Youth-in-Transition Service Guidelines

Division of Child and Family Services (DCFS)
Division of Juvenile Justice Services (DJJS)
Division of Substance Abuse and Mental Health (DSAMH)
Division of Services for People with Disabilities (DSPD)

I. Why an Interagency Service Guidelines on Youth-in-Transition

The Service Guidelines are developed to assist Divisions of Child and Family Services (DCFS), Juvenile Justice Services (DJJS), Substance Abuse and Mental Health (DSAMH), and Services for People with Disabilities (DSPD) to enhance their organizational capacity and workforce competence to support young people and their families so young people may successfully transition into adulthood.

II. Definition of Transition and Youth-in-Transition

Transition is the critical life stage when a person moves from late adolescence to young adulthood. Individuals vary in the age of onset and the duration of their developmental transition. The *youth-in-transition* for the service guidelines is young people between the ages of 14 and 25.

III. Why the need for youth-in-transition services

Transitioning into adulthood is an exciting and pivotal time for young people as they move into independence and the responsibilities that come with it. At the same time, it is a daunting task to conquer and navigate in a new territory: seeking higher education, getting a job, living independently, and developing relationships and healthy habits. Family members struggle to find the balance between letting loose and providing support. With the right types and amount of support, young people have opportunities for growth. Without, there is potential for lifelong hardship. The negative outcomes may include school dropout, substance use, homelessness, under- and unemployment, contacts with the juvenile or criminal justice system, poverty, and early or unplanned pregnancy.

The number of youth-in-transition is significant. In 2011-2012, 105,000 (14%) Utah children had one or more emotional, behavioral, or developmental conditions[1]. Below is the estimate of young people in transition age who received services from DCFS, DJJS, DSAMH, and DSPD:

System	Youth-in-transition population (ages 14-26), July 2012 – June 2013
DCFS	Served 1,534 transition age youth in out-of-home care
DJJS	Served 1,893 different youths under Case Management Supervision program
DSAMH	Public substance abuse system served 1,416 14- to 17-year-olds and 3,923 18- to 25-year-olds Public mental health system served 4,875 14- to 17-year-olds and 4,637 18- to 25-year-olds
DSPD	Served 1,429 individuals between 14-25 years old.

[1] *Children who have one or more emotional, behavioral, or developmental conditions | KIDS COUNT Data Center*. (n.d.). Retrieved from http://datacenter.kidscount.org/data/tables/6031-children-who-have-one-or-more-emotional-behavioral-or-developmental-conditions?loc=46&loct`=2#detailed/2/any/true/1021,18/any/12694,12695

IV. Intervention Focus

A. 14 to 16: Developing awareness and engaging in discussions on transition
B. 16 to 21: Building skills and developing knowledge for transition
C. 21 to 25: Putting knowledge and skills to use

V. Characteristics of the Population of Focus

A. Mental health and/or substance abuse disorders

According to the National Institute of Mental Health, research shows that half of all lifetime cases of mental illness begin by age 14[2]. Scientists are discovering that changes in the body leading to mental illness may start much earlier, before any symptoms appear. A large, nationally representative survey shows that at least half of all cases of bipolar disorder start before age 25. About 11 percent of adolescents have a depressive disorder by age 18 according to the National Comorbidity Survey-Adolescent Supplement. According to the World Health Organization, major depressive disorder is the leading cause of disability among Americans age 15 to 44.

Children's Defense Fund Mental Health Fact sheet indicates that:

1. One in ten children has a mental illness serious enough to impair how they function at home, at school, and with peers[3].
2. Low-income* children and children in child welfare or juvenile justice systems are disproportionately affected by serious emotional disorders.
3. Many children with mental health problems do not get the early care they need. This leads to less effective treatments and negative outcomes for children and families.
4. Untreated mental illness interferes with children's daily activities and education, contributing to substantial indirect costs of mental health problems.

According to the National Institute of Drug Abuse, January 2014:

1. Most people use drugs for the first time when they are teenagers.
2. Drug use is highest among people in their late teens and twenties[4].

For substance abuse and mental health co-occurring disorders, among youth who have received substance abuse treatment, estimates of lifetime co-occurring psychiatric disorder range from 59% to 87%[5]. For more information, please go to *Additional Resource I (Mental Health and/or Substance Abuse Disorders in Children and Youth).*

[2] Kessler RC, Chiu WT, Demler O, Merikangas KR, Walters EE. Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiatry*. 2005 Jun;62(6):617-27.
[3] New Freedom Commission on Mental Health. 2003. "Achieving the promise: Transforming mental health care in America". Final Report. 9DHHS Publication No. SMA-01-3832). Rockville, MD: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. www.mentalhealthcommission.gov/reports/report.htm.
[4] *DrugFacts: Nationwide Trends | National Institute on Drug Abuse (NIDA)*. (n.d.). Retrieved from http://www.drugabuse.gov/publications/drugfacts/nationwide-trends
[5] Garland, et al., 2001; Molina, et al., 2002; Robbins, et al., 2002; Westmeyer, et al., 1994

