrong, in which case you will just be ignored, dismissed and cursed at.)

10. Remember all the dangerous, ill-advised, destructive things you and your friends may have done as a transition age youth and consider that many of the disturbing behaviors that you are witnessing are not due to mental illness or deep-seated pathology.

TAY PRACTICES

1. Recognize and support developmentally appropriate relationships with young adults that may include: coach, teacher, mentor, sponsor, “awakener,” learner and even proxy parent.

2. Seek balance in all programmatic efforts and be prepared to adjust them often as needs change.
   - Between doing for, doing with and letting young adults do for themselves.
   - Between protecting and buffering young adults from natural consequences vs. allowing them full contact with natural consequences.
   - Between accepting a great deal of vile, obnoxious banter vs. teaching and coaching more acceptable styles of communication.

3. Don’t be afraid to incentivize, reward and outright bribe for constructive behaviors, remember you’re often competing with crack, Nintendo and incredible lethargy.

4. Involve members in activities that encourage them to practice delayed gratification, cause and effect, planning etc.

5. Accept and understand the young adults’ current behavior without assuming its permanence. Repeat to yourself; “it’s just a phase, it’s just a phase.”

6. Develop exposure strategies that provide life experiences that often precede the choosing, getting and keeping of jobs, permanent housing and relationships.

7. Consider “entitlement issues” (the expectation that others will provide for you) as an age appropriate attitude.

8. Get in touch with your “inner parent,” don’t be afraid to “encourage getting up” by shaking bed, pulling covers and making snippy comments.

9. If people being punctual and keeping their appointments is really important to you, you may want to consider another line of work.

TAY PROGRAM
1. Identify developmentally appropriate housing – consider family-like settings with caring adults, peer mediated college-dorm, semi-independent apartments etc.
2. Put as much staff support into your housing as possible and then add 2.
3. Career development should be at the center of any self-respecting TAY system of care with mental health and dual disorder services aimed at removing barriers to achievement in these areas.
4. Qualifying young adults with EBD for SSI may compromise their long term goals for short term survival and stability. Explore other funding sources and housing subsidies as well.
5. Strategies to reduce early parenthood are a crucial goal.

**TAY Policy**

1. Provide continuity of relationships across systems (transition facilitators). Stop abrupt, re-traumatizing terminations based on arbitrary age limits.
2. Change psychiatric diagnostic criteria for service eligibility; consider functional impairments or risk and protective factors. “All Youth – One System.”
3. Change Department of Rehabilitation standards for 90 days of employment as a definition of success. They are developmentally inappropriate and discourage experimentation.
4. Identify developmentally appropriate outcomes/milestones – consider drivers licenses, parenthood, graduation, etc.

**Recommendations for Transition Age Youth Programs**

The following suggestions are for providers who intend to provide mental health and/or case management services for Transition Age Youth (TAY). These recommendations are based on work experience as a Program Manager for Santa Clara County’s Young Adult Transition Team (YATT) and suggestions from clinical staff. These suggestions involve two dimensions of program development. These are the developmental phases of program design and the domains covered by the TAY Program. These suggestions also primarily pertain to youth who are being served by County Mental Health Systems but can be utilized by other providers as well with consideration as to the mental health needs of the TAY group being served.

**Developmental Phases**

1. *The Vision.* Each TAY Program begins with a vision of therapeutic services that would help meet the needs of young adults in the particular community being served. In order to best meet these needs, the involved mental health and social service leaders need to meet with all stakeholders and interested staff and community leaders for input to develop a shared vision of what the needs and goals would be for a TAY program. In addition, these same leaders should interview and meet with young adults to get their input on what type of services would be helpful and how service delivery could best be tailored to them. The availability of community resources, sources of funding and support are necessary consideration for program design. Exclusionary criteria such as age and diagnostic criteria need to be defined. Finally, the vision should be one that is culturally and clinically competent, includes family
involvement whenever possible and addresses the developmental opportunities and challenges associated with young adulthood.

