

# 19

## Services for Youth in Transition to Adulthood in Systems of Care

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“It is our hope that every youth who participates in our program will leave with a renewed sense of self and that they will be healthy, confident, capable, and empowered.”

—Melanie Green, Youth Coordinator, Options

Young adults experience dramatic changes across all areas of development during their transition to adulthood. Young people’s decisions, choices, and associated experiences set a foundation for their transition to future adult roles in the domains of employment, education, living situation, and community-life functioning. This period of transition is especially challenging for the more than 3 million youth and young adults with serious emotional disturbances or serious mental illness (SED/SMI) (Clark & Davis, 2000; Vander Stoep, Bersford, et al., 2000). This population of young people has a higher secondary school dropout rate, higher arrest and unemployment rates, and a lower independent living rate compared with their peers without disabilities (Davis & Vander Stoep, 1997; Wagner, 2005).

In a community-based study, young adults with severe psychiatric disorders were nearly 14 times less likely to complete secondary school compared with their peers without disabilities, and 44% of the failure to complete school was attributed to their disorders (Vander Stoep, Bersford, et al., 2000; Vander Stoep, Weiss, Saldana Kuo, Cheney, & Cohen, 2003). In addition, young adults with SED/SMI have significantly higher unemployment rates (34%–82%) after exiting high school in contrast to their peers without disabilities. This difference is largely attributed to the lack of social skills necessary to maintain a given job (Bullis & Fredericks, 2002; Carter & Wehby, 2003; Chadsey & Beyer, 2001; Gresham, Sugai, & Horner, 2001; Rylance, 1998). Fragmented services, varying eligibility criteria, different funding mechanisms, and distinctly different philosophies

across the child and adult mental health systems further complicate the situation for young people with SED/SMI by making their transition to the adult mental health system and their ability to obtain appropriate services and supports challenging endeavors.

The Partnerships for Youth Transition (PYT) initiative provided an opportunity for the establishment of five demonstration community sites to examine ways to improve the outcomes of transition-age youth with SED/SMI. In 2002, the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services and the U.S. Department of Education, Office of Special Education and Rehabilitative Services awarded approximately \$2.5 million annually for 4 years to fund five cooperative agreements to develop the PYT initiative. The cooperative agreement programs were created to allow competitively selected communities and counties to develop, implement, stabilize, and document models of comprehensive transition systems to improve outcomes for youth and young adults ages 14–25 with SED/SMI as they enter the period of emerging adulthood. To influence policy at the national level, SAMHSA leadership involved several national partners for this initiative. Some of these included the U.S. Department of Education, the Jim Casey Youth Opportunities Initiative, the National Center on Youth Transition (NCYT), and the Annie E. Casey Foundation. Representatives from these and other organizations became a part of the community of learning that emerged from the PYT initiative.

To achieve the goal of developing transition systems for youth and young adults, each of the PYT sites in Washington, Pennsylvania, Maine, Minnesota, and Utah undertook efforts to provide community-based transition services and supports to this population of youth and their families in a manner consistent with the community culture, accepted models, and state and local policy. Although the federal funding for these sites ended in September 2006, as of 1 year later, four of the five communities (i.e., Washington, Pennsylvania, Minnesota, Utah) have sustained all, or at least a substantial portion, of their transition services and supports for serving youth and young adults with SED/SMI and their families.

This chapter highlights the development, implementation, and preliminary evaluation of the transition systems developed by the PYT sites. Specifically, this chapter provides: 1) an overview of the PYT initiative and delineation of the age-appropriate interventions and support services that were common across the majority of the sites; 2) an overview of the Transition to Independence Process (TIP) model framework, including an outline of the transition domains of employment and career, education, living situations, and community-life functioning; 3) brief descriptions of the community transition systems implemented at the five PYT sites, with particular attention to the involvement of youth, family, and local and state partners; 4) preliminary PYT evaluation outcome findings; and 5) lessons learned at the practice, system, and policy levels. Thus, this chapter is designed to provide the reader with promising practices and lessons learned related to planning, implementing, and sustaining community transition systems for youth and young adults with SED/SMI and their families.

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## OVERVIEW OF THE PARTNERSHIPS FOR YOUTH TRANSITION INITIATIVE

Under the cooperative funding agreement, the PYT sites were required to conduct planning with community stakeholders to review, adapt, and adopt promising models of transition to adulthood systems to address the strengths and needs of the community as related to transition-age youth and young adults with SED/SMI and their families. The capacity to offer an array of relevant services was achieved through partnering with community agencies and organizations; developing new services; and employing the creative work of young people, families, and other informal and formal stakeholders in the community who were willing to provide necessary and appropriate services and supports.

Young people and family representatives were involved in the planning, design, and selection of services and supports provided within the PYT initiative. In collaboration with youth, families, and other PYT partners and stakeholders, a theory-based logic model was developed for each PYT community site to visually illustrate the underlying assumptions and service delivery strategies being designed and incorporated into their systems as active ingredients in working with this population of young people and their families. Table 19.1 provides an overview of the expectations for PYT sites, including the primary activities to be accomplished, the program elements to be implemented, and the desired results and products to be completed within each site over each of the 4 years.

The NCYT at the University of South Florida served as the training and technical assistance partner to assist the PYT community sites in their efforts across all of the required activities and products (see the NCYT web site for additional information about its programmatic, systemic, and evaluation services at <http://ncyt.fmhi.usf.edu>). The leadership of the NCYT worked with the communities and state leaders through site-specific consultation, training, cross-site teleconferencing, and biannual PYT cross-site forums. The teleconferences and PYT forums focused on themes that the sites and national partners established as priorities during the evolution of their programs (e.g., youth engagement, employment, educational opportunities). The PYT forums and cross-site teleconferences served to develop a community of learning, fostering an ongoing exchange of information about the issues that sites were wrestling with, challenged by, and succeeding with.

A major assumption underlying the PYT initiative was that communities could expand their collaborative efforts to tap into an additional array of relevant services and supports for these youth and young adults and their families. The PYT community sites were to consider the following features as they developed and implemented their transition service systems:

- Outreach and engagement
- Assessment of individual strengths and needs
- Age-appropriate mental health care, including transition from the child to adult mental health system where appropriate

**Table 19.1.** Partnerships for youth transition: Summary of program activities

Year	Primary activity	Program elements	Desired results/products
1	<p>Collaborative strategic planning process</p> <p><i>Goal:</i> To build upon the model comprehensive youth transition program proposed in the grant application by determining details for implementation.</p>	<p>Engage all relevant partner organizations in collaborative strategic planning that includes:</p> <ul style="list-style-type: none"> <li>• Mental health services</li> <li>• Substance abuse services</li> <li>• Foster care and/or child welfare</li> <li>• Corporate/business community</li> <li>• Criminal justice/juvenile justice</li> <li>• Education and/or special education</li> <li>• Community-based organizations representing the ethnic, racial, and cultural diversity of the geographic region in which the model will be implemented</li> <li>• Young people and their families</li> </ul>	<ol style="list-style-type: none"> <li>1. Theory-based logic model (to link the design of the transition program with implementation involving all community partner organizations)</li> <li>2. Written action plan</li> <li>3. Process evaluation (to document the strategic planning process)</li> </ol>
2	<p>Implementation of the program model</p> <p><i>Goal:</i> To implement the transition program.</p>	<p>Enhance existing programming to fill gaps in the model comprehensive youth transition program</p> <p>Align resources and coordinate services</p> <p>Train staff</p> <p>Execute/renew needed interagency partnerships</p> <p>Collect quality assurance data</p>	<ol style="list-style-type: none"> <li>1. Document the final operational transition system into a program manual.</li> <li>2. Enroll and serve young people, collect demographic and other data based on the logic model.</li> <li>3. Complete a process evaluation to examine how implementation occurred.</li> <li>4. The comprehensive youth transition program is addressing all specific domains and additional ones based on the logic model.</li> <li>5. A structure for the comprehensive youth transition program exists and coordinates and integrates services.</li> <li>6. Identify and define measurable short-term outcomes.</li> </ol>