B. Delayed or Interrupted Psychosocial Development:

A progressive psychosocial development increases youth's capacity to handle adulthood responsibilities. Young people with mental health conditions often experience delayed or interrupted development which impedes their abilities to succeed in adulthood[6]. Psychosocial development includes: cognitive development, social development, moral development, social-sexual development, and identity formation. For more information, please go to *Appendix I and Additional Resource II (Psychosocial Development).*

C. Family Cultures and Dynamics

Transitioning significantly impacts family dynamics when the roles and expectations of parents and young people change. Families provide critical support while young people exercise independence. Family cultures and dynamics also heavily influence the pace and outcome of the transitioning. Young people who are involved in social service systems encounter additional challenges receiving the necessary support from family when negotiating transition tasks. The challenges include:

1. Families are used to providing nurture and protection to children with special needs. They may fear how young people will survive in the world without them there to protect and advocate.
2. Families may not have the structure or stability to help young people acquire the skills for successful transition.
3. Young people experience multiple or extended periods of out of home placements that interrupt their bonding or attachment with families.

For more information, please go to *Appendix II and Additional Resource III (Family Cultures and Dynamics).*

D. Brain Development

New technology has allowed scientists to examine brain development. Adolescent brain development is a time of risk and opportunities. Toxic and prolonged stress such as trauma without adequate adult support can disrupt the development of brain architecture[7]. Consistent caring, supportive relationship can mitigate stress responses from toxic to positive or tolerable[8]. The teen brain doesn't look like that of an adult until the early 20s[9]. For more information, please go to *Additional Resource IV (Brain Development).*

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[6] Davis, M., Sabella, K., Smith, L. M, & Costa, A. (2011). *Becoming an Adult: Challenges for Those with Mental Health Conditions.* Research Brief 3. Worcester, MA: University of Massachusetts Medical School, Department of Psychiatry, Center for Mental Health Services Research, Transitions Research and Training Center.

[7] *Toxic Stress: The Facts*. (n.d.). Retrieved from http://developingchild.harvard.edu/topics/science_of_early_childhood/toxic_stress_response/

[8] Ibid.

[9] *NIMH · The Teen Brain: Still Under Construction*. (n.d.). Retrieved from http://www.nimh.nih.gov/health/publications/the-teen-brain-still-under-construction/index.shtml?utm_source=LifeSiteNews.com+Daily+Newsletter&utm_campaign=2c0fa9560b-LifeSiteNews_com_Intl_Full_Text_12_18_2012&utm_medium=email

E. Disruption in Education

Children with disabilities or emotional/behavioral challenges often struggle with traditional classroom setting, or their education is interrupted by out of home placements or hospitalizations. Poor educational attainment impacts a person's employment future, self-sufficiency, social roles, and community participation. For more information, please go to *Additional Resource V (Disruption in Education).*

F. System Coordination

Young people who age out of child-serving systems often have difficulty obtaining services in adult systems. Services are organized differently in the adult system, which is a barrier for many young people trying to navigate the system. Many young people have to change providers and re-establish relationships, which may contribute to young people dropping out of treatments. When children and adult system do not coordinate the transition of care, young people are the ones who suffer. For more information, please go to *Additional Resource VI (System Coordination).*

G. Trauma

More than 25 percent of American youth experience a serious traumatic event by the age of 16, and many children suffer multiple and repeated traumas[10]. Research has highlighted the central role of trauma in mental and substance use disorders and the linkage between trauma experiences and other chronic physical diseases. For more information, please go to *Additional Resource VII (Trauma).*

H. Youth Culture

Youth culture refers to the ways that youth conduct their lives: interests, styles, behaviors, communication, relationship, music, beliefs, vocabulary, clothes, sports and dating, etc. To engage youth, we need to be aware of, acknowledge, and respect youth culture and infuse youth voice into our system. For more information, please go to *Additional Resource VIII (Youth Culture).*

VI. Values and Principles

The youth-in-transition system adheres the following five values and guiding principles[11]:

A. Family-driven, youth-guided, person-centered, and strength-based

The needs and strengths of the young people and their families dictate the types and mix of services provided. Young people and their families are involved in all levels of decision making and policy making process.

B. Community-based

The locus of services and management and decision-making responsibility rests at the community level.

[10] *National Center for Child Traumatic Stress Online Press Kit | National Child Traumatic Stress Network - Child Trauma Home*. (n.d.). Retrieved from http://www.nctsnet.org/resources/audiences/for-the-media/online-press-kit

[11] http://www.tapartnership.org/SOC/SOCvalues.php

C. Integrated and coordinated
Services and systems are integrated, with linkages between child- and adult-serving agencies for coordinated care.

D. Culturally competent
Agencies, programs, and services are responsive to the cultural, racial, and ethnic differences of the populations they serve.

E. Outcome-based
Observable and measurable indicators of success guide the implementation process.

F. Developing formal and informal support system
Young people have the "natural support" available to them through strengthening interpersonal relationships and utilizing other resources that are available in their network of social and community relationships.