II. The Plan. Once the vision has been established, involved parties need to determine how to go about putting a plan into place that will include all the elements already identified. Involved staff requires training in the therapeutic approaches that are identified as promising or best practices for young adults. Lines of communication and coordination of services need to be established between the different service providers. Points of entry into the program also need to be clarified. In general, a clear plan is necessary on how to access services, what the services will be and when the services will be discontinued.

III. Implementation. After staff has been adequately trained, mental health services can be provided to identified clients. Referral processes and coordination of care can begin to take place between all relevant parties. Clear lines and channels of communication are important since providers can include staff from any of the domain areas identified below. For this reason, intensive case management is a core requirement of a good TAY program. Case management staff should have small caseload size (range of 15 to 25 clients, depending on job description and support staff). A multi-disciplinary approach is also recommended. Members of a team should include Master level clinicians (LMFT/LCSW), a psychiatrist, and rehabilitation counselors. Supervised interns and volunteers are also suggested to increase service range and provide training for potential future staff. An Occupational Therapist is also helpful to assist clients in the area of prevocational training as well as increasing their independent living skills. Finally, it is also helpful to explore whether clients who are advanced or graduated from the program would be willing to serve as mentors and positive role models for new clients.

IV. Program Modification. Ongoing program evaluation and modification is needed to respond to changing client needs and to enhance program efficacy and efficiency. Staff should actively seek client feedback along the way to find out how the program is working for them. It is also suggested that staff define clear outcome measures at program inception and used the feedback from these measures as an indicator of program efficacy and necessity for modifications and changes in services. Supervisors and staff should also establish ongoing meetings with members of the community (stakeholders, providers, DFCS, JPD, educators, etc) to get feedback on the accessibility of services and the degree to which services are helpful. Program modification is an ongoing process and a good TAY program is a dynamic one that changes as the cultures and needs of the clients change.

DEFINING TAY AT THE LOCAL LEVEL

Throughout the TAY Resource Guide, there are numerous references to youth who would be considered eligible and in need of TAY services. For example, it has been recommended in this guide that the age range be between 14 to 25 years. It is also recommended that TAY services be offered to youth who have been placed in the foster care system and TAY who are having difficulties associated with mental illness. In general, youth who have been in the Juvenile Justice system and Social Service system should be offered TAY services to help them navigate the transition to adulthood. At the same time, decisions regarding eligibility criteria need to be
determined to some extent by county systems and the community members and stakeholders who comprise these systems.

ACCESSIBILITY OF CARE

There should be relatively easy access for TAY who qualifies for these services. If the county system is large enough and set up to allow multiple entry points at different sites, than a centralized access and referral center is helpful. Information regarding eligibility criteria, screening processes and available services should be clearly indicated in written form and provided to all stakeholders as potential referring parties. Specially trained staff should be available at each site to answer questions pertaining to the above stated information. Ideally, there would be no such thing as a waiting list for youth qualified for this program. Information and services should be available to all TAY who are monolingual speaking when that language reflects a significant number of members of the community.

LENGTH OF CARE

Another general consideration for a TAY program is the length of time the youth will be assisted by the staff of that particular program. In the mental health system, TAY services can serve as a bridge between children and adult services. In this system, it is preferable to begin the transfer of mental health services from the children’s system to the TAY program at the point when this form of specialized service will be most useful in helping prepare the TAY for the challenges of young adulthood. In this sense, the main goal is the prevention of major problems in functioning in each of the life domains. In the event that TAY will require some ongoing support (e.g., medications, etc) through the adult mental health system, it is helpful to consider whether guidelines other that age will be a determinant in the decision making on the timing of this transition. This will help to reduce possible dependency on TAY services and allow for TAY staff to assist other youth who are transitioning into their program. In situations where TAY youth are transitioning to the community rather than adult mental health, the establishment of some criteria of client readiness would be beneficial.