Year	Primary activity	Program elements	Desired results/ products
3–4	Stabilization of the Comprehensive Youth Transition Program  <i>Goal:</i> To ensure that service delivery is consistent and of high quality.	Update sections of the written action plan regarding sustainability  Conduct annual process evaluations  Develop an integrated management information system that will allow cross-site evaluation  Report outcomes annually to CMHS/ SAMHSA	1. Draft sustainability plan 2. Process evaluation 3. Outcomes/data 4. Develop fidelity measures

*Key:* CMHS, Center for Mental Health Services; SAMHSA, Substance Abuse and Mental Health Services Administration.

- Substance abuse services
- Assistance with housing needs
- Vocational training, career development, and employment support services
- Educational support services
- Services to help develop and nurture instrumental living skills and proper socialization
- Family and peer supports
- Care management or service coordination

In their proposals, applicants were required to describe a model or framework for a Comprehensive Youth Transition Program they planned to implement under the PYT initiative. Applicants were to tie their proposed transition systems to previously existing literature on recommended practices and strategies for providing services to youth with SED/SMI. Most PYT sites developed a transition system that incorporated most, if not all, of the principles of the TIP model (Clark, Deschênes, & Jones, 2000; Clark & Foster-Johnson, 1996).

## OVERVIEW OF THE TRANSITION TO INDEPENDENCE PROCESS MODEL

The TIP system prepares youth and young adults for their movement into adult roles through an individualized process that engages them in their own futures

planning process and provides them with developmentally appropriate services and supports. The TIP model involves youth and young adults, their families, and other informal key players in a process that facilitates their movement toward greater self-sufficiency and successful achievement of their goals related to each of the transition domains: employment and career, education, living situation, and community-life functioning, which is composed of subdomains such as daily living skills; friends, family, and other social supports; emotional adjustment and well-being; leisure time skills; physical health; and parenting. The TIP system is operationalized through seven guidelines that drive practice-level activities with young people and also provides a framework for program and community systems to support and facilitate this effort. These guidelines, refined from those published by Clark and Foster-Johnson (1996), are listed in Table 19.2.

The TIP guidelines synthesize the current research and practice knowledge base for transition facilitation with youth and young adults with SED/SMI and their families. The TIP model is a *practice model*, meaning that it can be delivered by personnel within different service delivery platforms such as care management or a team format (e.g., Assertive Community Treatment [ACT]). At the heart of the TIP practice model are proactive care managers with small caseloads (i.e., transition facilitators such as life coaches, transition specialists, or coaches that serve 15 or fewer youth or young adults). In operationalizing their transition systems, the five PYT sites either fully implemented the TIP model or adopted many of the guidelines. Each site was required to develop a logic model to provide a visual display of their transition system. A generic logic model for the TIP model is provided in Figure 19.1 to illustrate the TIP system components, some of the community contextual factors to be considered in implementation, and indicators of the planned outcomes or impact from the transition system.

**Table 19.2.** Seven Transition to Independence Process (TIP) system guidelines

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Engage young people through relationship development, person-centered planning, and a focus on their futures.
Tailor services and supports to be accessible, coordinated, developmentally-appropriate, and build on strengths to enable the young people to pursue their goals across all transition domains.
Acknowledge and develop personal choice and social responsibility with young people.
Ensure a safety-net of support by involving a young person's parents, family members, and other informal and formal key players.
Enhance young persons' competencies to assist them in achieving greater self-sufficiency and confidence.
Maintain an outcome focus in the TIP system at the young person, program, and community levels.
Involve young people, parents, and other community partners in the TIP system at the practice, program, and community levels.

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Reprinted from Transition to Independence Process web site, <http://tip.fmhi.usf.edu>.

*Note:* For more detail regarding the TIP model and its guidelines and associated practices, refer to the TIP System Development and Operation Manual at the TIP web site: <http://tip.fmhi.usf.edu>.

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## **PARTNERSHIPS FOR YOUTH TRANSITION COMMUNITY SITES**

The key features of the transition systems developed by each of the PYT sites are summarized in Table 19.3, which provides a cross-site view of the variation in target populations and activities across communities.

### **Clark County, Washington: Options Program**

As part of the Washington State mental health managed care system, the Clark County Regional Support Network was initially the mental health provider for all of Clark County. Since the 1990s, Clark County has built a family-driven system of care based on the principles of individualized and tailored care. Through the PYT initiative, Clark County built on its system base to create a comprehensive, integrated system for transition-age youth and young adults with SED/SMI through the: 1) adoption of the TIP model; 2) use of an ACT team involving a service delivery model in which treatment is provided by a team of professionals such as mental health care managers, a psychiatrist, a nurse, a substance use specialist, and a vocational rehabilitation counselor (Bridgeo, Davis, & Florida, 2000); and 3) an emphasis on the supported employment approach as a key component of the PYT program.

During the strategic planning process, PYT stakeholders and partners, including young people and family members, developed a unified PYT vision, clarified the strengths and challenges of the service system, and developed a theory-based logic model for its planned transition system. The initial priority target population of the transition system was youth with SED/SMI exiting the juvenile justice system.

From the start of the Clark County PYT planning process, the voice of youth and young adults was viewed as essential in the development and implementation of the innovative transition system. Young people were active participants on the Community Transition Steering Committee, and they led the process in establishing the name for the program—Options. During the planning phase of the PYT initiative, young people insisted that, to be effective, outreach and activities needed to occur in youth-friendly locations that had no overt affiliation with any of the public mental health facilities. The PYT leaders listened to young people's suggestions, and they were ultimately successful in locating the Options personnel in a beautiful Victorian house in the community known as the Youth House. The mission of the Youth House, as articulated by young people, is to encourage positive youth development through strengthening youth and adult relationships and to support efforts by and for youth. It is an inclusive, youth-friendly location that honors diversity and operates with joy.

Young people helped to develop the space within the Youth House, including some areas that adults can only enter when accompanied by young people. The Youth House provides other youth services, including a TeenTalk “warm line” phone support service and the Clark County Youth Advisory Commission for the County Commissioners. Thus, there is no stigma associated with young

### TIP General Logic Model

The mission of the Transition to Independence Process (TIP) system is to assist young people with SED/SMI in making a successful transition into adulthood, with all young persons achieving, within their potential, their goals in the transition domains of employment, education, living situation, personal effectiveness/well-being, and community-life functioning.