G. Safety, permanency, well-being
Safety is a concept that incorporates three items: threats to safety, vulnerability and protective capacities. Threats to safety are conditions in the child's environment that can lead to harm. Vulnerability includes the child's age and development level, their visibility in the community and their role in the home. Protective capacities include caregiver behavior and resources that manage the threats to safety. **Permanency** is best achieved through a legal relationship such as parental custody, guardianship, or adoption. 'Stability' is not permanency. Life-long family connections are critical for children. It is our responsibility to promote and preserve kinship, sibling, and community connections for each child. We value past, present, and future relationships that consider the child's hopes and wishes. **Well-being** is the importance of providing services that meet the educational, emotional, physical, and mental health needs of children and families. A framework for well-being can be set around four domains: cognitive functioning, physical health and development, behavioral/emotional functioning, and social functioning. This focus on well-being is based on evidence that abuse and neglect can have adverse effects across a child's lifetime; but certain interventions can reduce the behavioral, social, and emotional impacts of maltreatment.

VII. Collaboration and Partnerships

A. Youth-adult partnership
Young people are more invested in services if they feel they are full partners in the process, meaning they are respected, their voice is heard, and people have confidence in their judgments. Youth MOVE National defines "Youth-Guided" as young people having the right to be ***empowered, educated***, and given a decision making role in the care of their own lives as well as the policies and procedures governing care for all youth in the community, state and nation. This includes giving young people a ***sustainable*** *voice and then* ***listening*** *to that voice.* Youth guided organizations create safe environments that enable young people to gain self ***sustainability*** in accordance with the cultures and beliefs with which they identify. Further, a youth guided

approach recognizes that there is a continuum of ***power*** that should be shared with young people based on their understanding and maturity in a ***strength*** based ***change process***. Youth guided organizations recognize that this process should be ***fun*** and ***worthwhile***[12]. For additional information on youth-adult partnership, please go to *Appendix III and Additional Resource IX (Youth-Adult Partnership).*

B. Partnership with families and other permanent adult relationships
Young people who have permanent and meaningful connections have a support network on which to fall back on when difficulties arise. This could be emotional support, financial support or even networking to find employment, further their education or build more support systems. Working with the youth's family and other permanent connections ensures communication regarding the youth's transition plan including what the family or other permanent connections role will be as the youth becomes an adult. Bringing the youth's family or other permanent connections to the table is paramount to a youth's success.

C. State-local-tribal collaboration
The Indian Child Welfare Act (ICWA) is a federal law that seeks to keep American Indian children with American Indian families. Congress passed ICWA in 1978 in response to the alarmingly high number of Indian children being removed from their homes by both public and private agencies. The intent of Congress under ICWA was to "protect the best interests of Indian children and to promote the stability and security of Indian tribes and families" (25 U.S.C. § 1902). ICWA sets federal requirements that apply to state child custody proceedings involving an Indian child who is a member of or eligible for membership in a federally recognized tribe. ICWA is an integral policy framework on which tribal child welfare programs rely. It provides a structure and requirements for how public and private child welfare agencies and state courts view and conduct their work to serve tribal children and families. It also acknowledges and promotes the role that tribal governments play in supporting tribal families, both on and off tribal lands. DCFS has Memorandum of Understanding with each of the Utah tribes. DCFS has a staff dedicated to ensuring the implementation of ICWA in Utah.

D. Collaboration with community-based organizations
One goal of transitioning is to assist young people in developing their own support networks so they gradually need fewer services from the Department of Human Services. The source of the support network can be peers, families and adult allies, community-based organizations, and advocacy groups. Community-based organizations may include faith-based groups, community service and action groups, educational groups, sports clubs, youth groups, community support groups, and advocacy groups.

[12] *Youth-Guided Definition, Youth M.O.V.E. National*. (n.d.). Retrieved from http://www.youthmovenational.org/youth-guided-definition

E. Collaboration with the adult system
One determinant of transition outcomes is how young people access appropriate and quality services in the adult system. Social service system is fragmented at the point of entry into adulthood and such fragmentation contributes to discontinuity in services.

1. Mental Health, Substance Abuse, and Co-Occurring Disorders
Child and adult mental health and substance abuse systems are different in many ways, e.g., treatment philosophy, evidence-based practices, and eligibility criteria. According to Dr. Maryann Davis, people ages 16-30 drop out of mental health treatment more frequently than other age groups. Reasons may be loss of health care coverage or a feeling that the treatment is not relevant to their lives. Substance abuse is wide spread over all types of offenders in the Juvenile Justice system. Drug offenders make up about ¾ of the youth transitioning out of the Juvenile Justice[13]. The unique cognitive and psychosocial development of young adults and their life circumstances can render either "child" or "adult" interventions inappropriate[14]. It is critical to understand the "in-betweenness" of this population and develop strategies to ensure appointments and transfers of services are put into place prior to the young people aging out of the children's mental health system.

2. Criminal Justices
Partnership with the adult system should focus on establishing stability factors to lessen the stay in the adult system and achieve better outcomes[15]. When dealing with youthful offenders, we should consider brain maturation that inhibits self-control and increases impulsive behavior. When these young people get transferred to the adult system, they tend to receive longer and more punitive sentences.

