Chapter Seven

Youth Voice and Transition Services

Youth Involvement in Infrastructure of Systems of Care: Policy Implications

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Introduction

Involving youths in the services they receive is an emerging phenomenon that still faces resistance but is becoming increasingly accepted. Youth report significant benefits associated with their involvement, such as developing positive relationships with adults, learning responsibility and new skills, and feeling positive about themselves and contributing to their community (Linetzky, 2000; Quinn, 1995). When youth participate in an organizations' activities and decision-making, adults who work with the youth develop improved perceptions of youth and become increasingly engaged in their organizations and communities, and organizations are better able to target programs to youth needs and use youth as effective spokespeople for fundraising (Zeldin, McDaniel, Topitzes & Calver, 2000).

Recognizing the value of youth involvement, the Substance Abuse and Mental Health Services Administration (SAMHSA) mandated youth involvement in all SAMHSA-funded system-of-care communities that have been awarded grants since FY2002. While the mandate specified that all of these systems of care were required to hire a youth coordinator, the details of the youth coordinators' role and the nature of youth involvement were left vague (Department of Health and Human Services, 2002). Consequently, each system of care is working to determine what youth involvement will mean in its community and how this involvement will be implemented, or continue to involve youth if they already did so pre-funding.

The national evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program (CMHS) has included a longitudinal assessment of the status of youth involvement in systems of care. The first stage of this assessment involved focus groups with youth coordinators and youths from across the nation. The findings from these focus groups shed light on how youth (a) are currently engaged in their communities, (b) have areas of absent or minimal involvement, (c) see challenges to youth involvement and strategies, and (d) benefit from being involved in their systems of care. The role of youth coordinators in developing youth involvement is a significant factor that is examined. The focus group findings were used to increase awareness, and inform the youth interview that will be piloted with selected communities with the final version administered longitudinally to youths in all Federally-funded systems of care as part of the CMHS national evaluation.

Methodology

Between May and October 2004, focus groups were conducted with youth coordinators and youths from system-of-care communities funded between 1999 and 2003. As part of the three-stage process for a youth-centered methodology, there were two types of focus groups (Ginsburg, Alexander, Hunt, Sullivan, & Cnaan,2002; Moore, 1987; Robinson, 1999). First, in the planning stage, there was an exploratory focus group teleconference with a few youth and youth coordinators who shaped topic areas for the more exploratory focus groups. This focus group helped guide and provide ideas around how youth were involved in their systems of care.

In the second phase, themed focus groups were held with youth and youth coordinators. The two youth coordinator discussions were held at a national system-of-care meeting and a national youth coordinators training conference. A total of 11 youth coordinators representing systems in varying stages of development and diverse geographical areas participated in the discussions. The topics discussed

in these focus groups were (1) the role of youth coordinators and youth in their systems of care, (2) the challenges that youth coordinators confront in conducting their work and in trying to get youth involved, and (3) strategies for addressing the challenges, and all were held to approved institutional review board standards. This included obtaining consent, having different themes in each focus group, and a standard introduction. One youth focus group was conducted at a national system-of-care conference, and the remaining two youth focus groups were held in system-of-care communities. A total of 22 youths (ages 14-22; 6 White, 16 African American/Black) participated in these focus groups. Topics covered in the youth discussions were youth groups, and youth involvement in the infrastructure (e.g., governance, conducting of trainings, quality monitoring) and service components of systems of care. Each focus group lasted 1.5 hours and participants were compensated $50 for their participation (youth coordinators received gift cards and youths received cash). Thematic analyses were conducted using Atlas.ti (Muhr & Friese, 2004). The result of these analyses guided the development of a mixed-methods instrument that would be used in the third phase—the pilot study—to test validity and reliability (Delbecq, Van de Ven, & Gustafson, 1975).

Findings

Consistent patterns about youth involvement emerged from the youth and youth coordinator focus groups. Both types of respondents identified youth groups as the key mechanism for youth involvement, and it was heavily stressed that these groups need to have a strong social emphasis. Primarily because of issues related to stigma, youth resist joining groups that are about emotional and behavioral problems. However, the youth do appreciate the opportunity to discuss their problems and get emotional support from other youths and staff within a context of coming together to form friendships and participate in fun activities.

Youths who are involved in youth groups derive significant benefits from the experience. They value the support they receive from their peers and the staff and the relationships they form in the group. The group also provides a safe place to go and this helps keep the youths out of trouble. As well, youths credit participation in the youth group with helping them develop strategies for coping with their problems.

Other than in youth groups, youth involvement in systems of care is limited. There was little evidence of youths being involved in participating in the decision-making process for their system of care (such as through membership on committees and boards), or providing trainings or other services, and only in some cases were they involved in planning their services or providing feedback on the services they receive. It appeared that youths were often unaware that they *could* be involved in these activities, although the youth coordinators were aware of the different domains in which youth could participate. In fact, some youth coordinators felt that system-of-care administrators were actively trying to prevent youth coordinators from informing youths about their rights and involvement options because of a general resistance to involve youth. Other barriers to youth involvement included an absence of a true commitment to creating environments in which youths are able, or feel welcome, to participate (e.g., when board meetings are held during school hours or food and transportation are not provided). Youth coordinators are actively working to engage youths in these domains from which they are currently excluded. Youth interest does raise questions as to the feasibility and benefit of implementing infrastructural involvement, and to the discernment needed between adolescent youth and transition-age youth, and perhaps that is where the discussion needs to begin (Chalmers, 2000).

Youth coordinators identified several key challenges to youth involvement. Most significant was a lack of support from the system-of-care community and a pervasive "tokenism" mentality. This lack of buy-in for real youth engagement impacts programmatic decisions such as budget allocations for youth involvement, which was often insufficient or unstable. In cases where youth were moderately involved in advisory boards, they seemed to do so with no real effect to shaping change at the infrastructural level in their systems of care. Moreover, it speaks to the underdevelopment of policy at the service level.

The Role of Policy for Youth and Infrastructure

The picture that is emerging from these focus groups regarding youth involvement in infrastructure points out the struggle of principle implementation. Youths are mostly confirming interest in having a voice in governance and management, but are largely uninformed as to how influential they actually are in shaping service infrastructure (Matarese, McGinnis & Mora, 2005). System of care administrators and staff struggle to find a balance in effective service delivery and youth involvement. At the same time, the policies and mandate governing system level change can be interpreted in many ways, and this may have encouraged varied implementation (Drake, Ling, Fitch, et al, 2000). However, as youths—especially transition-age youth—continue to use alternate means such as their youth groups, youth coordinators, and as they gradually become more involved in advisory committees, both the youths and policy at the service level will have to grow.

Conclusions

Both the youths and the youth coordinators conveyed similar experiences of youth involvement in systems of care, such as a lack of awareness by youths about the ways in which they *could* be involved in their communities, the importance of including social activities in youth groups, and an absence of a youth voice in decision-making arenas within systems of care. This consistency is important because two of the three youth focus groups were conducted in system-of-care communities and thus cannot be assumed to be representative of youths from other systems of care. Though it is unlikely that all of the experiences are shared by all of the communities, the findings identify areas that system of care administrators and youth coordinators can review to determine whether the identified shortcomings of youth involvement are present in their communities and then steps can be taken to address problem areas. Given the benefits of youth involvement, to both youth and the systems/organizations with which they are involved, finding ways to increasingly and effectively involve youth in their systems may be an important way to improve outcomes for youth in systems of care and to enhance the services, infrastructure, and sustainability of these systems.

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Community Integration of Transition-Age Youth: Voices of Youth and Young Adults

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Introduction/Purpose

While there is a growing literature on the challenges facing youth with mental health difficulties (e.g., Blackorby & Wagner, 1996; Davis & VanderStoep, 1997; Delman & Jones, 2002; Federation of Families for Children's Mental Health, 2001), far less attention has been paid to understanding how youth themselves view the meaning of a successful life in the community, and what helps or hinders achievement of such self-defined success. For this exploratory, qualitative study, our aim was development of understanding of community integration across life domains for this population of young adults. The study reported here was part of a larger study that also explored the perspectives of family members on the community integration of their children with mental health disorders.