<b>Situation</b> Where we are	<b>Activities</b> What we do	<b>Who</b> Who is involved	<b>Outcomes-Impact</b> What the impacts will be long-term
<p><b>Youth</b> <i>Challenges:</i> Poor outcomes in: Education (e.g., high drop out rates, difficulties related to accessing specialized training or higher education programs) Employment (e.g., unstable employment) Living situation (e.g., homeless) Community life (e.g., involvement with juvenile justice, mental health, co-morbidity, adolescent pregnancy) <i>Assets:</i> Individual strengths &amp; good will</p> <p><b>Family</b> <i>Challenges:</i> Difficulties relating/communicating with young person leading to conflicts</p>	<ul style="list-style-type: none"> <li>Engage young people through relationship development, person-centered planning, and a focus on their futures.</li> <li>Tailor services and supports to be accessible, coordinated, developmentally-appropriate, and built on strengths to enable the young people to pursue their goals across all transition domains.</li> <li>Acknowledge and develop personal choice and social responsibility with young people.</li> </ul>	<ul style="list-style-type: none"> <li>Young people/young adults</li> <li>Youth councils</li> <li>Families &amp; family advocates</li> <li>Natural supports</li> <li>Peers/mentors</li> <li>Schools (e.g., teachers, social workers, nurses, principals, guidance counselors, administrators, in-service/ training personnel)</li> <li>Vocational schools &amp; institutions of higher education</li> <li>Formal providers (e.g., transition facilitators/ specialists, children &amp; adult mental health,</li> </ul>	<p><b>Youth</b> Goal attainment &amp; positive engagement in: <i>Education</i> (e.g., ↑ graduate and school completers, successful entry to post-secondary education programs—college, vocational technical school) <i>Employment</i> (e.g., obtain and retain valued employment; access to positions with advancement possibilities &amp; benefits; sufficient income to support self) <i>Living situation</i> (e.g., access to safe, stable and affordable community living arrangement, stability in living with a preferred person or alone/independently, access to transportation, satisfaction with living arrangement) <i>Community life</i> (e.g., engagement &amp; participation in community life/activities; access to community-based/integrated leisure/activities; access to needed support services; affordable health care; ↓ adolescent pregnancy; ↓ JJ involvement; ↑ social, physical and</p>

<p>Feeling young person is vulnerable/needs to be protected (e.g., how to let go, yet be supportive)</p> <p>Assets: Family strengths</p> <p><b>System &amp; community</b></p> <p><i>Challenges:</i> Ignorance of needs (e.g., health insurance, access to community-based services, self-advocacy skills) Stigma &amp; segregation (e.g., SED centers, jail) Gap of services (e.g., no low-cost housing available, different eligibility criteria) Lack of coordination &amp; flexibility (e.g., between youth serving agencies and adult systems, co-morbidity) Lack of knowledge/training (e.g., how to empower youth while being family-centered/focused)</p> <p>Assets: Dedicated staff Awareness of challenge Neighborhood resources Increasing levels of inter-agency collaboration Legislation Funding</p>	<ul style="list-style-type: none"> <li>• Ensure a safety-net of support by involving a young person's parents, family members, and other informal and formal key players.</li> <li>• Enhance young persons' competencies to assist them in achieving greater self-sufficiency and confidence.</li> <li>• Maintain an outcome focus in the TIP system at the young person, program, and community levels.</li> <li>• Involve young people, parents, and other natural and community partners in the TIP system at the practice, program, and community levels.</li> </ul>	<ul style="list-style-type: none"> <li>• health clinics &amp; physicians, probation officers)</li> <li>• Private agencies/practitioners</li> <li>• Employers</li> <li>• Housing</li> <li>• Parks &amp; recreation</li> <li>• Media</li> <li>• Community/resources development</li> <li>• Justice representatives/police</li> <li>• Government representatives—local, state and federal</li> <li>• Legislators/political representatives</li> <li>• Foundations/grants initiatives</li> </ul>	<p>emotional well-being; ↑ supportive relationships and life long family-like connections)</p> <p><b>Family</b></p> <ul style="list-style-type: none"> <li>↑ Competency for family members/representatives (e.g., self-efficacy)</li> <li>↑ Social support (e.g., maintenance of positive relationship with young person and others)</li> <li>↑ Positive relationship with young person &amp; others</li> <li>↑ Involvement/engagement in planning, implementing, evaluating activities at youth &amp; system levels.</li> </ul> <p><b>System &amp; community</b></p> <ul style="list-style-type: none"> <li>↑ Number of transitioning youth accessed and engaged</li> <li>↑ Linkages between youth, families, providers and community (e.g., flexible infrastructure/partnerships, data sharing)</li> <li>↑ Training and support for youth, family, providers and community (e.g., expanded eligibility to programs; development of required community-based supports and services)</li> <li>↑ Public support &amp; practices fostering opportunities for young people to succeed in 4 transition domains (e.g., flexible funding arrangements; inclusive policies and legislation)</li> </ul>
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**Figure 19.1.** Transition to Independence Process (TIP) generic logic model. (Reprinted from Transition to Independence Process web site, <http://tip.fmhi.usf.edu>) (Key: JU, juvenile justice; SED, serious emotional disturbances; SMI, serious mental illness.)

**Table 19.3.** Overview and highlights of the transition systems in the Partnerships for Youth Transition sites

Site	Target population	Goal	Program characteristics and activities
Clark County Department of Community Services in Vancouver, Washington (Options)	<p>Youth and young adults ages 14–21 with serious emotional disturbances (SED) or serious mental illness (SMI), and then may continue serving up to age 25</p> <p>Emphasis on youth who are in, or at imminent risk of, an out-of-home placement (e.g., incarceration, hospitalization, homelessness)</p> <p>Most were initially involved with an established wraparound team in juvenile justice system</p>	<p>Develop an effective approach to supporting youth with complex needs and their families as they complete their transformation to adulthood, based on an investigation of best practices.</p>	<p>Theory-based logic model</p> <p>Adoption and adaptation of the Transition to Independence Process (TIP) system to their community</p> <p>Strong commitment to implementing positive youth development principles and practices</p> <p>Options services and supports provided by TIP team operating out of a Victorian Community Youth House</p> <p>TIP model and supported employment</p> <p>Continuous quality improvement using data to inform their management and broader decision-making</p>
Allegheny County Department of Human Services, Pennsylvania (PYT-SOCI sites)	<p>Youth and young adults ages 14 to 21 with SED or SMI, and then may continue serving up to age 25</p> <p>Priority given to serving their families in the communities of Sto-Rox and Wilkinsburg, two municipalities with economic challenges that border the City of Pittsburgh</p>	<p>Obtain productive employment, safe living situations, community involvement, including satisfying social relationships, and cultural and ethnic integration.</p>	<p>Two distinct programs, each located in a community setting with support and oversight from one central office</p> <p>Integration of the TIP and system of care (SOC) principles to create a developmentally appropriate system of supports and services for these young people</p>

<p>Authentic community-driven practice: youth, family, community, and system partnerships</p> <p>Value-based service delivery process</p> <p>Connecting to and strengthening of community resources</p> <p>Youth involvement, including paid positions for young people at the community and administrative levels</p> <p>Continuous quality improvement</p> <p>Multidisciplinary team of professionals</p> <p>Located at the Career Center</p> <p>Early identification of needs</p> <p>Linkages with medical services</p> <p>Transition Linkage Coalition (TLC)</p> <p>Supported employment</p> <p>Educational component: mentors and anatomy of leadership.</p> <p>Support/services offered to family members</p> <p>Implemented in four rural counties (three community mental health centers)</p>			
		<p>Youth and young adults ages 14–21 with SED or SMI, and then may continue serving up to age 25</p> <p>Selection of those with first-time hospitalization in a psychiatric treatment facility</p>	<p>Increasing educational achievement and employment for youth is a desired result for young people because of the rationale that work plays a central role in the lives of adults.</p>
<p>Department of Behavioral and Developmental Services and Maine Medical Center, Portland, Maine (Odyssey)</p>			<p>Assist youth and young adults with mental health needs to successfully transition into adulthood.</p>
<p>PACT-4 Families Collaborative in Willmar, Minnesota (PRIDE-4)</p>		<p>Youth and young adults ages 14 to 21 with SED or SMI, and then may continue serving up to age 25</p>	<p>(continued)</p>