VIII. Practice and Support

A. Pathway into Care

1. DCFS: Children enter into custody of DCFS through an order of the Juvenile Court. The majority of children in foster care are there due to issues of abuse, neglect or dependency. Youth can also be ordered into foster care due to ungovernable or delinquent behaviors. There is a Transition to Adult Living (TAL) Coordinator at each of the five DCFS regions (Western, Southwest, Eastern, Salt Lake Valley, and Northern). When a youth turns 14, the TAL Coordinator reviews his/her Casey Life Skills Assessment to determine the need for transition services. Young people are eligible for funding for housing and work-related expenses. TAL Coordinators do not provide transition

[13] Walters, Zanghi, Armstrong, and Sutter, 2010

[14] IOM (Institute of Medicine) and NRC (National Research Council). 2013. *Improving the health, safety, and well-being of young adults: Workshop summary.* Washington, DC: The National Academies Press. http://www.nap.edu/download.php?record_id=18340 (accessed October 23, 2013). P. 51

[15] Walters, Zanghi, Armstrong, and Sutter, 2010

services, but help link young people to community resources so they may develop the necessary skills and competency for adulthood. These services and supports continue until the youth exits custody.

2. DJJS: The youth-in-transition services at DJJS focus on from placement to placement. There is not a formal transitioning-into-adulthood program per se. Transition services begin when placement starts. Case Managers evaluate whether youth have a viable placement with family or responsible adult to return to. Stability factors such as stable housing, vocational/education, criminogenic needs, financial stability, and medical/health needs are evaluated when making placement decisions.

3. DSAMH: Mental health and substance abuse treatment services are provided by local mental health and substance abuse centers. DSAMH works with the mental health and substance abuse centers to enhance the youth-in-transition services through case management, recovery support and family/peer support services. If young persons are already receiving services from the mental health/substance abuse center, they or family members can request to have youth-in-transition services included in treatment plans. If young persons are not receiving services from the mental health/substance abuse center, they would need to go through the regular intake process and request youth-in-transition services. For a directory of the mental health/substance abuse center, please go to: http://dsamh.utah.gov/.

4. DSPD: The Division of Services for People with Disabilities serves persons on four Medicaid Waivers. Once a person is on a Medicaid Waiver they remain in service for the duration of their life. Hence, DSPD begins the pathway into care as soon as the person is brought into one of the waivers. The transition process into adulthood begins while the person is in high school. The person has a Support Coordinator that advocates and provides case management for the person to ensure that health and safety needs are met. The Support Coordinator also guides the person to discover what skills they possess to make the transition smoothly. The person is encouraged to lead and direct their person centered planning meetings. These are held once a year to go over goals and aspirations. As they near the completion of school, they are encouraged to meet with a Vocational Rehabilitation Counselor who will assess their abilities and assist them to find suitable work. If work is not a possibility after exploration, then other options are explored to help the person live a productive and independent life. The person may be his or her own guardian, or may have a guardian to help them make important decisions. In either case, it is the choice of the person to choose the course of action they would like to pursue to live as independently as possible. This may be living with family members, in his/her own apartment with minimal supports or in a full residential setting depending on the person's abilities.

B. Transition assessment

1. Housing and Money Management: They include the following skills and services: finding and maintaining appropriate housing; filling out a rental application and acquiring a lease; handling security deposits and utilities; understanding tenants rights and responsibilities; handling landlord complaints; transportation issues; accessing community resources; healthy beliefs about money; understanding the benefits of saving; understanding income tax and preparing tax forms; understanding banking and credit; how to create a budgeting/spending plan; opening and using a checking and savings account; balancing a checkbook; developing consumer awareness and smart shopping skills; accessing information about credit, loans and taxes; and how income effects spending.

2. Work, Career Planning and Education: They include the following skills and services: making short and long term employment, vocational, and/or educational goals (including goals for post-secondary education); decision making skills; study habits and skills; searching for and maintaining employment; applying for a job; creating a resume; completing a job application; interviewing for a job and following-up; job shadowing and/or coaching; receiving job referrals; using career resource libraries; understanding basic workplace technology; understanding employee wages, benefits, and rights; knowing how to change jobs; knowing the rights and protections in place for employees; appropriate communication skills and other workplace values (timeliness and appearance, etc); understanding authority and customer relationships; academic supports and counseling; preparation for a GED, including assistance in applying for or studying for a GED exam; test preparation for SAT or ACT; tutoring; help with homework; literacy training; help accessing educational resources; counseling about college; information about financial aid and scholarships; help completing college or loan applications; or tutoring while in college.

3. Health, Mental Health and Wellness: They include the following skills and services: personal hygiene; nutrition; health, dental, and mental health issues; understanding the effects and consequences of alcohol, drug, and tobacco use; substance avoidance and intervention; understanding issues regarding sexuality; pregnancy prevention and family planning; education regarding HIV, AIDS, and other sexually transmitted diseases, including their prevention; fitness and exercise; basic first aid; and medical and dental care benefits and insurance.

4. Daily Living: It includes the following skills and services: meal and menu planning; grocery shopping; home clean up and storage; home management; home safety; legal issues; properly using kitchen equipment and other home appliances; proper clothing care; basic home maintenance and repairs; how to handle emergency situations; computer and internet basics; keeping a healthy

and safe home; safe and proper food preparation; laundry; housekeeping; and living cooperatively.