Method

A research team of collaborators in Portland, Oregon and Seattle, Washington was formed in the fall of 2004. Local advisory groups of young adults and family members were created at each research site. Youth and family member research assistants were hired and trained in focus group methods and qualitative analysis in the spring of 2005. In consultation with local advisory groups, the team developed focus group questions and planned recruitment strategies. The project was approved by Portland State University's Human Subjects Research Review Committee.

Young adults and family members were recruited through contacts with schools, colleges, family support organizations and mental health agencies in the Portland and Seattle areas. Research staff at both locations distributed brochures and literature inviting youth who had experience with mental health services and were between the ages of 17-24 to contact project staff. Parallel materials were developed to recruit family members of such youth as well. A total of twenty 90-minute separate focus groups for youth, young adults, and family members were held in a variety of community settings, including public libraries, family support organizations' meeting rooms, and service agencies. In moderating the focus groups, the youth and family member research assistants took the lead roles, while principal investigators and the project manager took secondary roles.

This presentation focused on the experiences and of youth and young adults, as related in 12 focus groups in the Seattle, Washington and Portland, Oregon metropolitan areas. Participants completed a short demographic survey and they received $30 as compensation for their time. Sampling was designed to seek diversity in ethnicity, age, sexual orientation, rural/urban locations, and socioeconomic status.

Focus group questions focused on the meaning of community integration and a successful life in the community; barriers and supports to community integration; young people's hopes, goals, and dreams; and advice to others in similar situations. Groups were audio-taped and transcribed, and transcripts were analyzed with the assistance of N6 (QSR International, 2002), a qualitative analysis software program. After reading and becoming familiar with the content of the transcripts, the team members developed a coding framework that identified and categorized examples of young people's definitions of community integration across seven domains: personal, family and friends, living situation, school/college, employment, service system and service providers, and community. The analysis also incorporated

barriers and challenges facing young people in each of these domains, and strategies and supports they used to achieve a successful life in the community. Finally, codes were assigned to content that spoke to young people's hopes, dreams, and goals, as well as their advice to other young people with mental health difficulties. After all team members had independently coded one transcript and reached an acceptable level of agreement in coding, pairs of team members coded transcripts independently and reconciled their codes. Finally, when team members achieved a high level of consistency in coding, the remaining transcripts were coded independently.

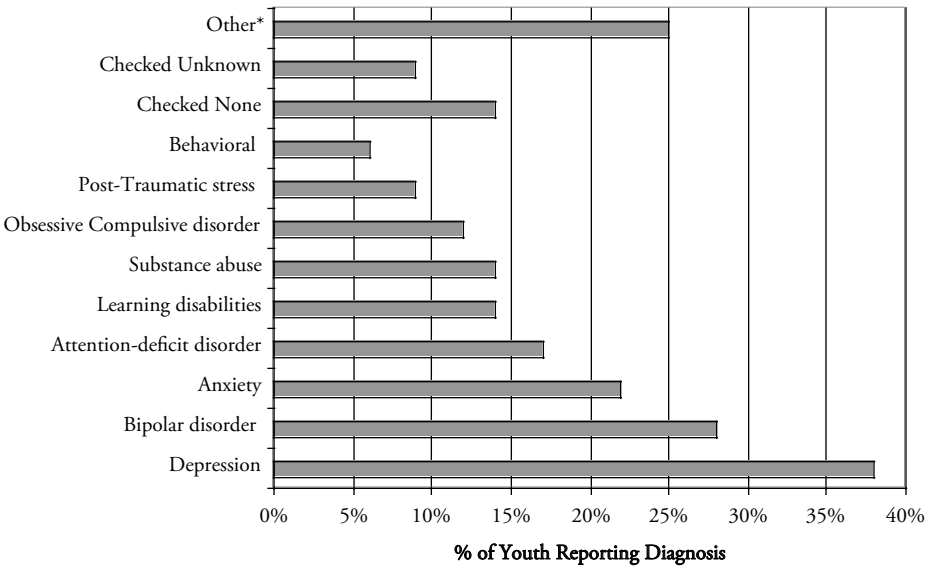
Results

This summary will report on findings related to selected youth characteristics and domains that were shared at the conference presentation itself[1].

Participants

Fifty-nine young adults (36 young men, 23 young women) participated in focus groups and completed survey forms. Ages ranged from 15-28, with a median age of 19.5 years (*SD* = 2.4). Sixty-six percent of the youth were European American; 15% African American; 10% Multi-racial; 7% Asian Pacific Islander; and 2% Native American. Figure 1 depicts self-reported mental health diagnoses, while Figure 2 illustrates youths' current use of, and access to, mental health services. The largest percentage of youth were living with their parents (42%), with 21% living with roommates, 16% alone, 10% with other extended family, 7% with a partner or spouse and 9% in a homeless shelter.

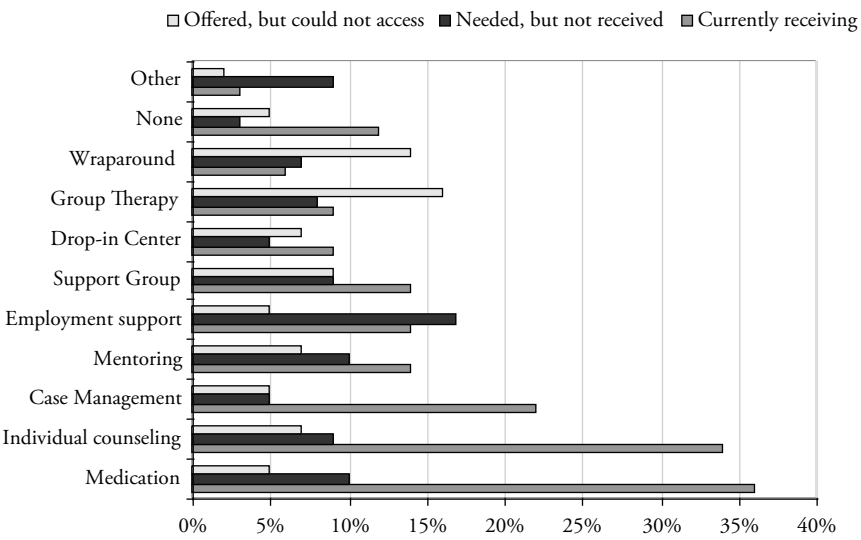
Figure 1
Youth Self-Reported Diagnoses
(*N* = 59; percentages add to more than 100% because of multiple diagnoses)



* "Other" includes Aspergers, attachment, behavioral, oppositional-defiant, schizophrenia, and other disorders

[1]*Please contact the lead author, Jean Kruzich, for information about complete findings.*

Figure 2
Youth Self-Report of Service Use and Access
(*N* = 59)



Youth perspectives on the meaning of community integration

Three central themes that emerged around this area of questioning were: (a) having opportunities to meet goals, (b) the value of relationships, and (c) having access to resources. As one young adult responded,

> *"I think whenever I have things in common with other people, those are the times that I feel more part of that community."*

Hopes, dreams and goals of these youth

These young people wanted to feel a sense of success, to feel connected to community activities and causes, and to give back to others. The goal of connecting, while overcoming stigma, was described thusly by one young woman:

> *"I would want to be a part of something…I would like to be comfortable enough with my disability to not feel like I have to hide anything from anybody. That would allow me to really be around other people."*

Youth views on barriers and supports to community integration in domains of school/college, employment, and formal services

Themes that arose out of groups' discussion of barriers included stigma; high school culture and educational system shortcomings; lack of accessible, developmentally appropriate resources and services; uncaring, clueless and "by the book and by the clock" professionals; the effects of the disorder itself on personal motivation and behavior; and a pervasive lack of understanding of mental health difficulties. This final point is brought home by a young woman's thoughtful comments:

> *"You are going back and forth, you are bipolar, you are suicidal…but nobody else understands you, because you can't explain what you are going through… So they push you away, so you have absolutely no support to integrate back into society, to be able to figure out who you are, what you are doing, how you can function with this disorder that you have."*

Supports for community integration were characterized by youth as involving supportive relationships with friends and family, including siblings, grandparents and foster parents; caring, skilled professionals and mentors; opportunities to give back and to be productive; programs focused on transition-age youth offering practical and emotional support; opportunities for rejuvenation, spiritual guidance, and self-expression; solid information about mental illness and mental health that gave encouragement and fostered hope; and awareness of others living successfully with mental health difficulties. In one young person's words,

> *"The best support I've gotten is from people who have the same problem as me, because you can relate to it. My therapist was only a couple of years [older]—she is 26…she had gone through the same things, and she basically showed me some new treatments."*

Advice to others struggling with mental health difficulties

Two strong themes emerged in response to this question: Youth advised other young people to seek support from people who've had similar experiences, and urged them to "take charge of your life." An example of this sense of empowerment was a youth's assertion that

> *"If you feel like your therapist isn't really listening to you or if something is not right with a particular doctor or therapist, go ahead and see someone else."*

Conclusion

Although this study has limitations such as being a geographically limited, modestly diverse sample that cannot be said to represent all youth, the implications drawn from these findings are useful for families, service providers, policymakers, youth advocates and youth themselves. They include:

- We need to focus on recovery, success and strengths—youths' competencies and desire to give back to the community should be recognized.
- Schools and colleges are seen by youth with mental health difficulties as especially important in their lives, yet a pervasive lack of understanding of mental health issues persists in educational settings, and this needs to be addressed.
- Stigma cuts across all domains of living, and broad educational efforts are needed for family members, professionals, employers and communities.
- Successful role models—close in age and experience to youth themselves—can normalize disclosure and provide hope.

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Symposium

Partnerships for Youth Transition (PYT): Evaluating Process and Progress Outcomes of Community Initiatives

Chair
Hewitt B. "Rusty" Clark

Authors
Hewitt B. "Rusty" Clark et al.
Gwendolyn White et al.
Nancy Koroloff et al.

Symposium Introduction

Hewitt B. "Rusty" Clark

In 2002, five Partnerships for Youth Transition (PYT) community sites were funded for the purpose of planning, developing, implementing, and documenting models of comprehensive community-based programs to assist in improving the outcomes for youth and young adults with serious emotional disturbances or serious mental illnesses (SED/SMI) as they prepare for and enter adulthood. This symposium summary provides data on the: (a) cross-site analyses of process activities undertaken by sites, (b) system of care decision making focused on hope contrasted with trauma and known risk factors, and (c) testing fidelity to the Transition to Independence Process (TIP) model. The implementation experiences and findings from across the sites will contribute to the field's instrumentation and knowledge base related to program design, as well as to youth and family progress, community partnerships, and system/policy reform.

An Analysis of Partnerships for Youth Transition (PYT) Cross-Site Findings

Hewitt B. "Rusty" Clark, Nicole Deschênes, Arun Karpur, & Peter Gamache

Introduction

This paper describes cross-site findings of process activities undertaken by the five Partnerships for Youth Transition (PYT) community sites in serving youth and young adults with serious emotional disturbances or serious mental illnesses (SED/SMI) and their families.

Process information on the services and supports provided at the sites will further inform our efforts in the refinement of a fidelity assessment instrument and in a forthcoming analysis of youth process/outcome findings. The site stakeholders have also found these data to be valuable as they revise their transition program manuals. By comparing process activity to progress/outcome findings by domain in our future analysis work, a pattern of "efforts to outcomes" will provide communities serving these young people with strategies on how to achieve similar gains.

Methods

The PYT Process Survey: Efforts to Outcomes (Deschênes, Clark, Gamache, & Karpur, 2005) instrument examined process activities specifically targeted to improve transition progress/outcomes for the approximately 526 youth and young adults enrolled across the five sites over the course of a nearly 2.5 year period. The PYT Process Survey examines the services and supports that sites provided across the 4 transition domains, with the last one separated into the 8 subdomains of Community life and functioning (Clark, Deschênes, & Jones, 2000). The transition domains are:

- Employment
- Education
- Living situation
- Community life and functioning
  - daily living and leisure time activities
  - interpersonal relationships: family, friends, and mentors
  - community involvement and social responsibilities
  - emotional and behavioral well-being

- physical health
- parenting
- self-determination
- communication skills

The PYT Process Survey provided activity selections to check, as well as open-ended questions for description of other activities not given as selections. Additional open-ended questions asking for descriptions of the barriers/difficulties experienced and how these were overcome were given for each domain.

The five PYT sites were sent the PYT Process Survey during the fourth year of the initiative. Surveys were completed by a group consisting of the Project Director, two transition facilitators, and one young person at a minimum. The inclusion of the Project Evaluator, parents, parent advocates, or others who could inform survey responses was encouraged.

Results

Selection data indicating activities undertaken by the sites were examined by frequency counts. A summary of the primary service and support activities are presented below for the 11 domains. Qualitative descriptions for barriers/difficulties and how these were overcome were summarized and presented by theme frequency. Qualitative descriptions representing explanatory depth and clarity from the sites are given when present.

Employment

Primary service and support activities reported to improve employment outcomes (e.g., drop-out prevention, returning to school) included helping young people with job searches (e.g., via Internet, newspaper); job shadowing; improving interview skills (e.g., sample questions, role-play) and networking skills (e.g., introducing one's self, follow-up with contacts); completing paperwork (e.g., application, understanding tax forms); establishing employment goals; accompanying them on job searches (e.g., provide transportation); providing directive feedback and encouragement, and; making referrals to vocational rehabilitation and career/employment resource centers.

Two of the recurrent themes cited across the sites on employment barriers included transportation difficulties and finding employment for youth with criminal backgrounds. One site discussed the youth self-determination and motivation issue in the following manner: "Why a young person is seeking employment in the first place [is a major factor]…once a youth is motivated to seek employment for his/her own reasons, the outcome is successful."

Education

Primary activities to improve education outcomes included all sites helping young people with improving school attendance, encouraging school work (e.g., homework) completion, searching for postsecondary programs (e.g., writing/applying to colleges, looking for programs in catalogs or on the Internet), referring to guidance counselors, making use of state resources, and gaining an educational representative for their respective site's oversight structure.

The one overriding difficulty for educational achievement was the young person's disinterest and the associated lack of motivation. One site stated that, "a lot of youth have had negative experiences with education, especially special education, which hinders their willingness to explore other educational opportunities."

Living Situation

Primary activities to improve living situation outcomes included all sites helping young people in a homeless state find housing, completing applications for housing, evaluating housing options, and making use of state resources for housing.

Many different themes emerged from the sites with respect to living situation barriers and difficulties, including a lack of social skills pertaining to living with others, poor budgeting skills, the availability of low-income and safe housing, and the inability to rent their own place because current homeless or at-risk youth "are under 18…[have] poor credit or no credit," are unable to have someone co-sign a lease, and cannot afford move-in costs that are "often three times the amount of rent."

Daily Living and Leisure Time Activities

Primary activities reported across the sites to improve daily living and leisure time outcomes included helping young people with identifying and accessing activities, budgeting (e.g., balancing checkbook, managing credit), utilizing public transportation (e.g., understanding bus schedules), and developing an organized schedule of activities.

Recurrent barriers and difficulties included transportation, limited financial resources, and limited availability of evening and weekend activities.

Interpersonal Relationships: Family, Friends, and Mentors

Primary services and support activities to improve interpersonal relationships included providing cultural competency training to staff, developing a youth group (e.g., peer support groups, Youth Council), and helping young people access integrated community activities (e.g., YMCA classes, summer camp).