**Table 19.3.** (Continued)

Site	Target population	Goal	Program characteristics and activities
PACT-4 (continued)	<p>Served across a four county rural area</p> <p>Priority given to youth who need to complete their high school education requirements or are in immediate need of a place to live</p>		<p>Adaptation of SOC and TIP system guidelines</p> <p>Family liaison – family involvement staff – assists parents of program participants in obtaining information and support</p> <p>Youth involvement</p> <p>Collaborative of more than 100 agencies</p>
Utah Department of Human Services (RECONNECT)	<p>Youth and young adults ages 14–21 with SED or SMI, and then may continue serving up to age 25</p> <p>Priority on three subgroups:</p> <ol style="list-style-type: none"> <li>1. Traditional community mental health center (CMHC) clients (Medicaid eligible, youth in custody)</li> <li>2. Nontraditional CMHC clients: (GLBTQ, homeless, physical disabilities)</li> <li>3. Underserved (currently receiving services at CMHCs, but at an inadequate level—ethnic/racial minorities, refugees, deaf/hearing impaired, and youth as parents)</li> </ol>	<p>Mobilize and coordinate community resources to assist youth to successfully transition to adulthood and achieve full potential in life.</p>	<p>Implemented in five community mental health centers serving an 11-county catchment area</p> <p>Adaptation of SOC and TIP system guidelines</p> <p>Transition Facilitators were also trained as job coaches</p> <p>Use of Ansell-Casey Life Skills Assessment</p> <p>Youth Action Council (YAC)</p> <p>“Growing Up Without Growing Apart” curriculum for parents and family members</p> <p>Plan is for the demonstration to lead to the application of the transition system in communities throughout the state. This replication is occurring.</p>

Key: GLBTQ, gay, lesbian, bisexual, transgender, or questioning youth.

people entering this facility. The Options' team includes a project manager, a youth coordinator, transition facilitators, and a job developer to assist youth in establishing and achieving goals across the transition domains of employment and career, educational opportunities, living situation, and community-life functioning.

As noted, the Options transition system was originally based on the three foundations—the TIP model, ACT, and supported employment. Over the course of system implementation, it was found that the TIP model, with its employment-oriented transition facilitators, was the most effective and economically feasible model to sustain. A job developer was maintained, and an employment specialist position was converted to create another transition facilitator position. The Options leadership and stakeholders also determined that the TIP model delivered through a care management platform (i.e., each transition facilitator being assigned a specific set of youth) was more compatible with serving the targeted youth population than through an ACT model platform (i.e., the treatment team care managers serve all of the youth and the team also includes a psychiatrist and nurse). The leadership and stakeholders determined that they wanted the TIP practices delivered through a platform that maximized the relationship features of the transition facilitator–youth dyad.

The Options transition system is guided heavily by youth voice, and as such, the system continues to be engaging and nonstigmatizing for youth and young adults with SED/SMI as they pursue their transition goals. An illustration of the types of services and supports provided through Options and the other transition sites is provided in the story of Kendra in Box 19.1.

### **Allegheny County, Pennsylvania: Partnerships for Youth Transition–System of Care Initiative Sites**

Having developed a system of care for children and families under a previous SAMHSA grant, Allegheny County leaders were eager to demonstrate that some of the features of their system of care initiative (SOCi) could be used to benefit young adults with SED/SMI as they made the transition to adulthood. They focused on three primary features of their SOCi: 1) youth, family, community, and system partnership; 2) the value-based service delivery process; and 3) continuous quality improvement. During the planning phase of their PYT-SOCI, focus groups were conducted with young people who endorsed aspects of the SOCi and advocated for elements of the TIP model. The planning process with the youth and young adults, as well as other stakeholders, led to the integration of TIP and SOCi values and practices to create a developmentally appropriate transition system capable of meeting the diverse needs of this population of young people and their families.

The Allegheny County PYT-SOCI was implemented in two communities with economic challenges that border the City of Pittsburgh, namely the neighborhoods of Sto-Rox and Wilkinsburg. Young people ages 14–21 with SED/SMI were enrolled in the PYT-SOCI programs with proactive support and services also offered to their families. Service could be continued to age 25 for those who were still in need.

**Box 19.1.** Description of a young person, illustrating how a transition system functions

Kendra, a 17-year-old-girl diagnosed with bipolar disorder, refused to take her prescribed medications. Her use of street drugs may have been her way of self-medicating. Although she was in high school, her attendance, disciplinary record, and grades were all on the edge. Ronda, Kendra's transition facilitator, began meeting with her in comfortable settings such as Starbucks and neighborhood parks. As they took walks together, Ronda began conducting informal strength discovery assessments and person-centered planning. During the first 6 weeks, Ronda was earning Kendra's trust and learning about her interests, strengths, needs, resources, challenges, dreams, and social connections by speaking to her and to her mother and an older sister, who also lived at home. During this period, Ronda was also prompting, cajoling, and supporting school attendance, as well as teaching Kendra ways to manage her anger when she was faced with someone who was intimidating or teasing her.

School remained a major challenge, and Kendra continued to use drugs on occasion. She also experienced episodes of severe depression. Although she seemed to be developing more of a trusting relationship with Ronda, Kendra refused to attend any therapy or medication reviews. Ronda continued to reach out to her, and after about to two-and-a-half months, Kendra revealed that the loss of her grandmother a year earlier had been devastating to her because she was the only family member who Kendra found to ever express that she loved her. Ronda also learned through the informal strength discovery conversations that Kendra dreamed of being a nurse, as her grandmother had been.

Based on this new information, Ronda worked with Kendra to explore how she could improve her sense of family with her mother and her older sister, as well as explore the options she'd have in the nursing profession. Ronda arranged for Kendra to visit the community college program for nursing and meet with the program coordinator. The program coordinator gave Kendra a tour, discussed program options, and arranged for Kendra to sit in on some classes to get a feel for the subjects being studied and to meet some of the students. Kendra was very inspired by what she experienced and learned about the associate's degree program option.

Concurrently, Ronda and Kendra met with a mental health therapist to see if Kendra would be willing to engage in individual therapy and try a new type of medication that might not have the side effects that she had experienced previously. She reluctantly began attending individual therapy twice per week, often asking Ronda to attend with her. Over the course of the next month, Kendra was stabilized on a new medication and decided to expand her therapy to include her mother and sister in an attempt to create a sense of family.

Ronda worked with Kendra on composing a résumé and developing interview skills so that she might obtain a receptionist position at a doctor's office for the summer. Ronda had also learned from conversations with Kendra and her mother and sister that Kendra and her sister used to enjoy roller skating when they were younger. Ronda asked Kendra and her sister if they wanted to do some in-line skating at the local rink. The two sisters enjoyed their time together at the rink and began to spend more time together.