5. Communication, Relationships, Family and Marriage: They include the following skills and services: developing self-esteem; knowing and understanding personal strengths and needs; understanding the benefits of ethical, caring, respectful behavior; clearly communicating in different settings; safely using electronic communication; being appropriately assertive; anger management; conflict management and resolution; developing and using a support system; developing strong community supports and interdependent connections; developing connections to trusted adults; maintaining appropriate and healthy friendships and relationships; having cultural awareness; appropriate etiquette; parenting and marriage issues; childcare skills; teen parenting; responsible fatherhood; domestic and family violence prevention; and proper social communication.

   Adult Needs and Strengths Assessment for Transition to Adulthood (ANSA-T) and Casey Life Skills are two instruments that assess the aforementioned domains. For additional information on these two instruments, please go to *Additional Resource X (Transition Assessment).*

C. Person Centered Planning

"Person Centered Planning discovers and acts on what is important to a person. It is a process for continual listening and learning, focusing on what are important to someone now and in the future, and acting on this in alliance with their family and their friends"[16]. It is an approach designed to assist someone to plan the person's life and supports. "It is used most often as a life planning model to enable persons with disabilities or otherwise requiring support to increase their personal self-determination and improve their own independence"[17].

The Person Centered Planning is designed to take into consideration the following: sharing ordinary spaces; making choices; developing abilities; being treated with respect and have a valued social role; employment; and grow in relationships.[18] Person-centered planning places the person at the center of decision-making and treating family members as partners. The process focuses on discovering the person's gifts, skills and capacities, and on listening for what is really important to the person. It is based on the values of human rights, interdependence, choice and social inclusion, and can be designed to enable people to direct their own services and supports, in a personalized way.[19]

[16] Thompson J. Kilbane J. Sanderson H. (2008) Person Centered Practice for Professionals. Open University Press
[17] Families Leading Planning 'What is Person Centered Planning? http://www.familiesleadingplanning.co.uk/Documents/WHAT%20IS%20PERSON%20CENTRED%20PLANNING.pdf
[18] O'Brien J. (1989) What's worth working for? Leadership for Better Quality Human Services. Syracuse NY. The Center on Human Policy, Syracuse University for the Research and Training Center on Community Living of University of Minnesota.
[19] Mount, B (1992) Person Centred Planning; A Sourcebook of Values, Ideas and Methods to Encourage Person-Centered Development. New York, Graphic Futures

It is during the Person Centered Planning that attainable goals are set by the person and his or her team. These goals are worked on during the year and assessed monthly. Goals are supported by strategies to help the person accomplish their goals. When a goal is reached the person may choose to set a new goal to work towards. There are also non-goal based supports that represent tasks that are intended to address health and safety issues for the person. For more information, please go to *Additional Resource XI (Person Centered Planning)*.

D. Transition supports

Transition supports should take a whole-person's approach and focus on key life domains[20]:

1. Employment and Career: They include competitive employments, work experience opportunities, supported employment, and transitional employment opportunities.
2. Educational Opportunities: They include post-secondary education, vocational or technical certification, and high school completion or GED.
3. Living Situations: They include independent residence, residing with family, semi-independent living, and supported housing.
4. Community Life Functioning: They include:
    a. Daily Living (self care, money management, and independent living skills)
    b. Leisure Activities
    c. Community Participation (transportation, knowledge of community resources, citizenship responsibilities, social support, and cultural and spiritual resources)
    d. Health (health care, fitness, emotional self-management, healthy sexuality)
    e. Self-Determination (goal setting, advocate for one's rights and positions)
    f. Communication
    g. Interpersonal Relationships
    h. Personal Effectiveness and Wellbeing

For more information, please go to *Additional Resources XII (Transition Supports)*.

E. Peer Support

Peer Support is different from other types of social support in that the source of support is a peer, a person who is similar in fundamental ways to the recipient of the support. A peer is in a position to offer support by virtue of relevant experience: he or she has "been there, done that" and can relate to others who are now in a similar situation.[21] Peer Support occurs when people provide knowledge, experience, and

[20] Clark, H.B. (2004, original version 1995). *Transition to Independence Process: TIP System Development and Operations Manual.* Tampa, FL: Louis de la Parte Florida Mental Health Institute, University of South Florida.

emotional, social or practical help to each other.[22] During the typical stage of transitioning into adulthood, peer influence plays a significant role in young people's social and identity development.

Peer support is an evidence-based practice for supporting people with mental illness and substance use disorders. DSAMH has training and certification programs for Certified Peer Support Specialists and Family Resource Facilitators (FRFs). Certified Peer Support Specialists people who self-identify as current or former consumers of mental health or dual diagnoses services, are well-grounded in their own recovery, are at least 18 years of age, successfully complete a 40-hour training program, and pass a proficiency test. Certified Peer Support Specialists utilize their own recovery experiences to help engage and motivate others and advocate for them. FRFs are family members of individuals with complex needs who complete a 40-hour training program and receives mentoring from experienced Family Mentors. FRFs act as advocates and resource coordinators for children, youth and families. Both Certified Peer Support Specialists and FRFs work alongside other mental health and substance use professionals to improve the quality of life of those they serve.