LEVEL OF SERVICE

The level of need for support and guidance by TAY will vary from person to person and tend to fluctuate across time and experience. For example, TAY who have been traumatized, are homeless, lack a primary support system, and/or have experienced the recent acute onset of mental illness, will need a higher level of support cope with these stressful events. Conversely, TAY who has a high level of internal and environmental support will tend to have relatively lower levels of need. TAY programs should be constructed to offer that level of support that is consistent with each clients needs while he or she is in the program. This is particularly relevant with regard to housing. Clients needs in this area can vary from the most to least intensive in the following order: hospitalization, crisis residential, supportive housing, transitional housing, and independent housing. The level of client need may also substantiate additional services. At the lowest level case management and medication may be sufficient. At higher levels, psychotherapy-in the form of individual, family and/or group treatment may be required.

LIFE DOMAINS
As previously stated at various points in this Resource Guide, there are four basic life domains which each TAY program would hopefully include as essential service areas for youth they serve. These domains include housing, education, vocation, and community living. Each of these basic aspects of living represents such vital needs for TAY that is difficult to imagine a program meeting the needs of this population without providing some degree of service in each of these four areas. Services such as housing can either be provided by county or contracted agencies. Collaboration with local education providers, such as adult education and colleges is necessary. Similarly, it is necessary to establish this same coordination with vocational programs throughout the community. Finally, community supports in the form of social networks, clubs and organizations, support groups and specific peer interest groups are needed. Overall, it is important that each TAY staff have access to as much information as possible regarding community resources in each of the areas listed above.

**INTENSIVE CASE MANAGEMENT**

At any point in time, TAY may require basic linkage and support in one or more of the domains indicated above. When this domain involves basic needs such as housing, it is important to have immediate assistance. TAY who needs food or shelter should receive this service on the same day as the expressed need. In addition, in order to be effective, TAY may need to spend a significant amount of time with TAY staff for case management and/or other therapeutic services. It is recommended that TAY staff have smaller caseloads than is normally associated with adult mental health systems in order to respond to TAY needs at a potentially intensive level.

**PSYCHOTHERAPY**

The vast majority of TAY clients have suffered form a traumatic experience and/or mental illness. Psychotherapy is essential to help TAY recover and cope from these stressful events and to minimize the impact of these same negative experiences on the functioning and well being of our youth. TAY programs need to consider both the psychotherapeutic modalities and theoretical approaches used by TAY clinicians. In terms of modalities, individual, group and family counseling are recommended as types of counseling that can be offered depending on the need of each TAY. Each of these types of treatment can be useful in building peer and family relations as well as increasing TAY resiliency and communication skills.

Insofar as therapeutic orientation is concerned, it is recommended that TAY staff be capable of providing supportive psychotherapy at the very least. All TAY will benefit from having the therapeutic support of a humanistic counselor who provides active listening, accurate empathy, and genuineness as part of their approach. However, it is important to also provide evidenced-based psychotherapeutic approaches to assist TAY.

There is a growing body of research that substantiates the efficacy of Cognitive Behavioral Therapy (CBT) as the treatment of choice to help ameliorate the symptoms associated with serious mental illness, such as major depression, bipolar disorder and psychosis (site multiple references). Therefore, it would appear that at least some TAY staff should be sufficiently trained in this type of psychotherapy so that TAY will be given the best opportunity to cope with their emotional difficulties and improve their problem solving skills. Furthermore, CBT is extremely beneficial in helping TAY address other difficulties they may be experiencing, such as chemical dependency or recovery from traumatic events. (Site multiple references). Finally, psychotropic
medications are often necessary to help TAY cope with the symptoms associated with mental illness. Every TAY program needs to have a qualified psychiatrist who understands the mental health needs associated with TAY.

Day Rehabilitation Programs can also be of benefit to TAY. Such programs offer a structured format in a social setting for TAY to increase independent living skills; learn to increase socialization with peers and others, and to better understand how to cope with their mental illness in general. Typically, such services are beneficial to TAY who has higher level of service needs. Ideally, such programs should also include family members and other means of support and should include a psycho-education component to help TAY and family members better understand the particular mental illness the youth and family are learning to cope with at the time. Psychiatric services in the form of evaluation, prescription and monitoring as well as approaches to assist TAY in medication compliance are necessary.