Efforts to improve interpersonal relationships ranged from peer-to-peer mentoring, group activities, and providing links to outside youth groups, to a large-scale leadership conference.

Community Involvement and Social Responsibilities

Primary activities to improve community involvement and social responsibility outcomes included all sites assisting young people with their driver's license requirements, helping young people with learning about relationships (e.g., controlling anger, getting along with family), getting along with friends and peers, finding or doing fun and enjoyable positive activities, becoming involved with community activities (e.g., volunteering, mentoring), helping with legal problems (e.g., meeting with parole officer, going to court), understanding public assistance paperwork, and obtaining referrals to community resources (e.g., anger management or marshal arts classes). Additionally, the use of state resources for community development and the attainment of a community representative for the site's oversight structure were each indicated by every site.

Barriers and difficulties included stigma, limited volunteer opportunities for teens with criminal histories, symptoms and effects of mental illness, and comfort level from the perspective of the youth. Efforts to address these issues included utilizing the youth's social network (e.g., staff, families), psychoeducation, cognitive behavioral therapy, exposure training, and networking with community organizations.

Emotional and Behavioral Well-Being

Primary activities by all sites to improve emotional and behavioral well-being outcomes included: helping young people understand their condition or diagnosis and the effects on his/her behaviors; maintaining prescription regimens; understanding side-effects of medications; helping young people with their grieving process; teaching young people how to express concern and caring for others, reciprocation, managing one's anger, frustration, and impulse control; and providing young people with strategies to avoid alcohol abuse and street drugs or illegal substances. All sites also reported that they referred young people to resources (e.g., psychologists) to discuss plans, making use of expert consultants/technical assistance and state resources, and gaining an adult mental health representative to serve as a liaison to that system.

Resistance to mental health services, lack of mental health insurance coverage, dual-diagnosis complexities, and transportation problems (e.g., to appointments) were cited as barriers to accessing mental health services. Additionally, mental illness stigma and its effects, youth difficulties with appointment time management, resistance to therapy, and low motivation confound these difficulties.

Physical Health

Primary activities to improve physical health outcomes included all sites helping young people with dietary skills (e.g., nutrition, cooking), helping with exercise and physical activities, and developing a healthy lifestyle (e.g., sufficient sleep schedule).

Barriers and difficulties included limited resources for the uninsured, lack of community exercise facilities, limited financial resources, and transportation problems.

Parenting

Primary activities to improve parenting outcomes included all sites helping young people with understanding the responsibilities associated with parenting and child rearing, assisting young people with searching for resources (e.g., parenting classes, financial support), and making use of expert consultants/ technical assistance and state resources.

While many barriers overlap with those found in other domains, particularly transportation and limited finances, these issues were described as being compounded by parental responsibilities. Difficulties unique to this domain included the maturity level of the young parent, a desire to conceal pregnancy due to embarrassment and fear of negative reactions, and an inability (perhaps due to their own childhood trauma) to emotionally bond with their children.

Self-Determination

Primary activities to improve self-determination outcomes included all sites assisting young people with advocacy skills, choice-making, problem solving, goal setting and attainment, self-knowledge and understanding, self-observation, evaluation, and reinforcement, risk taking and safety, knowledge of self (e.g., knowing interests, preferences, strengths, needs), and leadership skills.

In addition to youth directive considerations, such as a lack of motivation, effects of mental illness, shyness and inhibition, and the unfamiliarity of "having power in a situation when they are so used to having people tell them what to do," ecological factors such as neighborhood crime, poverty, and transportation problems were cited as confounding stressors.

Communication Skills

Primary activities to improve communication outcomes included all sites assuring that young people were involved in developing their site's program brochures/logo, assisted with negotiation skills, and provided cultural competency training to their staff.

The minimization of face-to-face communication via technological changes (e.g., instant messaging, email, chat rooms) was cited as presenting communication difficulties. Other communication difficulties included a lack of confidence and experience, anxiety, negative past experiences, and the effects of mental illness. The perception by youth that "they won't be heard or people don't want to hear what they have to say" was also cited.

Discussion

This paper provided an overview of the services and supports that were available at the PYT sites across the transition domains of employment, education, living situation, and community life functioning – with this domain being composed of eight sub-domains. The results also summarized some of the barriers that existed across these domains. Clearly sites had made progress in creation of developmentally-appropriate, individualized services and supports for these youth and young adults with SED/SMI. However, site personnel still faced many obstacles in the provision of a complete service system tailored to meet the needs of these young people and those of their families.

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Transitioning Young Adults: A Hopeful Life View . . . Traumatic Life Experiences

Gwendolyn White & Robin A. Orlando

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Introduction

As a Partnership for Youth Transition (PYT) grantee community, Allegheny County, Office of Behavioral Health System of Care Initiatives (SOCI) has worked with transition aged young adults to inform the overall planning and implementation of a transition system. In 2002, SOCI was awarded a Substance Abuse and Mental Health Services Administration (SAMSHA) Partnerships for Youth Transition (PYT) grant agreement to expand the service population in the system of care to ages 14 through 25. The evaluation component is a critical element of this agreement.

The goal of the SOCI evaluation is to collect, analyze, and disseminate vital information regarding system of care performance and effectiveness in ways that will ensure that the information is used to improve the quality of supports to young adults. The data collected are also used as an educational tool for staff working with the young adult population. As part of the two-year outcomes study that is currently being conducted with transition aged youth, the notion of hope and resiliency has been reflected in the data collected. The focus of this paper is to discuss the presence of hope as identified by the young adults despite the significant evidence of trauma and known risk factors.

Method and Early Findings

Program data collection began with the first referral in March 2004. As of June 2006, 153 young adults were referred to the program and 79 are enrolled. The majority of referrals are self-referrals from either the caregiver or the young adult (68%). The average age of PYT enrollees is 17. More than half of the consumers served by PYT are female (62%). The majority of enrollees are African American (56%), followed by Caucasian (26%). Many of those served (67%) have more than one mental health diagnosis. Currently, the most common diagnoses of PYT enrollees are Major Mood Disorders (64%), Attention Deficit Disorder (37%), and Adjustment Disorders (20%).

Program Data Collection

In addition to the Transition to Adulthood Assessment Protocol (TAAP; Davis, Deschênes, Gamache, & Clark 2004), SOCI uses additional measures as part of the service planning process to assess consumer needs, strengths, hopes, and dreams. The Young Adult Needs and Strengths Assessment (Lyons, 2003) collects information on the young adult's needs, strengths, and culture and is used for service planning. This assessment is administered at enrollment and every six months until disenrollment. The Consumer Strengths Discovery is a qualitative tool that questions young adults about their hopes and dreams for the future as well as their general goals for their lives. It is used for service planning and is collected at intake and prior to each consumer support team meeting.

Consistent with the findings of national studies, Allegheny County young adults ($N = 79$) with serious emotional disturbances (SED) are subject to a number of risk factors in their homes and communities.

These include, but are not limited to: having children (16%); living in temporary situations (29%); having experienced homelessness (18%); having dropped out of high school (25%); not having a source of income (23%); being addicted to drugs and/or alcohol (27%); having a parent with a mental illness (63%); having a parent convicted of a crime (48%); and not having adequate transportation to work/school (24%). Risk factors were specifically investigated to illustrate the confounding factors that significantly impact the sustainability and achievement of outcomes for these youth.

Outcomes Data Collection

SOCI is committed to collecting outcomes on young adults and families. Although not required under the PYT grant agreement, SOCI decided to conduct a two-year outcomes study with the young adults who consented to participate. Data are collected within 30 days of enrollment into PYT and every six months through the end of the grant. As of June 2006, 59 young adults have participated in the longitudinal study. The study was designed to gather information similar to that collected under the SAMHSA system of care grant to provide comparisons between the younger and older populations. Data in the PYT outcomes study are collected in the following areas: perceptions of opportunities, substance use/abuse, exposure to violence, delinquency, functioning, sexuality, service history, and cultural competency.