Peer support doesn't have to be a formal program to have a positive impact. Informal peer support can take place every day and everywhere. It can be the time when young people just talk, vent, have fun, laugh or even cry together. It is times when they can be true self and count on each other's genuine support to celebrate success or just get through the adversity. For more information, please go to *Additional Resources XIII (Peer Support).*

F. Family and adult allies support for enduring social connection
Youth who have family and adult allies have an increase in their social capitol. Social Capital are personal relationships youth may have that could facilitate employment, such as access to an adult who could provide assistance getting a job or access to a social network that could provide information about employment opportunities.[23]

G. Working with Special Populations (For more information, please go to *Additional Resources XIV (Working with Special Population.)*
    1. Young people with intellectual or developmental disabilities
    All of the issues that affect young people, such as access to education, employment, health care and social services, also affect youth with disabilities, but in a far more complex way.[24] "Attitudes and discrimination linked to disability make it much more difficult for them to go to school, to find work or to participate in local activities. In many communities, both rural and urban, the environment is immensely challenging with physical and

[21] Wikipedia, http://en.wikipedia.org/wiki/Peer_support
[22] Shery Mead, David Hilton, Laurie Curtis, "Peer Support: A Theoretical Perspective."
[23] Caspi, Entner, Wright, Moffitt, & Silva, 1998
[24] Burchardt T. 2004. Aiming high: The educational and occupational aspirations and of young disabled people. Support for Learning 19(4):181-6.

communication barriers that make it hard for them to participate in social life".[25] When working with a person with a disability it is important to remember that they have the same dreams as anyone and want to be treated with respect. The challenge is to discover what they want to do when they transition into adulthood and help them realize their aspirations. Discovery is an amazing journey for any person and it takes time. Often times we expect them to work as janitors or greeters but they do have skills to do so much more. It is through asking the person what they like to do: Do they want to further their education? What are their hobbies? What kind of work do they like? Only after asking these and other questions will a fitting job be found with the skills they possess. It is investigating the work establishments and asking employers about their businesses to see if it would be a possibility for employment for the person. If school is the goal, there are accommodations for people with disabilities, scholarships, and other resources that can be accessed to help with the demands of campus life. There is a disability culture and in essence they want to be known for their abilities and not for their disabilities. They will also need access to but not limited to these agencies: DSPD, Vocational Rehabilitation, Mental Health, Health Care, Social Security, Medicaid, and Service Providers. Their support should come from but not limited to family members, guardian(s), Case worker, schools, friends, providers, and medical professionals.

2. Young people with or at risk of developing mental health/substance use disorders
   Individuals between the ages of 16 and 25 are at high risk for developing mental illness or substance use disorders and suicide. Unfortunately, these young people are among the least likely to seek the help they need to assume safe and productive adult roles and responsibilities. As a result, it is important to identify these young people whether they already are receiving mental health/substance abuse services or not. Outreach and engagement are essential to identify and retain the participation of these young people and their families, as many of them are disconnected from social and other community supports. Many of these young people are not working, in school, or in vocational or higher education programs. Some face the additional challenges of homelessness, early pregnancy, or contacts with the juvenile or criminal justice system. They may be admitted into hospitals, residential treatment programs, and correctional facilities. Once identified and engaged, it is essential to help young people improve emotional and behavioral functioning so they can progress into adult roles and responsibilities and lead full and productive lives.[26]

[25] DESA: http://undesadspd.org/Youth/ResourcesandPublications/YouthWithDisabilities.aspx

[26] *"Now is the Time" Healthy Transitions (HT): Improving Life Trajectories for Youth and Young Adults with, or at Risk for, Serious Mental Health Conditions | SAMHSA Beta*. (n.d.). Retrieved from http://beta.samhsa.gov/grants/grant-announcements/sm-14-017

3. Young people in foster care
   National studies on kids aging out of foster care show that:
   a. 60 percent of females had given birth.
   b. 90 percent have no health-care coverage.
   c. Are more likely to be homeless.
   d. Have lower math and reading skills and only half complete high school.
   e. Are more likely to be involved in the criminal justice system with about 19 percent incarcerated.

   It is critical that we provide youth assistance in transitioning from foster care to adult living through a private/public network of support, in order to promote their success. This assistance should include assessment, mentoring, self-esteem building, personal future planning, caregiver and family networking, basic life-skills training, housing, leisure skills, education, employment, on-the-job training, information and referral, crisis support, medical, mental health and limited financial assistance.

4. Young people with trauma histories
   Unfortunately, trauma is rather prevalent in today's society. We can reasonably expect that it takes trauma survivors a long time to feel safe to discuss the trauma and the impact of trauma in their lives. The system should take a universal precaution approach and treat every young person as if trauma has been part of his/her life.

5. Young people with personality disorders or traits
   A personality disorder is a type of mental disorder in which the person has a rigid and unhealthy pattern of thinking, functioning and behaving. The disruptive behaviors and unstable moods resulting from personality disorders or traits in young people often are misdiagnosed as psychiatric disorders, such as bipolar. The misdiagnosis leads to wrong treatment, including medication. It is important to accurately identify personality disorders or traits in young people so effective treatment can be provided.