**INITIAL AND ONGOING TRAINING**

In order to be helpful TAY staff need to know how to help. This requires initial and ongoing training, especially in each of the following areas:

- **Clinical training:** To help increase TAY staff knowledge of current best practice approaches and how to use the techniques associated with these approaches.

- **Cultural competency training:** To increase TAY staff knowledge of the culture of the clients who are receiving their services.

- **Young Adult Developmental Phase training:** TAY staff in particular need to know the challenge and opportunities associated with this phase as well as the associated needs that TAY have for making the successful transition to adulthood.

- **Miscellaneous Staff and Program Characteristics:** There are some staff and program characteristics that are difficult to measure and quantify but are appreciated by TAY and their families when they are present and harmful when absent. Such human qualities as compassion, dedication, and ongoing commitment should be integral to every TAY program. Moreover, TAY staff should possess personal characteristics of resiliency, flexibility, a sense of humor, and a positive approach to their work in order to engage TAY and help them on the path to adulthood. TAY staff also need to have exceptional skills in the areas of planning, organization, and decision making in order to help TAY cope with daily and developmental demands and to collaborate with TAY in developing their vision of the future and building the road to get there. Finally, TAY staff should have a natural interest in assisting TAY cope with the challenges of this developmental phase, perhaps arising, in part, from the remembrance of a mentor or other adult who similarly helped them get through this time of life in successful fashion.
SCC YATT Referral Form

Client Name ___________________  DOB: _________  Client Primary Language: _________
Ethnicity: _________________  Marital Status: __________  Sex: ____________________
SSN#_____________________  SD#________________________________________
Referral Source: ________________________________________________________
Worker’s Phone #:___________  Worker’s Fax: _____________  Referral Date: _________

REASON FOR REFERRAL AND PRESENTING PROBLEM:

SUPPORTS & STRENGTHS OF CLIENT AND FAMILY:

TARGET SYMPTOMS & BEHAVIORS TO BE TREATED:

DESCRIBE PARENTAL INVOLVEMENT:

CLIENT’S LEVEL OF MOTIVATION:

LIVING SITUATION

□ IMD  □ Board & Care Facility  □ Parent/Guardian  □ Other
□ Homeless  □ Residential Treatment Facility  □ Family Member/Friends
□ Juvenile Hall  Current Address ________________________________

Describe stability of living situation:

__________________________________________

DIAGNOSTIC/MEDICATION HISTORY

TAY Resource Guide
Chapter XV
A. Diagnosis Axis I

Axis II

Axis III

Axis IV

Axis V Current GAF _______ Past GAF ________________

B. Current Psych. Meds

Treating Psychiatrist:_____________________________________

1.__________________________________________________________________

2.__________________________________________________________________

Is the Client Meds. Compliant? Yes____ No______ If no, describe ________________

Medical Problems? No_____ Yes_____ If yes ,describe__________________

PSYCHIATRIC HISTORY

A. Age of Onset of Psychiatric Symptoms _______ First Contact with Mental

Health System if known________________________

B. Number of Previous Psychiatric Hospitalizations_____ Age at First Hospitalization,

if known __________________________

Circumstances of Most Recent Hospitalization and date: ______________________

C. Current Mental Health Treatment; type, length and with whom: ______________

CURRENT AT RISK BEHAVIOR

Suicide Ideation/Self harm Threats/Aggression towards others

Sexualized Behavior Drug/Alcohol Abuse  □ Other

Please describe any areas check above________________________________________

EDUCATION

Last Year of School Completed_______ Most Recent Educational Program _________

History in Special Education: Yes___No____ Unknown___ 26.5 Services: Yes__ No__

Prospective HS Graduation Date or completion of 26.5 Services___________

Legal Status
Voluntary_____ Conserved _____ Parole/Prob_____ Wardship____ Dependency _____