While risk factors confound and in some cases even magnify the probability of achievement difficulties, exposure to violence and trauma represent experiential differences among Allegheny County's PYT enrollees and illustrate how (in addition to why) outcomes are disparate among this population. Using the My Exposure to Violence (Selner-O'Hagan, Kindlon, Buka, Raudenbush, & Earls, 1998) instrument, these data reflect a high level of victimization in physical, emotional, and sexual abuse and violence. Disparity is reflected in the level of suicide ideation (42%) and suicide attempts (24%). More than half report knowing someone who has thought about suicide and 37% know someone who has attempted suicide. Table 1 illustrates the young adults' self-reported history as a victim or witness to violent and/or traumatic incidents at baseline.

In contrast to these traumatic life events, young adults report a strong sense of hope and opportunity. They have identified career goals, family and living plans, and positive familial relationships as part of their recovery and future. Several instruments are used to collect this information including: Perceptions of Opportunity, Young Adult Needs and Strengths Assessment (YANSA; Lyons, 2003), and the Consumer Strengths Discovery. Based on the YANSA and the Consumer Strengths Discovery data, the four goals most often identified by the young adults ($N = 72$) are: career, steady income, housing, and relationship/starting a family. Several young adults identified their hopes for a career in social work, culinary arts, graphic arts, computer design, nursing, and medical assistance. On the Perceptions of Opportunity instrument (adapted from the Pathways to Desistance Study [Griffin, 2006]), the young adults ($N = 59$) rated their life aspirations and expectations. Table 2 illustrates the young adults' hopefulness regarding career, education, and family.

Table 1
Exposure to Violence
***N* = 59**

Violent/Traumatic Events	*Victim*	*Witness*
Beaten up or seriously threatened	44%	83%
Emotional or verbal abuse	53%	73%
Physical abuse	29%	51%
Attacked with a weapon	21%	42%
Shot at	7%	32%

Table 2
Perceptions of Opportunity
***N* = 59**

	Very Important for this to occur	*Good Chance this will happen*
Graduate from college	76%	57%
Have a good job/career	93%	72%
Earn a good living	91%	76%
Have a good relationship with parents	85%	58%
Have a good relationship with children	97%	88%
Stay out of trouble with the law	95%	86%

Conclusion

There are many issues to explore when looking at the contrasting data. Further research questions to consider are:

- What factors lead to hope in the face of trauma and violence?
- What are the source(s) of hope?
- How can the service process build off of hope to produce better outcomes?
- How can hope be maintained as an individual moves into adulthood?

Beyond the remaining questions, there are numerous lessons learned. Hope can be translated into best practice. Since it is developmentally appropriate to be hopeful as a young adult, hope needs to be nurtured. Some of the ways to build on hope in the practice arena include:

1. ***Use a planning process centered on hopes and dreams.*** A standardized instrument such as the YANSA provides for a discussion of hope, validates that hope and provides the basis for evidence-based practice.
2. ***Build on those self-identified strengths.*** Reflect these strengths in written plans and documents, and build on the small successes identified in the service plan. Identify short-term goals that lead to long-term success.
3. ***Value social connections and natural supports.*** This includes: (a) inclusion in the service plan; (b) building on existing positive relationships; and encouraging support groups and educational activities
4. ***Recognize that staff relationships with young adults are critical.*** Young adults report low trust with the system as a whole, therefore staff should be coached in the principles and values of system of care, and to encouraged to work from a "position of hope" when interacting with young adults.

Data tell us that young adults have a hopeful world view despite traumatic life events. These data challenge us to build on hopes and dreams. All young adult service plans should include "hopefulness" as a best practice. This builds confidence and enables the individual not just to survive but to thrive in their world.

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From the Ideal to the Real: Testing Fidelity to the Transitions to Independence Process (TIP) Model

Nancy Koroloff & Lyn Gordon

Introduction

The Clark County, Washington, Department of Community Services and Corrections has established a Partnerships for Youth Transition (PYT) site project, subsequently named Options. The goal of the Options project is to build an enhanced system of treatment to address the particular difficulties that youth with serious emotional disturbances or serious mental illnesses (SED/SMI) face in making a successful transition to adulthood. This comprehensive continuum of services builds upon existing programs and works to bridge gaps between the children's mental health and adult mental health systems.

The program, based upon the TIP model (Clark, 2004) and augmented by the use of a "Core Gifts" approach (Anderson, 2005), focuses on the life domains of youth that are most critical during the transition years—education, employment, housing, and community life functioning. Program staff include four transition specialists and a job developer who consult with an on-site supervisor. They work with youth in flexible, innovative, non-clinical ways. Youth are referred to Options from Connections (a specialized mental health program based in juvenile justice) and Catholic Community Services (a provider of crisis and intensive mental health services). Youth qualify if they are age 14-25, meet criteria for a mental health diagnosis, and are at imminent risk of out-of-home placement or homelessness.

As part of Options, researchers from Portland State University's Regional Research Institute for Human Services have conducted process and outcome evaluations; preliminary findings have previously been reported on at this conference. This presentation reports on the methods and findings from our latest process evaluation effort: an examination of the Options program's fidelity to key TIP principles.

Methods

This phase of the evaluation was undertaken to answer the following questions:

1. Are services being provided according to the TIP System guidelines and other principles adopted by the program?
2. What are the perceived levels of effectiveness of services offered to youth?
3. How satisfied are youth with the services they have received?

The process evaluation and fidelity assessment was accomplished by collecting case study data on a stratified random sample of eight Options program youth (1-2 per transition specialist). For each youth selected, we reviewed his/her case record and service activity data; interviewed the youth directly about the services s/he has received; and interviewed the youth's transition specialist about the services provided to the youth.

Once a youth agreed to participate, a research interviewer visited the Options offices and reviewed the case record for that youth. This involved reading through the contents of the case records (including assessment, plans, progress notes and correspondence with other service providers) and completing a checklist. The case record review looked for evidence that services were being delivered according to the theory base and philosophy established for the program. After the case record was reviewed, the researcher first interviewed the youth and then the transition specialist. Both interviews were conducted using parallel structured interview schedules, adapted from the TIP Case Study for Continuous System Improvement Protocol (Deschênes, Gomez, & Clark, 1999). Youth who were eligible for selection all had given consent to being involved in the project's evaluation, which included extracting data from the youth's case record. Specific informed consent was obtained from both youth and transition specialists for the individual interviews. Youth received a $20 gift certificate for participating in the interview.

All interviews were taped and reviewed manually to confirm direct quotes; audiotapes were not transcribed. A detailed 'case by data source' matrix was constructed, and evidence for each TIP practice

guideline was entered for each case. Evaluators independently assigned ratings of *high* (3), *medium* (2), or *low* (1) for each case within a given guideline, then discussed ratings until agreement was reached. Average scores, rating frequencies, and summaries of the evidence were reported for each practice guideline; program staff were provided with a four-page principle and practice guideline matrix that included all of this information, along with a one-page ranking of scores across practice guidelines (see Table 1) that allowed for comparison of strengths and areas for improvement at a glance.