6. Young people with Acquired Brain Injury
   Teenagers with an acquired brain injury may have visible physical disabilities and many of the invisible effects of brain injury. These invisible disabilities may include problems with learning, memory, attention, problem solving, and behaviors. Those who are turning 18 – 21 years old and graduating from local school-district programs, are faced with having to make vocational, continued education and other life choices. Employers, supervisors, trainers, and educators though may not have had a lot of experience in the field of acquired brain injury, and it is important to raise awareness and educating those occupational groups to have those affected by acquired brain injury integrate better.

7. Young people who are homeless
   "By age 26, 36% of the young people who have aged out of the foster care system whose outcomes were known had reported at least one episode of homelessness. Some predictors of homelessness include: males, youth who have runaway from at least once from proctor placement, youth who experience multiple placement changes, prior physical abuse before entering foster care, delinquent behaviors, and symptoms of mental illness.[27]

   Homeless youth face a number of challenges. They often have educational difficulties. They tend to have a higher risk of mental health issues. They engage in more risky behaviors which include being sexually active with the lack of use of precautions that can help to reduce risk of pregnancy or sexual transmitted diseases. Further they are more often engaged in criminal activity like prostitution, dealing drugs, thefts etc. These types of activities increase their risk of being victims of physical or sexual abuse.[28]

8. Young people who are in the correction systems
   It is important to find ways to better collaborate with the adult criminal system for youth who age out of the juvenile justice system. When youth move into the adult system they tend to receive longer sentences. Many young people who age out of the juvenile justice system lose the healthcare coverage. They are expected be old enough and prepared to be independent. Without continuous support, only about 30% of delinquent youth are involved in continued education/vocational services. About half of the youth who age out of the juvenile justice system commit another offense within a year of aging out, or one in five experiences homelessness, and only 60% finish high school, compared to 87% of youth not involved in the juvenile system.[29] Providing better supports for these youth will increase cost savings in the community, increase community safety and enable youth to become more successful members of society.

   Young people who age out of the juvenile justice system are often reintroduced into society without the necessary tools to function productively in society. Despite the fact that reentry services that connect youth and young adults to case managers, employment and education services, and mentors have proven to reduce recidivism rates, "plans are rarely in place to support

[27] Dworsky, A. (2012, January 1). Chapin Hall at the University of Chicago. *Predictors of Homelessness during the Transition from Foster Care to Adulthood*. Retrieved April20, 2014, from http://www.chapinhall.org/research/inside/predictors-homelessness-during-transition-foster-care-adulthood

[28] Dworsky, A. (2012, January 1). Chapin Hall at the University of Chicago. *Predictors of Homelessness during the Transition from Foster Care to Adulthood*. Retrieved April20, 2014, from http://www.chapinhall.org/research/inside/predictors-homelessness-during-transition-foster-care-adulthood
Toro, P. A., Dworsky, A., & Fowler, P. J. (2007, March 1). Homeless Youth in the United States: Recent Research Findings and Intervention Approaches. *2007 National Symposium on Homelessness Research: Homeless Youth in the United States: Recent Research Findings and Intervention Approaches*. Retrieved April 20, 2014, from http://aspe.hhs.gov/hsp/homelessness/symposium07/toro/

[29] Altschuler, D., Stangler, G., Berkley, K., Burton, L., & , (2009). Supporting Youth In Transition to adulthood: Lessons learned for child welfare and juvenile justice. *Center for Juvenile Justice Reform*

youth as they exit confinement and reintegrate back into their family, school, and community".[30] "Reentry services and aftercare programs for youth who are exiting custody can reduce recidivism. Reentry supportive services are designed to improve family relationships, reintegrate youth into school, offer independent life skills, build resiliency, and bolster positive youth development to divert juveniles from harm and problematic behaviors".[31] "Youth who spend time in facilities have higher recidivism rates; are less likely to naturally age out of illegal behavior; suffer from more mental illness and are at a higher risk of suicide; they are less likely to succeed at education and employment at the same level of youth who were never incarcerated".[32] The following are stability factors that need to be put into place to help young people involved in the juvenile justice system successfully transition into adulthood:

a. Vocational training
b. Life Skills training
c. Housing
d. Drug rehabilitation
e. Work programs/ or stable employment
f. Pre-release program in order to guide EA in transition
g. Social integration into the family and community system care/support
h. Advancement in school studies
i. Development of pro social relationships
j. Mental health service linkage in the community
k. Health care coverage to assist in medical and medication needs
l. Addressing criminogenic needs in lowering risk of recidivism

Expungement - An expungement is a crucial step in the closing of juvenile record. Many youth and their families are under the misconception that juvenile records are automatically expunged or sealed when the minor turns 18. This is not true. An expungement requires additional actions on the part of the minor but is an incredibly important step. It is an option that every juvenile should consider. A young person is eligible for an expungement once he/she turns 18 and the court jurisdiction has been terminated for 1 year. The Judge can waive the above conditions for good cause.

When the young person decides it is time to file for an expungment, the process is begun by obtaining a Criminal Background Check from the Department of Public Safety, Bureau of Criminal Identification (BCI) at 801-965-4445. This has to be done in person and the cost is currently $15.00. Once a BCI is obtained you must submit it to the court with a petition for

[30] Youth Reentry Task Force of the Juvenile Justice and Delinquency Prevention Coalition (2009). *Back on Track: Supporting Youth Reentry from Out-of-Home Placement to the Community*. p.5.