Legal Issues or Current Legal Problems: Yes___No___

Please describe any areas checked above: ______________________________________
________________________________________________________________________

Financial Information

A. Source of Income: General Assistance ____ SSI____SSA____ SDI___ VA___ job___
Family ____ Other_____

B. Is SSI pending? No____ Yes___ If Yes, Approximate Date:_______________

C. Medi-Cal #____________________ Medicare # _________________________

D. Other Insurance? Yes___ No___ if Yes, Specify and explain____________________

APPENDIX #15.2

YATT OT Program

Best Practice

Prepared by Cathy Smiddy, OTR/L, collaborative with the following OTIs: Melissa Garland, Sophia Jones, Rob Domrese, Jeni Yamashita

The definition of Occupational Therapy (OT) according to the American Occupational Therapy Association is a skilled treatment that helps individuals achieve independence and increased satisfaction in all facets of their lives. OT strives to assist clients with achieving a balance of work, rest, leisure and self-care. The Young Adult Transition Team (YATT) OT program collaborates with clients and facilitates optimal functional performance through the following services:

- Cognitive assessments and performance skills assessments
  - The OTR/OTI serves clients in a variety of settings ranging from emergency psychiatric facilities to home care.
  - The OTR/OTI administers standardized evaluations including Allen’s Cognitive Levels (ACL) assessment that provides objective, measurable functional outcomes.
  - The OTR/OTI assesses client’s functional performance outcomes using skilled observation during Activities of Daily Living (ADLs and IADLs)
such as grooming and hygiene, meal preparation, caregiving, money management, pre-vocational and other life management skills.

- Customize treatment programs to improve one's ability to perform daily activities
  - Through 1:1 interviews based on the Canadian Occupational Performance Measure (COPM) the OTR/OTI in conjunction with the client identifies goals and areas for improvement and then structures the treatment specifically for that client.
  - During group therapy, tasks, the amount of structure, and the type of instructions are graded according to the individuals learning style and cognitive level.

- Health and Safety
  - The OTR/OTI assists clients in obtaining valid identification such as California ID cards.
  - The OTR/OTI will create an emergency card that contains the client’s address, contact information for Las Plumas and the case manager’s name, medications, and allergies if known.
  - The OTR/OTI provides a Medication Journal to each client, and provides training on the use of journal.
  - The OTR/OTI provides education on the importance of medication compliance and monitors behavioral and functional changes on a regular basis.
  - The OTR/OTI promotes wellness and awareness in the areas of sexual education.

- Community mobility and integration
  - The OTR/OTI assist client in obtaining bus pass and disability discounts.
  - The OTR/OTI provides opportunities and assistance in using the transit system.
  - The OTR/OTI informs about community resources and encourages participation in various community programs with emphasize on education, health, work and leisure.
  - The OTR/OTI provides training in communication and social skills.

- K-9 Therapy
  - Used to assess and improve multi-tasking skills
  - Provide opportunity to be responsible for another being
  - To aid in communicating with a withdrawn client
CHAPTER XVI

RECOMMENDATIONS FOR IMPLEMENTATION

“Courage is not the towering oak that sees storms come and go; it is the fragile blossom that opens in the snow.”

— Alice Mackenzie Swaim
CHAPTER XVI

INTRODUCTION TO RECOMMENDATIONS

These recommendations were consolidated from the chapters of the TAY Resource Guide and extensively reviewed by the TAY Subcommittee. The lead writers of each chapter were asked to develop a more detailed list of recommendations that can be found at the end of each chapter. Also, for every chapter much of the information and subsequent recommendations were obtained with the input of knowledgeable providers who are in the midst of developing promising practices.

It is in the spirit of true humility that these recommendations are offered. Each county is unique with its own set of circumstances and stakeholders. There cannot be a “one size fits all” approach. The following recommendations might be better called ideas to “try on” and see how they might apply in your setting. Hopefully, they represent what the TAY Subcommittee learned in its work: that there is depth and complexity in the issues facing TAY and those who work with TAY.