Table 1
Clark County Options Program 2005 Fidelity Study, Practice Guidelines by Rank

Item Number	*Practice Guideline*	*Fidelity Indicator*	*Frequencies*
16*	Transition facilitator and other Options staff are committed to the youth.	3	8-H
8*	The youth has access to a range of services and supports in all transition domains identified in the Success Plan.	2.9	7-H, 1-M
14*	There is one person assigned, over time and across agencies who is responsible for coordination of the youth's services.	2.9	7-H, 1-M
22*	The youth is able to voice his/her concerns.	2.9	7-H,1-M
23*	The youth and his/her family are able to make informed choices during the transition process.	2.9	7-H,1-M
4*	The youth participated in the transition planning process.	2.75	6-H, 2-M
11*	Supports and services are provided in a community-based setting.	2.75	6-H, 2-M
17*	The youth feels that staff allow him/her to explore and take risks.	2.7	6-H, 2-M
18*	Services and supports are offered in a flexible manner to meet the changing needs of the youth.	2.7	6-H, 2-M
1*	The strengths of the youth have been identified.	2.6	5-H, 3-M
12*	The youth has access to coordinated services in all domains.	2.6	5-H, 3-M
15*	The transition facilitator maintains a good collaborative relationship with youth and all services and supports.	2.5	4-H, 4-M
19*	The youth feels hopeful and encouraged through the actions of the transition team.	2.5	4-H, 4-M
20*	Relevant and meaningful skills for community settings are being taught.	2.5	4-H, 4-M
25*	An assessment of progress toward goal achievement is conducted.	2.5	5-H, 2-M, 1-L
29	Transition specialists incorporate Core Gifts strategies and techniques as appropriate in their work with this youth.	2.5	3-H, 3-M, 2-deferred
9*	Services and supports are implemented in a timely fashion.	2.4	3-H, 5-M
6*	The culture of the youth and family are valued in the planning process.	2.3	2-H, 4-M, 2-NA
5*	The goals of the plan reflect strengths, resources and priorities of the youth.	2.25	3-H,4-M,1-L
13*	Difficulties regarding access to supports and resources are quickly eliminated.	2.25	4-H, 2-M, 2-L
7*	The cultural and linguistic diversity of this youth and family is reflected in services and supports received.	2.2	1-H, 5-M, 2-NA
2*	A thorough assessment of needs in all domains has been conducted.	2.1	1-H, 7-M
10*	Natural resources (including family members, per youth's choice) are included in supports and service delivery.	2	2-H, 4-M, 2-L
21*	The youth experiences successes during the transition process.	2	2-H,4-M,2-L
3*	The youth, in partnership with transition team, has identified natural supports who can help with transition plan.	1.9	2-H,3-M, 3-L
26*	The transition services and support help the youth meet his/her transitional needs and improve his/her situation.	1.9	1-H, 5-M, 2-L
27	The youth, in partnership with the transition facilitator, has identified his or her Core Gift.	1.7	3-H, 1-M, 4-L
30*	Transition specialists incorporate TIP strategies and techniques as appropriate in their work with this youth.	1.6	1-H, 3-M, 4-L
24*	The transition plan has measurable goals and objectives in all relevant transition domains.	1.5	4-M, 4-L
28	The Core Gift has been integrated into the Success Plan and is recognized when being used.	1.5	4-M, 4-L
31	Transition specialists coordinate with youth's wraparound or ITC teams.	Not scored	2-H, 6- N/A

Note. * = TIP-specific guidelines. Fidelity indicators are rated 3 = *high, well met*; 1 = *low, poorly met*; dark shading indicates a strength, while lighter shading indicates areas for improvement

Findings

Qualitative analysis was completed in late December 2005, discussed with Options program staff in early January 2006, and reported to the program's community steering committee in early 2006. Key findings suggested that the Transition Specialists are working with youth in a way that is highly consistent with key TIP principles, and that adherence to practice guidelines related to encouraging youth voice and youth decision-making were particularly strong. In fact, 15 of the 26 TIP practice guidelines received a mean rating of 2.5 or better, meaning that almost everyone was scored as either *medium* or *high* on these principles. Only three of the 26 TIP practice guidelines received a mean rating of 1.9 or lower (on a scale of 1 = *low* to 3 = *high*). Overall, scores for the following three TIP principles pointed to particularly high fidelity: Providing Coordinated Services and Supports, Providing a Safety Net, and Providing Services that are Competency Based.

Areas Needing Improvement

There were few instances of natural supports being involved in either the development or the implementation of the Success Plan. Family members were the most frequent examples of natural supports. Although a lot of work was being done with each of these youth and concrete examples of success were found, most youth were not in "improved situations." Further, goals in the Success Plan were usually stated in general terms and were not measured systematically, nor was progress toward goals easily tracked. Also, the use of the Core Gift process was inconsistent. In three cases, the approach was integrated into the Success Plan and the youth responded well, but in four cases the Core Gift process had not been completed for a variety of reasons. Finally, in most cases, wraparound teams appeared to have dissolved as soon as, or within a few months after, youth were accepted into Options. There were only a few examples of integration between the wraparound team process and the Options program.

Discussion

This time- and labor-intensive case study process provided the Options program staff and stakeholders detailed documentation of the consonance of their daily practice with the program model they had been implementing. While the study confirmed relatively high fidelity to key TIP principles and related practice guidelines, it also identified areas that could be improved, including the need for new staff to have more training and supervision around the TIP and Core Gifts approaches, and for greater efforts around coordination with natural supports and formal services when wraparound teams dissolve.

Undertaking this process also underscores the need for a fidelity evaluation approach that is tailored to the community and program being studied, and for the evaluators themselves to have a thorough understanding of the elements of the model being tested. Furthermore, the value of going beyond simply reviewing case file information was affirmed by the depth and quality of information provided by interviewing youth and program staff. Although in some instances youth did not have much to say (which suggested that the pilot Options-specific interview instrument could be streamlined, and raises the question of whether trained youth evaluators might have elicited more response), their heartfelt and honest comments provided strong evidence of the youth-driven nature of the program.

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Transition to Adulthood Program Information System (TAPIS)

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Introduction

The transition from adolescence to adulthood presents bewildering challenges for young people with emotional/behavioral disturbances (EBD). In the National Longitudinal Transition Study (NLTS), researchers observed a substantially lower rate of employment and enrollment into postsecondary education, and higher rates of incarceration for youth and young adults with EBD compared to their peers with no disability classifications (Blackorby & Wagner, 1996; Vander Stoep et al., 2000). Strikingly, a decade later, in the National Longitudinal Transition Study – 2 (NLTS2), the postsecondary outcomes for youth and young adults with EBD did not show any substantial improvements (Wagner, Newman, Cameto, Garza, & Levine, 2005). The Transition to Independence Process (TIP) system was developed at the Louis de la Parte Florida Mental Health Institute, University of South Florida to address these challenges and to help improve the outcomes for young people with EBD.

The TIP system was conceptualized to engage youth and young adults in their own futures planning process and to provide them with developmentally-appropriate services and supports. Further, the TIP system involves youth and their families and other informal key players in a process that prepares and facilitates youth in their movement toward greater self-sufficiency and successful achievement of their goals related to each of the transition domains. The TIP system is currently being implemented at various sites across the state of Florida and nationally. The TIP system has developed a multi-pronged approach in evaluation based on various qualitative and quantitative methodologies.

The Transition to Adulthood Program Information System (TAPIS) is one of the evaluation strategies within the TIP system. The TAPIS is an internet-based four part information system that consists of various instruments. These instruments were designed to inform transition programs on the progress indicators for young people transitioning into adulthood roles and provide program evaluation data. The summary provides an overview of the conceptual layout of the TAPIS system, brief description of the instruments, and sample reports. Some of the components of TAPIS are in the production phase and one is currently being pilot-tested.