Now in her senior year of high school, Kendra is working, making good progress toward completing high school, taking one class at the community college, making some new friends there, and living with a better sense of family. Ronda facilitated this through informal strength assessments and person-centered planning that engaged Kendra and revealed her strengths, needs, and dreams. Ronda then provided tailored supports and services to assist Kendra in addressing her needs and achieving her goals. This process has allowed Kendra to find a new trajectory for her life and future.

The SOCI central office team and teams from the two partner communities developed an authentic community-driven partnership with youth, families, parent advocates, and representatives from community and faith-based organizations, as well as from the formal systems of education and special education, vocational rehabilitation, housing, child welfare, and child and adult behavioral health, including the area's managed care organization. Both of these communities are ethnically diverse and economically challenged. This community-driven partnership works to carry out a common vision and build on the SOCI infrastructure and the TIP model to support youth and young adults in meeting their goals of productive employment, career education, safe living situations, and community involvement, including satisfying social relationships.

The PYT-SOCI transition systems in both Sto-Rox and Wilkinsburg are designed to facilitate access to transition-relevant services and supports for young people and families in the communities where they live. Informal networks of support are essential in these communities, as formal services there are in need of better coordination and not trusted by many youth and adult residents. Thus, the PYT-SOCI supports and services provided include:

- Strengths, needs, and cultural discovery assessments
- Support and assistance in the development and maintenance of a consumer and family support team
- Consumer-directed service and support planning, coordination, and implementation
- Transition planning and goal setting
- Crisis and safety planning
- Support and assistance with housing and other needs (e.g., health insurance, food, clothing, transportation)
- Support and assistance with vocational and educational needs (e.g., college and financial aid applications, linkage to vocational training)
- Support and assistance with employment needs (e.g., assistance with résumés, job coaching, training, career counseling)
- Linkage to appropriate mental health services and supports (e.g., evaluations, psychiatric services, counseling)
- Monitoring mental health services and supports and progress
- Social connection and informal supports through youth and young adult peer support groups, mentoring, recreational activities, and linkage to community resources and natural supports for youth and families (e.g., YMCA, church groups, community organizations)

Commitment to youth involvement is evident at all levels of the Allegheny County PYT-SOCI. Two extremely powerful youth features evolved out of the

community planning process that encouraged youth voice and leadership. A young adult from the community who was actively involved in the planning process emerged as a leader. During the second year, this young person was hired as the Youth Support Coordinator for the PYT-SOCI sites and also as the NCYT Youth Representative to increase the youth perspective on a national level. The PYT-SOCI also promotes youth leadership through the Youth Outreach Union (Y.O.U.). Y.O.U. grew out of the planning process for this initiative. It was formed by young people to utilize the strengths and experiences of youth leaders within the mental health system to assure that current and future generations in Allegheny County could obtain the information and support needed to become successful adults. The goal of Y.O.U. is to create opportunities for young people to socialize, discuss mental health concerns and issues, organize recreational and educational activities, and serve as leaders in their communities. The PYT-SOCI transition facilitators and youth support specialists in Sto-Rox and Wilkinsburg work closely with young people to secure their voice in guiding and refining all aspects of the transition system.

Accountability and quality assurance within the Allegheny County PYT-SOCI is evident in its structure, as well as in its use of evaluation tools and measures. Structurally, the PYT-SOCI was designed for accountability by hiring young people and family members as staff members, as well as by ensuring that young people and family members participate in decisions about operations, programming, and fiscal management. Furthermore, both the Sto-Rox and Wilkinsburg offices made a commitment to recruit and hire qualified individuals from these communities. By virtue of living and working in these communities, the PYT-SOCI teams are held accountable by their fellow community members, as well as by the continuing quality improvement features of the initiative.

Throughout the years of the cooperative agreement, those involved with the PYT-SOCI program developed and conducted a variety of user-friendly assessments that reflect the youth and family members' point of view. To make these assessments and related instruments accessible to and relevant for program participants, the PYT-SOCI involved young people and family members in the development and modification of instruments by engaging them to serve on the Youth Think Tank Quality Improvement Committee and by compensating them as partners in the development of these tools. Young people and family members were also compensated for their contributions when completing optional assessments that were used to evaluate programmatic outcomes.

In collaboration with the developer of the Child and Adolescent Needs and Strengths (CANS; Lyons, Sokol, & Lee, 1999), the site evaluator and the Youth Think Tank modified the CANS to create an assessment tailored to transition-age youth. The instrument is referred to as the Young Adult Needs and Strengths Assessment (YANSA). A link to the YANSA is available through the NCYT web site at <http://ncyt.fmhi.usf.edu>.

The Allegheny PYT-SOCI periodically publishes reports to illustrate the challenges, successes, and impact of the program. One such publication is the biannual outcome report entitled *Making Waves*, featuring progress on PYT-

SOCI milestones and outcomes. This PYT-SOCI has established a recommended practice of consulting with young people and families in the development of such reports, giving them the opportunity to share personal stories that enhance the interpretation of the data and to provide valuable insight into the design of youth and family-friendly publications.

### **Portland, Maine: The Odyssey Program**

The Odyssey program focuses on a group of young people who are most difficult to serve—those between the ages of 14 and 21 with SED/SMI at the point of their first hospitalization. The goal of this PYT program is to increase the number of graduates from high school and college, increase employment rates for this population of young people, and decrease homelessness, substance abuse, and criminal activity. By targeting youth and young adults experiencing a first hospitalization, the Odyssey program is able to intervene early and track outcomes within a particularly vulnerable group of young people as they transfer back to school, work, and family life.

To increase opportunities for these young people, the project operates at both the programmatic and systemic levels. At the programmatic level, the Odyssey program focuses on inspiring and supporting young people to achieve their education and career goals. The program promotes the message that hopes and dreams can be realized beyond hospitalization. To assist program participants, the Odyssey team applies a comprehensive set of strategies that include multidisciplinary assessment; futures planning; referrals to relevant services; and transition supports and services focused on mental health treatment, education, employment, independent living, and social support.

At the heart of the Odyssey program are transition specialists to whom each young person and his or her family are assigned. The Odyssey team also includes an interdisciplinary group of professionals with expertise in employment, social work, psychiatry, psychiatric nursing, occupational therapy, and education. The team is structured to meet regularly to share information on each young person and his or her family and on available community resources. The team assists participating youth and their families in gaining access to needed resources such as employment opportunities and housing.

At the systemic level, the Odyssey program builds on existing resources to develop a comprehensive program for this population of young people and their families. An array of services offered through this PYT initiative allows these individuals maximum access to community supports, which minimizes their penetration into the mental health system. The Odyssey team is located in a local career center to minimize stigma and to allow easy access to personnel who provide employment-related services and who know how to maneuver the arena of vocational rehabilitation services, funding, and supports. A Mental Health Employer Consortium was established that meets on a quarterly basis to generate education, work, and career opportunities for program participants. The Odyssey program also taps into existing high school programs to secure services relevant to partici-

pants, including a student mentoring program and services offered through the Office of Multilingual and Multicultural Programs, the Anatomy of Leadership program, and Jobs for Maine's Graduates.