This list of General Recommendations would be useful in presentations to staff or stakeholders about the most important recommendations in the areas of TAY Developmental Issues, Organizational and System Change, Practice and Program Strategies, and Policy and Fiscal Issues. It is also hoped that some of the recommendations may support policy changes at county, state and federal levels that would ultimately benefit TAY, their families, and those who are involved with them. A crosswalk showing where each recommendation is discussed in the chapters is also included.
I. General Recommendations Related to Developmental Issues

A. Transition age youth are characterized by specific developmental processes and tasks that have implications for unique approaches to assessment, service planning, and therapeutic interventions. These developmental issues provide opportunities to promote wellness by identifying needs and strengths, and in partnership with the client, developing individualized strategies to increase competencies in key domains and promote positive outcomes. Ideally, transition services for many youth should begin at age 14 and continue into the mid-20s.

B. In order to maximize making a successful transition into adult life transition age youth need integrated and coordinated support in the areas of housing, education, employment, and social and family supports.

C. Due to the heightened risk in young adulthood of the onset or exacerbation of disorders such as psychoses, addictive disorders, and others, plans for services should actively address the unique diagnostic issues for this age group. High rates of co-occurring substance abuse and mental health problems in this age group require an integrated approach to the concurrent assessment, referral, and treatment of both sets of problems.

II. General Recommendations Related to Organizational and System Change

A. Services specifically designed for transition age youth should be staffed by those who are knowledgeable and genuinely enthusiastic about working with youth and young adults.

B. Transition age youth should be provided opportunities to participate in all activities of planning, implementation, and oversight of services. Meaningful support for participation includes financial compensation, childcare services, flexibility for meeting time and place, and other strategies that will provide incentives for their valued assistance.

C. Coordination is required at all levels of administration of children and adult Community Support Services and planning groups at the State and local levels. These coordination efforts should serve as models for effective communication and partnerships at the practice level.

D. Oversight at the County level would be facilitated by TAY-specific organized forums and workgroups, such as a county-wide manager level workgroup or a team composed of staff from multiple levels of job tasks. Such forums would encourage agency support at all levels. The establishment of a TAY Coordinator position is highly recommended.

III. General Recommendations Related to Practice and Program Strategies

A. Given the unique developmental tasks of emerging adulthood, identifying strengths through “strengths discovery” is a key component of the assessment and service planning phases, and in all subsequent phases of involvement. This involves person-centered planning which is driven by the person’s interests, aspirations, dreams, strengths, and cultural and family values.

B. Transition age youth are no less than others subject to barriers such as stigma and racial discrimination, which exacerbate other age-related barriers to continuity of care resulting
from developmental and systemic factors. *Taking into account the cultural and language context of the person, his/her family, and community* are vital to developing strategies for a successful transition to adulthood. The transition age youth should have a central role in this exploration.

C. **The outcomes of services** should be defined in ways that are culturally relevant, appropriate, measurable, and driven by the person and his/her family. Service planning goals should be practical, they should have realistic timeframes, and they should be focused on youth-identified areas such as work, school, friends, and so on. Evaluating the success of the intervention should be a continuous activity.

D. **Educational support** for the transition to adulthood should be age-appropriate and proactive. In the secondary grades, for youth with Individualized Education Plans (IEPs) the transition to post-secondary education, employment training, or other realistic objective should be addressed from age 14 on. Promising practices in post-secondary education for transition-age youth with special needs include, for example, targeted strategies for recruitment, orientation, assistance with administrative tasks (such as application forms), tutoring, mentoring, financial aid, and linkages to employment training.

E. **Employment** is an important “rite of passage” for young adults in our society, and is typically a top priority from the youth’s point of view. Activities such as obtaining a driving license and social security card are important milestones on the road toward competing in the marketplace. Job skills for youth who have never worked, or whose illness/disability makes it hard to interview for and maintain a job, need to be developed with help from others. Promising practices in employment services include components of comprehensive support, information, skills training, and linkages to the community.