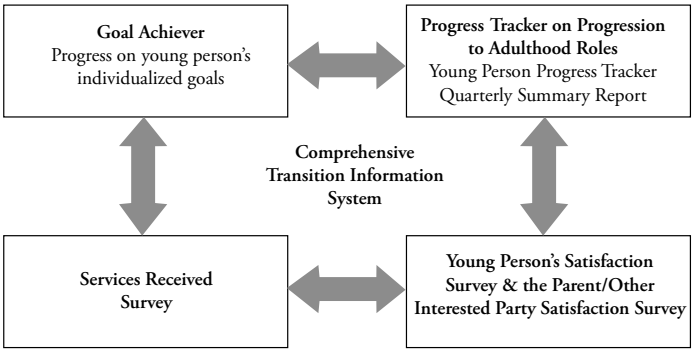
Methodology

The TAPIS data elements were developed based upon various other transition assessment systems that have been researched (Ansell-Casey, 2003; Bullis & Fredericks, 2002; Clark & Patton, 1997; Clark, Knapp, & Corbett, 1996; Davis, Deschênes, Gamache, & Clark, 2004a, 2004b, 2004c). Literature was also searched to identify variables or indicators of progress that impact future functioning of young people with EBD, and these were also considered as potential elements in the instruments (Clark & Davis, 2000; Karpur, Clark, Caproni, & Sterner, 2005; Luecking & Fabian, 2000; Neel, Meadows, Levine, & Edgar, 1988; Newman, 2005). Additionally, focus groups were conducted with various stakeholders (e.g., transition facilitators, administrators, teachers, parents, and case managers) across the state of Florida and nationally to get their input on the TAPIS concept and variables within the TAPIS instruments.

Description of the TAPIS components

Figure 1 depicts the conceptual layout of the TAPIS system. TAPIS is a four-part system consisting of: (1) TAPIS Goal Achiever, (2) TAPIS Progress Tracker, (3) TAPIS Services Received Survey, and (4) TAPIS Young Person's Satisfaction Survey and the Parent/Other Interested Party Satisfaction Survey. Following is a brief description of each of these components.

Figure 1
Conceptual Layout of the TAPIS



The *TAPIS Goal Achiever* is used with youth and young adults to assist them in setting their own individualized goals and tracking their progress across such goals and the related tasks involved in achieving them. The Goal Achiever is currently being pilot-tested with a limited number of sites.

The *TAPIS Progress Tracker* secures data on the indicators of progress and difficulty, across the various transition domains, on youth and young adults transitioning into adulthood roles. Information within each transition domain consists of: (a) objective information on the indicators of young person's progress and/or difficulty, and (b) assessment of overall levels of functioning within each of the 11 transition domains mentioned in the TIP system (Clark, 2004). The Progress Tracker is completed by the *transition facilitator* (or other personnel most knowledgeable of the young person's recent experiences or personnel working with the young person on transition-based issues), drawing on all of the sources of information available to him/her, including, but not limited to: the youth, parents, foster parents, various agency records, school reports, and other informal and formal key players in the life of the young person. Data on all of the young people will also be stored in a spread sheet for program evaluation purposes.

The *TAPIS Services Received Survey* collects information on the services received by the youth over the past 90-day period and allows for the rating of the helpfulness of those services. It also requests information on any additional services that appear to be needed by the young person. This survey is completed by the young person within the transition program.

The *TAPIS Young Person's Satisfaction Survey* can be completed through mailings, person-to-person interviews, or telephone interviews with the young persons every six months and addresses issues such as the following:

- How satisfied are you with your progress in each of the transition domain that you are working on?
- How confident are you that you can make progress in each of the domains?
- How satisfied are you that you are getting the help you need to achieve in this domain?
- Do you have additional needs for which you require help?

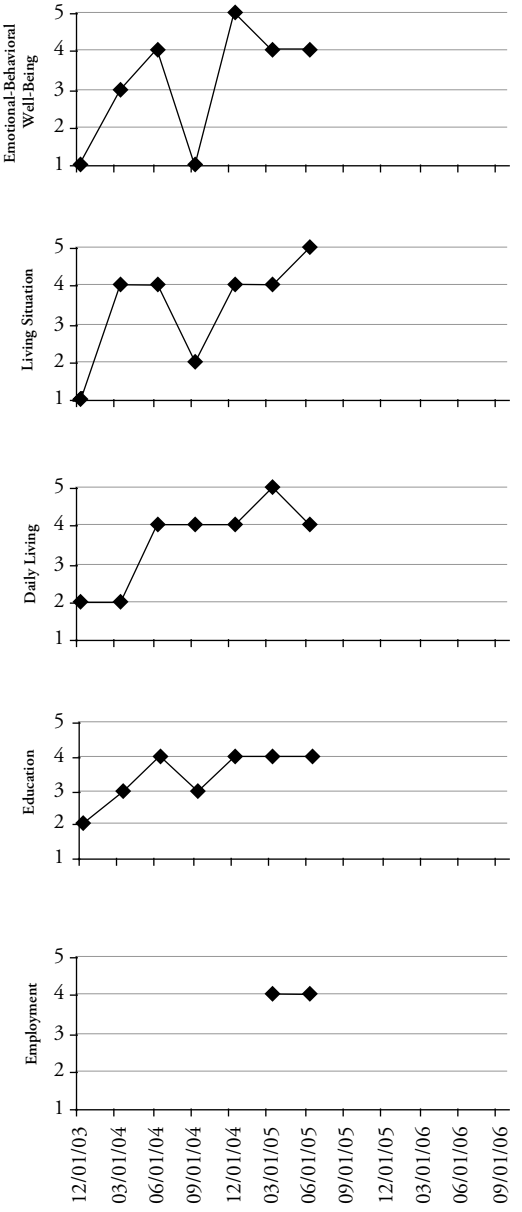
Another version of this satisfaction survey will be developed for parents and other key players associated with the young people.

TAPIS reporting format

The TAPIS Goal Achiever reporting format includes young person's individualized goals, associated tasks/strategies, and their corresponding progress rating. The TAPIS Progress Tracker report consists of: (a) Graphic Display Output and (b) Text-based Summary. The Graphic Display Output is a graphic layout of the levels of functioning of the young person for each of the 11 transition domains (e.g.,

Figure 2). It is intended to provide: (a) a global picture of the progress of the young person, and (b) an opportunity for celebrating the young person's success with the young person and his/her transition team (may consist of formal and/or informal key players). Customization for printing the most current month's responses to items or cumulative months will be built into the system. The database can be utilized to conduct an aggregated analysis for effectiveness studies for program and/or intervention impact assessment.

Figure 2
Sample Graphic Output from the Progress Tracker Report
Young Person PT Profile: Keisha W.



System description

As previously mentioned, the *TAPIS Goal Achiever* is currently being pilot-tested, with the remaining components of TAPIS in the production phase. The TAPIS is a web-enabled software system with a user-friendly graphical interface[1]. Currently the database is being designed in a SQL Server database system and the front end is provided by ASP.net. The data entered in the TAPIS system will be streamed through the internet into a database stored behind a firewall secured server at the program site. The system is designed to have an encrypted password protected access feature for maintaining data security. Administrative level access will be provided to data administrators for editing the data. The transition personnel will have the capability to view and edit records of young persons with whom they are working. The TAPIS system can be modified for transition programs serving youth and young adults with other disability classifications (e.g., physical disabilities, sensory-motor disabilities).

The TAPIS Goal Achiever and TAPIS Progress Tracker are designed to be interconnected for reporting purposes on an individual as well as aggregate basis. The TAPIS Services Received Survey and TAPIS Young Person's Satisfaction Survey and the Parent/Other Interested Party Satisfaction Survey are optional components and they are stand alone sub-systems within the TAPIS and the reports will be generated on an aggregate basis only. By design, TAPIS can function as an internet-based version as well as a stand alone system on one's laptop computer. The advantage of completing TAPIS electronically is to provide summarized instant graphical reports (as shown in Figure 2) for the transition facilitator to discuss with the young person, parents, and other informal and formal key players to encourage participatory planning.

Conclusion

TAPIS is an integrated data collecting system that is designed to inform the transition programs on: (a) the progress of young each person on their individualized goals, (b) status of each young person on the indicator progress and/or difficulty, (c) services received, and (d) the young person's/parent's/other key player's perceptions of services received and progress across all the transition domains. An integrated approach is a unique feature of the TAPIS system, which will also provide data for conducting program evaluation.