The Odyssey team works with representatives from various transition-related agencies by participating on the Transition Linkage Coalition (TLC). The TLC community forum was created to enable service providers to collaborate to improve and better integrate service delivery. It enables community agencies and organizations to identify solutions to existing and perceived barriers to service delivery for transition-age youth. The group meets regularly to secure information regarding barriers at the practice, program, or system levels. Priority issues are assigned to different time-limited subcommittees known as solution teams. Each solution team meets monthly to define a target issue, learn more about the specifics of the issue, and formulate a proposed action plan to address this priority issue at the practice, funding, policy, or system level. The TLC forum then determines which of these action plans, or parts therein, to implement immediately and which to implement on a long-term basis.

### **Minnesota: PRIDE-4**

The Putting All Communities Together (PACT) 4 Families Collaborative is a system of care serving four rural counties in Minnesota. When the opportunity arose to apply for federal funding, family members persuaded PACT leaders and staff members that services and supports for young people ages 14–21 were desperately needed. With the PYT grant funds, Minnesota's PACT-4 Families Collaborative—comprising 110 organizations, agencies, and community partners—created a transition program to serve their four-county rural area. They named their initiative Persons Realizing Independence and Developing Empowerment (PRIDE-4), a name created by a young man who contributed to the design of the program. With the addition of this initiative, the PACT-4 Collaborative offers an array of mental health services spanning from birth to adulthood, an unusual accomplishment for a rural area.

PRIDE-4 was the first PYT site to draft a logic model to encompass the area's vision of fostering healthy and safe communities where individuals, families, and youth care and support one another. As can be seen in their logic model shown in Figure 19.2, PRIDE-4 encompasses elements of the TIP system and features young people surrounded by layers of nurturing and supportive opportunities that begin with the family and then circle wider to include the broader community and other service systems. The logic model also reflects a commitment to assist youth and young adults across all of the transition domains of employment and career, educational opportunities, living situation, and community-life functioning.

PRIDE-4's logic model is brought to life by pairing every young person with a transition facilitator referred to as a coach. The coaches, along with other PRIDE-4 staff members (i.e., project coordinator, clinical supervisor, family liaison), support each young person in identifying his or her transition goals and coordinating the community supports and resources needed to meet the needs and challenges identified through the individualized service planning process.

As the TIP guidelines indicate, coaches engage young people through relationship development, person-centered planning, and a focus on their futures by meeting with young people individually, conducting strength discovery assessments, assisting them in setting short- and long-term goals, and coordinating services and supports accordingly. The coaches act as hubs for a wheel of opportunities and resources. Being in rural areas with few formal services, each coach works with 12–15 young people to determine an appropriate set of activities and interventions for assisting each in learning new skills and achieving his or her desired goals. These interventions may include teaching improved social skills, guiding young people through the process of securing their driver's licenses, helping young people prepare for and attend the high school prom, creating occasions for young people to get together and socialize at the bowling alley, and securing and maintaining their first jobs. Mental health services and supports are provided by local mental health service providers.

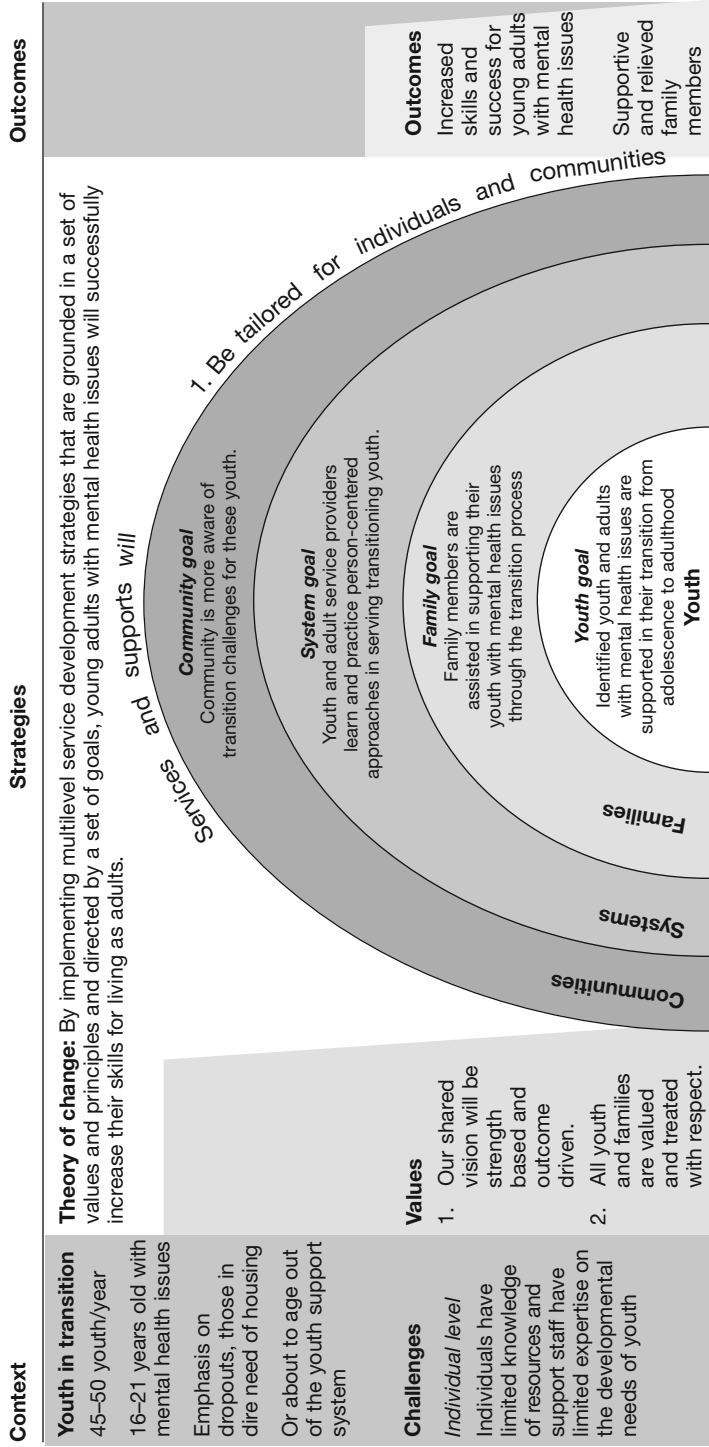
Through this PYT initiative, PRIDE-4 made connections with system partners that resulted in many new opportunities for young people to make successful transitions to adulthood. For example, in conjunction with Goodwill Industries, PRIDE-4 formed a Job Club that provides opportunities for young people to acquire job readiness skills such as interviewing techniques, résumé writing, and job searching. PRIDE-4 also partnered with other agencies and organizations to improve transition opportunities by securing funding to provide new housing options for young adults in the form of scattered-site apartments. PRIDE-4 also partnered with the juvenile justice system on a restorative justice initiative called Community Sentencing Circles. Through this effort, which involves the County Attorney's Office, the local police departments, the District Court, the Public Defenders Office, and the PACT-4 Families Collaborative, judges remand young people to PRIDE-4 as a sentencing option. This alternative system reports a zero recidivism rate.

PRIDE-4's implementation of the TIP model includes a family liaison position in addition to the coaches. The role of the family liaison is to support young people's family members in their understanding of the transition process and to assist them in securing other services that the family might need, such as employment or substance abuse treatment. The coaches and the family liaison coordinate their activities as necessary to ensure continuity for the young person and other family members.