F. Transition age youth with special needs are at risk for homelessness. **Housing** should be made available that is age-appropriate, (i.e. normative group-living situations), and culturally congruent, with intensive case management and linkages to other services. The living environment should foster hope, support independence, and encourage positive social group interaction.

G. Emerging adulthood is a time of “turning points” in a young person’s life, which are enabled through normative social activities that provide opportunities for positive reinforcement of strengths and relationships. Youth point out the importance of activities that foster positive peer relationships, that avoid stigmatizing or labeling, and that are integrated within the community. Transition-age youth also need opportunities to help others in volunteer activities, or by mentoring and coaching other children and youth by sharing their own experiences.

**IV. General Recommendations Related to Policy and Fiscal Issues**

A. Each county and state agency should have specific policies related to the development and funding of services for the transition-age youth population, and should also make concerted efforts to coordinate and integrate services with those of other organizations and agencies.

B. State agencies should revisit general policies and outcome standards for children and adults that may be contradictory to the developmental stage of transition-age youth. For
example, some standards were developed for adults who would be expected to participate
fully in the labor force (e.g., the Department of Rehabilitation’s 90 day standard of full
employment as an indicator of success).

C. **Fiscal policy**, (i.e., determining the funding alternatives for services and associated
eligibility criteria at the state and county levels) should be guided by the “vision” of
program development — identifying gaps in services, gaining youth and community
consensus, developing agency partnerships, and incorporating promising or best
practices.
## Chapter XVI

### Crosswalk of General Recommendations and Chapters

<table>
<thead>
<tr>
<th>Recommendation Number</th>
<th>Recommendation</th>
<th>Chapter(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I A.</td>
<td>TAY Developmental processes and tasks require unique approaches</td>
<td>III</td>
</tr>
<tr>
<td>I B.</td>
<td>Integrated and coordinated supportive services</td>
<td>All</td>
</tr>
<tr>
<td>I C.</td>
<td>Address unique diagnostic issues of TAY</td>
<td>IV, VII</td>
</tr>
<tr>
<td>II A.</td>
<td>Staff should be knowledgeable and enthusiastic about TAY</td>
<td>XV</td>
</tr>
<tr>
<td>II B.</td>
<td>TAY should participate in system change and planning</td>
<td>II, V</td>
</tr>
<tr>
<td>II C.</td>
<td>Coordination is required at all organizational levels</td>
<td>II, VI, X-XIII</td>
</tr>
<tr>
<td>II D.</td>
<td>Establish TAY Coordinator position; develop county-wide forums to monitor services</td>
<td>XV</td>
</tr>
<tr>
<td>III A.</td>
<td>“Strengths discovery” is key</td>
<td>VIII, IX</td>
</tr>
<tr>
<td>III B.</td>
<td>Importance of cultural and language contexts</td>
<td>IV, VIII, IX</td>
</tr>
<tr>
<td>III C.</td>
<td>Defining outcomes of services for TAY</td>
<td>III, IV, VI-XIV</td>
</tr>
<tr>
<td>III D.</td>
<td>Education support practices</td>
<td>X</td>
</tr>
<tr>
<td>III E.</td>
<td>Employment support practices</td>
<td>XI</td>
</tr>
<tr>
<td>III F.</td>
<td>Housing support practices</td>
<td>XIII</td>
</tr>
<tr>
<td>III G.</td>
<td>Normative social activities</td>
<td>XIV</td>
</tr>
<tr>
<td>IV A.</td>
<td>County and state policies related to TAY services</td>
<td>II</td>
</tr>
<tr>
<td>IV B.</td>
<td>Revisit general outcome standards for children and adults</td>
<td>III, V-XIII</td>
</tr>
<tr>
<td>IV C.</td>
<td>Fiscal policy and vision building</td>
<td>XII, XV</td>
</tr>
<tr>
<td>IV D.</td>
<td>Policy strategies to minimize eligibility barriers</td>
<td>XII</td>
</tr>
</tbody>
</table>