[1] *For more information on TAPIS please visit the TIP website at http://tip.fmhi.usf.edu and follow the link for TAPIS. Also, you can email Hewitt B. "Rusty" Clark or Arun Karpur (addresses below). Beta version of TAPIS Goal Achiever is now available online at http://tapisproto.fmhi.usf.edu*

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Survey Outcome for Youth with Mental Health Illnesses Transitioning from State Care

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Introduction

In the U.S., an estimated 20,000 youth leave the child welfare system every year (Propp, Ortega, & NewHeart, 2003). While in the child welfare system, these children experience an average of 4.6 out-of-home placements in various settings including foster homes, group homes, and residential programs (Courtney, Piliavin, Grogan-Kaylor & Nesmith, 2001). As young adults, they are discharged from the child welfare system at age eighteen and are often sent into the community with the expectation that they will not only survive, but also contribute to society. Due to the lack of stability in their formative years, children in state care experience many difficulties in transitioning to adulthood and are to likely develop unhealthy living patterns as well as mental health issues. According to Reilly, 2003, this group of transitioning young adults is likely to experience homelessness, incarceration, poverty, early pregnancy, unstable employment, and financial government dependency. A review of the literature indicates that about 38% of youth exiting foster care were diagnosed as having an emotional disturbance (Stoner, 1999). There appears to be very little data collected on children with a DSM-V-R Axis I diagnosis in state care. The lack of literature yielding guidance on how to best provide services and aid to this smaller segment of the transitioning young adults is problematic. This study was designed to better inform the community of the needs of these individuals.

Method

This study analyzed data on clients, ages eighteen to twenty-two, receiving outpatient services with Northside Mental Health Center's Clinical Case Management (CCM), who were admitted to Florida's state inpatient psychiatric program, admitted to the child welfare system, or both.

The targeted population in this study included all CCM clients in the past three years who were eighteen to twenty-two and receiving outpatient services. The population constitutes 30 individuals, including 10 females and 20 males, all of whom have been diagnosed with a mental health illness on Axis I. Northside CCM provided services to clients for an average of four years before the cases were closed, and thirteen of the thirty cases were open with CCM at the time of the study. The majority of CCM clients have at one time been admitted to Florida's State In-Patient Psychiatric Program (SIPP). Two-thirds of the population was also involved with the child welfare system and were transitioning from foster care into adulthood at the time services were provided.

The data were gathered by reviewing clients' charts and interviews with clients' case managers and other clinicians who worked with the clients. Data were analyzed using correlations.

Areas researched include length of stay in Northside CCM care, reason for case closing (when applicable), highest level of education achieved, employment history, type of community support system, residential placements, psychiatric emergencies, and duration of volunteer services such as therapy and respite services. Residential placements included living with relatives or friends, adult assisted living facilities, structured apartments, group homes, and shelters. Types of psychiatric emergency situations that occurred with these clients were also studied, and generally these emergencies consisted of admissions to the Crisis Center, 911 calls that did not result in any further action being pursued, arrests, and admissions to the hospital.

Information was also gathered on the types of independent living skills that these clients lacked, related to less successful transitional periods. These main categories include: maintaining proper hygiene, maintaining psychiatric stability, stress management and coping skills, ability to use the public transportation system, money management and budgeting skills, job readiness skills, and domestic skills such as cooking and cleaning.

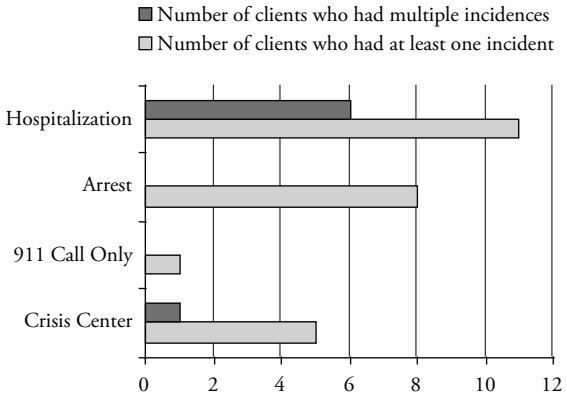
Findings

The most significant finding was the lack of stable housing for these clients. There was a significant correlation between former foster care and multiple residential placements throughout the treatment period at r = .80, as compared to an r = .70 correlation for the entire population. Over half of the population had at one time resided at adult assisted living facilities. The nine clients who terminated their care at Northside prematurely had multiple residential placements. Cases closed prematurely and psychiatric emergencies compared with a correlation of r = .78.

A correlation between all clients in treatment and occurrence of psychiatric emergencies was found to be r = .57. Clients with only one residential placement had a significantly lower correlation to occurrence of psychiatric emergencies at r = .22. The most significant positive correlation in this comparison set was for clients with multiple residences and occurrence of psychiatric emergencies at r = .71. The variance between findings for one residence as compared to multiple residences as correlated with psychiatric emergencies is statistically significant.

Clients who lived in adult assisted living facilities were more likely to experience one of these emergencies than clients who had not. The break down of types of emergencies and their frequency of occurrence are depicted in Figure 1.

Figure 1
Types of Psychiatric Emergencies



The majority of clients needed assistance in all the areas of independent living skills. The respite services are provided on a voluntary basis and are conducted in the community on an outpatient basis. There is a significant relationship between length of exposure to respite services and the amount of independent living skills addressed. For the clients who received these services for less than one month only 24% of the areas addressed included independent living skills, as compared to 57% for clients who receive these services for more than one month.

Sustaining long-term employment for this population was not common. In comparing the population's employment history, only 26% held employment for over one week. A correlation of r = .62 was found for clients who had multiple residential placements and were never employed. For clients who resided at adult assisted living facilities and were never employed, a more significant correlation of r = .85 was found. There was a correlation of r = .62 for clients who were never employed and had an arrest. Clients who were arrested and were former foster care youth had a correlation of r = .75.

The level of education these clients achieved by their early twenties was also investigated. None of these clients had high school diplomas by the age of eighteen. While receiving services at Northside,

only eight of the thirty clients completed some type of secondary education, such as a GED, a special education diploma, or a regular high school diploma. There was no direct correlation between the level of education and having multiple residences.

Conclusion

Finding a stable and motivating place of residence was shown to be paramount. The results suggest that having multiple residences relates to being more likely to be unemployed, to have psychiatric emergencies, and to terminate services prematurely. It is clearly difficult to attend school or work on a regular basis while changing residences often. It is also difficult to be contacted by potential employers when the individual does not have a stable residence. In adult assisted living facilities, these youths often live with a high proportion of adults with chronic illnesses, most of whom are no longer active in the community. Transitional youths placed in adult assisted living facilities decompensate more frequently and significantly than transitional youths in different placements. The environment found in such residences is shown to have impacts on the clients' goals and motivations.

A secondary concern was acquisition of independent living skills. These clients struggle with simple independent living tasks such as making and keeping appointments, shopping, maintaining personal hygiene, managing their money, cooking for themselves, and eating nutritious meals. Many clients are reluctant to utilize public transportation for fear of getting lost or of leaving a familiar area alone.

The respite service program is on an outpatient basis and is susceptible to compliance issues. It is concerning that only a small percentage of clients participated in these voluntary services. Possible reasons for termination of respite services may include anything from a compatibility issue to trouble contacting the client. With the instability facing the client, respite services may not be a high priority. Respite services provide a long-term benefit for the clients, and basic unmet physical needs not being met, such as food, shelter, etc., may render these services overwhelming to clients. In this manner, clients cannot see their immediate need for these services.

It appears that the current system of care does not meet the immediate needs of these clients very efficiently. Having a transitional residence including onsite independent living skills training would provide a possible solution to meeting these needs as a potential pilot program for further research. By having these clients in one residential placement for their transitioning years, clients may benefit from group socialization, consistent staff, personal mentors, on-site and hands-on life-skill training, and easier access to public services such as transportation.

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