## **Utah: Project RECONNECT**

Project RECONNECT was named through a youth-driven contest and stands for Responsibilities, Education, Competency, Opportunities, Networking, Neighborhood, Employment, and Collaboration for Transition. Project RECONNECT is a statewide initiative that was initially implemented across five community mental health centers (CMHCs), serving 11 counties in the Greater Salt Lake metropolitan area and associated rural communities. Most of the young people served are between the ages of 16 and 21 and come from culturally and

**Mission:** Pride-4 will work at multiple levels to further the PACT-4 Families version of “healthy and safe communities where individuals, families, and youth care and support each other” by assisting youth and young adults with mental health needs to successfully transition into adulthood.



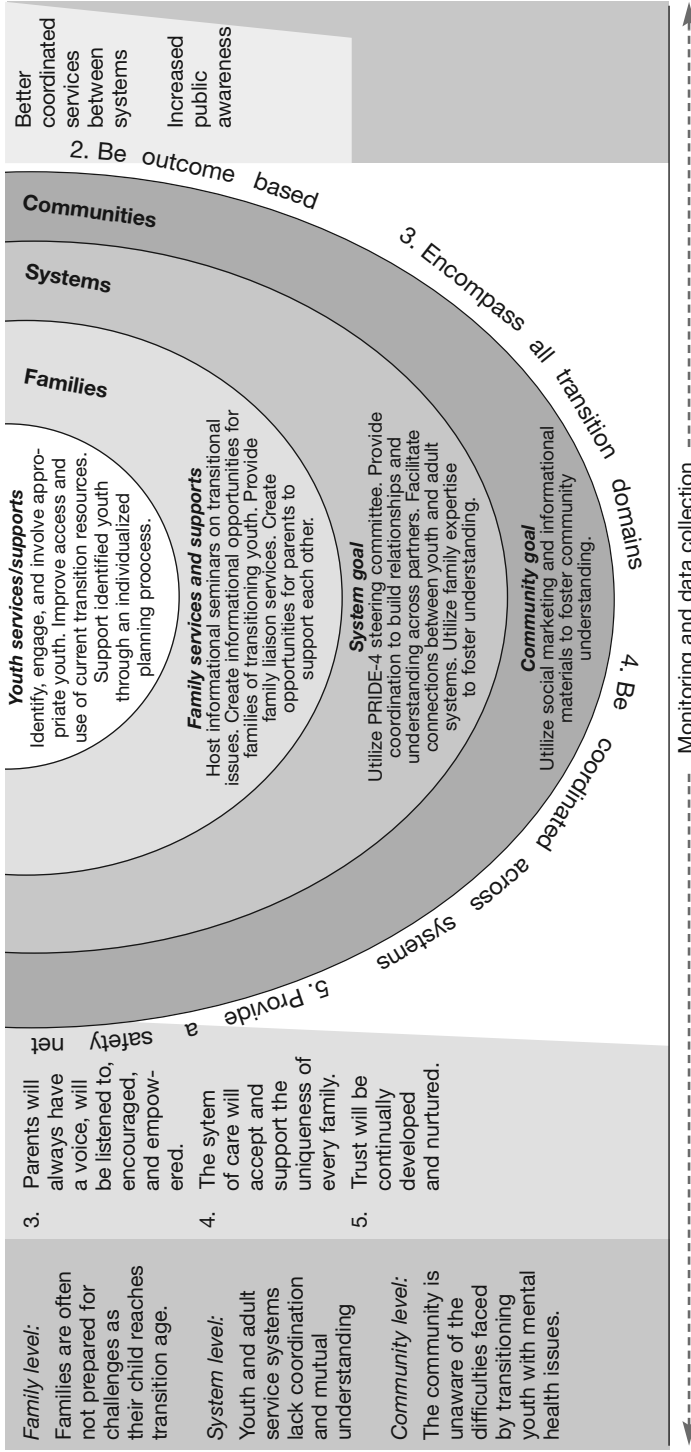


Figure 19.2. PRIDE-4 theory-based framework.

ethnically diverse backgrounds. In addition, at least half of the young people served are from populations that are typically underserved and overlooked (i.e., homeless youth, children from immigrant families, youth who are state custody dependents, or very young parents with small children).

Transition facilitators and their supervisors received training to implement the TIP model. The transition facilitators were also trained and certified as job coaches to help strengthen their employment support expertise. They serve as a young person's primary contact, and in their roles as resource brokers, they help to ensure that services, supports, and informational resources are coordinated. The transition facilitators use informal assessments such as strength discovery (Blase, Wagner, & Clark, 2007) and the Ansell-Casey Life Skills Assessment (Ansell & Casey Family Programs, 2000) to assist youth in the development of individualized plans based on their strengths and needs (e.g., finding safe and affordable housing, securing jobs, learning to manage anger, dealing with feelings of loneliness, completing paperwork for U.S. citizenship to pursue postsecondary education and employment opportunities in this country).

To support this youth-centered approach to transition, Project RECONNECT has an active Family Council led by Allies with Families, Utah's chapter of the Federation of Families for Children's Mental Health. Through Allies with Families, parents and family members participate in educational workshops and retreats. In addition, Allies with Families offers support to family members affected by their youths' mental health concerns, even if the young people in their lives are not officially involved in Project RECONNECT. Another contribution of Allies with Families was the development of a curriculum aimed at assisting families and parents during their children's transitions to adulthood. The curriculum provides classes on topics ranging from guardianship and person-centered planning to developmental issues and milestones associated with the transition period. The curriculum entitled *Growing Up Without Growing Apart* is available through the NCYT web site at <http://ncyt.fmhi.usf.edu/partnerships/index.htm>.

Project RECONNECT also brings young people together, depending on their interests and time availability, through Community Youth Action Councils (CYAC) convened by each of the four CMHCs and a statewide Youth Action Council (YAC). The community councils provide young people with opportunities to participate in leadership training, learn life skills, expand their network of peer supports, carry out community service and fundraising projects, take on collective action projects, and otherwise pursue their interests individually and in groups. One example of how influential these councils are is demonstrated by two enterprising young men and their peers. These young men conducted a 3-month community resource mapping project, which led them to draft a business proposal with a local foundation to purchase two real estate properties to create housing options for young people. The foundation funded the proposal, and the properties were purchased, renovated, and converted into housing complexes for young people. The statewide YAC brought great visibility to many issues related to transition-age young people. The governor established a Transition to Adult Living initiative led by the Department of Human Services and Project RECONNECT, which also involved various statewide task groups focused on recommen-

dations regarding the development of living skills, physical and mental health, mentoring, employment, and housing. The governor's initiative, in conjunction with the statewide and local councils, made numerous recommendations regarding practices, funding, and policy during the course of this initiative.

Project RECONNECT is approaching sustainability of this transition initiative by building on and enhancing the relationships within and outside the existing mental health infrastructure across its communities and counties. The TIP model laid the framework for Project RECONNECT to build and expand partnerships across the mental health system and other public and private provider agencies and organizations. Allies with Families enhances family involvement during this transition to adulthood period. The Project RECONNECT transition initiative developed through the PYT initiative in Utah is transformative in its approach and enhances the delivery of child- and adult-serving services at the practice, program, and policy levels.

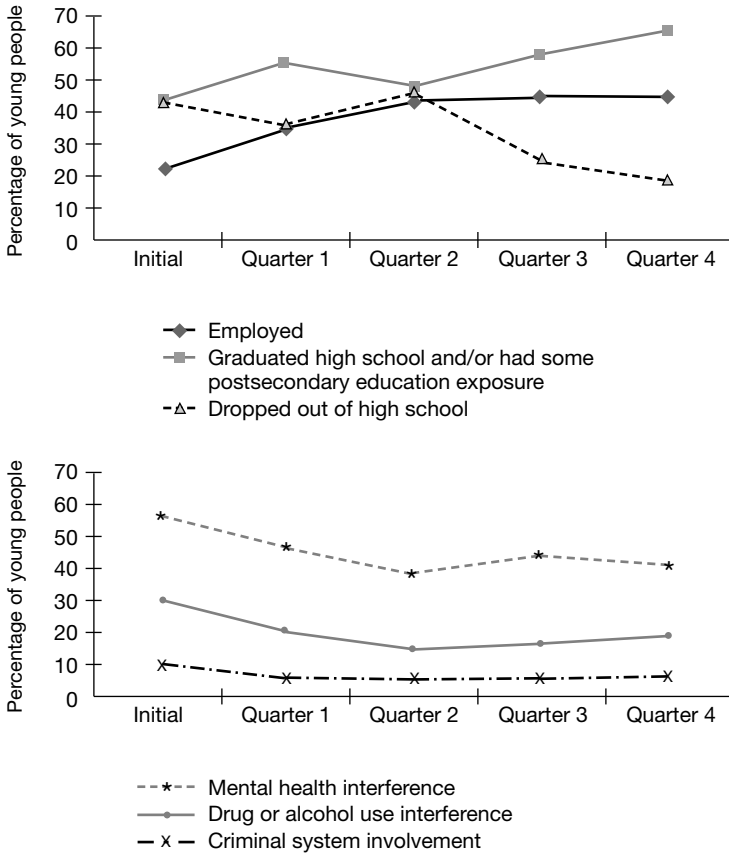
## **COMMUNITY TRANSITION SYSTEMS: FINDINGS AND LESSONS LEARNED**

### **Preliminary Findings**

The NCYT team conducted a cross-site analysis of the PYT projects. The preliminary findings from a group of 192 young people who were involved with their sites for at least 1 year are encouraging (Clark, Karpur, Deschênes, Gamache, & Haber, 2008). Initial findings revealed that an increasing proportion of the transition-age youth improved over time in six major outcome areas. The young people were more likely to be employed and more likely to be pursuing high school or postsecondary education. They were less likely to have dropped out of high school, less likely to experience interference in their lives from their mental health conditions, and less likely to experience interference from drug or alcohol use. These improvement trends were statistically significant across the year of enrollment in the PYT programs. Although involvement in the criminal justice system showed a slight decrease from the initial assessment, this trend over all of the assessments was not statistically significant.

These improvements across the transition progress indicators are illustrated in Figure 19.3 for the first five assessments (i.e., Initial Baseline at intake through Quarter 4 assessment) conducted on each participant. The asterisks on the outcome legends indicate that these are statistically significant trends.

Young adults with SED/SMI have the poorest outcomes of all people with disabilities as they enter adulthood. Still, these PYT findings, as well as others (e.g., Karpur, Clark, Caproni, & Sterner, 2005), have shown that outcomes for these young people can improve with futures planning that builds on their strengths, interests, and goals. Developmentally appropriate services and supports tailored to help this population of young people can facilitate goal achievement, enhance their social and life skills, and strengthen their connections to important people in their lives. Additional information on progress and outcome studies can be found in the Theory and Research Section of the TIP web site at <http://>



**Figure 19.3.** The percent of young people exposed to each of six outcome indicators of progress at the initial baseline assessment prior to entry to a transition program and the trends across the four 90-day assessments after entry. (From Clark, H.B., Karpur, A., Deschênes, N., Gamache, P., & Haber, M. [2008]. *Partnerships for Youth Transition [PYT]: Overview of community initiatives and preliminary findings on transition to adulthood for youth and young adults with mental health challenges*. In C. Newman, C. Liberton, K. Kutash, & R.M. Friedman [Eds.], *The 20th annual research conference proceedings: A system of care for children's mental health: Expanding the research base* [pp. 329–332]. Tampa: University of South Florida, The Louis de la Parte Florida Mental Health Institute, Research and Training Center for Children's Mental Health; reprinted by permission.)

tip.fmhi.usf.edu. In addition, the NCYT has developed the Fidelity Protocol for Continuing Improvement of Transition Systems (Deschênes, Clark, & Herrygers, 2008); a description of this protocol and its process is provided on the NCYT web site at <http://ncyt.fmhi.usf.edu>.

### Lessons Learned from the PYT Initiative

Many lessons have been learned from the experience and evaluation related to the PYT initiative, providing valuable guidance for communities and states seeking to improve services for youth and young adults in transition to adulthood:

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- Young people with SED/SMI can be engaged through relationship development, person-centered planning, and a focus on their futures.
  - Transition facilitators and other program personnel who use informal strength-based assessments rather than traditional formal assessments that tend to be deficit-based are more likely to engage a young people.
  - Services must be provided in youth-friendly, nonstigmatizing community environments (e.g., at home, over lunch, in school, in a park).
  - Young people with SED/SMI have many dreams as they make the transition to adulthood. With informal and formal supports, young people can develop goals and become successful in the transition domains of employment and career, educational opportunities, living situations, and community-life functioning.
  - The period of transition to adulthood is one of discovery, one where many young people tend to take risks. Young people are capable of being strong, responsible community members. Competency-building approaches allow them to make wiser choices and help them to achieve greater self-sufficiency and confidence.
  - Young people can be instrumental in assisting in the planning and implementation phases of community transition initiatives that are relevant to them. Involvement of young people in these processes requires the use of youth-friendly strategies. Some of these strategies include stipends for their services and understanding that youth might not be willing to sit through 2-hour meetings. They will, however, be actively involved for the first hour with the agenda shifted to include the youth-relevant items early on. Of course, pizza always helps!
  - The development and implementation of community-based transition systems can inform already existing practices and policies that support the belief that young people with SED/SMI are able to discover and recover.
  - Advancing the PYT initiatives required champions. Some of these people were adults and others were young people, but they were all transformative.
  - Sometimes system barriers are myths that are not grounded in reality. For example, in one of the PYT sites, a barrier to services was that the bureaucracy consistently indicated that a particular set of funds was only available to serve a certain age group. This proved to be a myth due to changes in state law that had been put into place a number of years prior, but had seemingly gone unnoticed by the bureaucrats and system providers. Thus, funding was available up to 21 years of age and not terminated at 18.
  - Younger teens between the ages of 14 and 16 seem to require activities that differ from those implemented for the greater majority of young people between the ages of 16 and 21. As the PYT initiative unfolded, it became appar-

ent that the process and types of activities selected by more mature young adults were less appropriate and beneficial for younger adolescents. Systems of care should consider implementing a different set of transition strategies for young people ages 14–16 such as greater family involvement or enhanced efforts of high schools to address transition issues (e.g., daily living skills, budgeting).

## CONCLUSION

The PYT initiative provided a rich learning experience both for community stakeholders and national partners. There were many examples of the significance of youth voice in the planning, implementation, and sustaining phases of the PYT experience. Site stakeholders also found that the transition arena was inherently transformative to their child- and adult-serving systems in that it was typically the first time that they had ever confronted and coordinated activities across both sectors. Community leaders and stakeholders, however, should understand that developing a meaningful and effective transition system is an extremely challenging task, but one that holds great rewards for all if a collective, serious, and explicit commitment is made to the needs of young people and to ensure the presence of their voice in system planning and service delivery.

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