[31] Youth Reentry Task Force of the Juvenile Justice and Delinquency Prevention Coalition (2009). *Back on Track: Supporting Youth Reentry from Out-of-Home Placement to the Community*. p.10.

[32] Justice Policy Institute (2009). *The Cost of Confinement: Why Good Juvenile Justice Policies Make Good Fiscal Sense*. Retrieved on November 29th, 2011 from http://www.justicepolicy.org/images/upload/09_05_REP_CostsofConfinement_JJ_PS.pdf, p.9

expungment. A sample petition can be obtained from the juvenile court or from the Utah State Courts website. Time is of the essence once you have obtained the BCI certificate. So be prepared to file the petition immediately after obtaining the BCI. There is a $135.00 filing fee to file a petition for expungment and it can be waived based on income guidelines.

Once the court files the petition the expungement must be set for a hearing before the Judge, unless the record consists only of non-judicial closures. If there was a victim in the juvenile court case, the court will notify the victims that they have the right to attend the hearing and testify regarding the expungement. The court will consider whether the young person has been rehabilitated to the satisfaction of the court in deciding whether to expunge the record. If the court grants the expungement, the court will provide the young person with orders for the correlating agencies. The young person must deliver the orders to the agencies. The only charges prohibited from expungement are aggravated murder and murder.

9. Young people who are pregnant or parenting
   Each year, there are approximately 750,000 teen pregnancies and 400,000 teen births in the United States. Nearly 3 in 10 girls get pregnant at least once before age 20; higher rates for youth of color. When working with pregnant or parenting young people, it is important to consider their unique needs. Services should emphasize self sufficiency, housing stability, developmental outcomes of their children, healthy relationship, and sexuality issues. It is important not to overlook young fathers who also need specialized assistance in transitioning. For more information, please go to *Additional Resources XIV (Working with Special Population).*

10. Young people with cultural and/or linguistic diversities
    Diversities include, but are not limited to, race, ethnicity, gender, sexual or gender orientations, socioeconomic status, geography, religion, language, immigration status, and disability. Cultural diversity impacts many components of transitioning: adolescent development, expectations of adult roles, community resources or support they have access to, and the quality and appropriateness of the care. Staff should keep in mind following points when working with young people of diversity:
    a. Eliminating barriers to access to care and support
    b. Involving families and the community in the young person's treatment
    c. Conducting assessment that incorporates cultural perspectives
    d. Provision of linguistic assistance

    For more information, please go to *Additional Resources XIV (Working with Special Population).*

IX. Workforce Development

A. Skill sets and key knowledge for administrators, supervisors and line staff:
   1. Youth and family development approach
   2. Brain development
   3. Cultural competency
   4. Trauma
   5. Youth engagement
   6. Motivational enhancement
   7. Community resources

B. Coaching/Training/Supervision
   1. Ensuring staff safety
   2. Boundaries – professional and ethic
   3. Fidelity to practice standard
   4. Reframe youth behavior – no shaming and blaming
   5. How trauma and mental illness may present in young people
   6. Ensuring continuity of care between children and adult systems

X. Organizational Commitment

A. Understanding youth culture and creating youth friendly environment
   1. Texting policy – While the primary method of communication with youth may be through texting, it is important to remember these conversations fall within your professional responsibility to engaged the youth in the decision making process for their case. Make sure the youth is developing interpersonal skills as well as texting skills. These conversations via text are also part of the case record and must be documented appropriately. Always follow your agency's policy regarding texting.

   2. Social Media policy – Social media can be a very useful tool for both service delivery and information regarding a youth's choices. Professional and ethical boundaries must be maintained when using social media to interact with youth. Follow your agency's policy regarding the use of social media in a professional setting. If your agency allows you to create a professional Facebook page, it may be a useful tool to engage youth. Interactions with youth via social media are also part of the case record and must be documented. For more information, please go to *Additional Resource XV (Social Media Policy)*.

   3. Staff availability – When making appointments with young people, staff need to consider other commitments in young people's lives, e.g., school, work, family and friends. Additionally, crises often happen during after work hours (evening or weekends.) It's important that staff is available beyond the regular working hours.

B. Positive youth development approach
The focus of the positive youth development approach is to help youth acquire the knowledge and skills they need to become healthy and productive adults. Positive youth development builds on young people's strengths and recognizes their unique contributions. Implementing the positive youth development approach requires preparation of the organization, adults, and youth. Policy and practice must be reviewed to ensure that they support the positive youth development philosophy. Barriers should be addressed. Adults must examine their views of young people and work to see them as "resources" rather than "problems to be fixed." Training, such as the *Youth Development: The Vital Link* from the National Resource Center for Youth Development (NRCYD) can assist in this process. Young people also need preparation to be able to fully participate in the opportunities provided to them. For more information, please see *Additional Resources VIII (Youth Culture)*.

C. Youth leadership development
Young people need leadership skills so they may be full partners and meaningfully participate in decision making at all levels. Leadership skills include advocating for self and others, sharing personal stories strategically, public speaking, working as a team, communicating effectively, and resolving conflicts productively. They need training, mentoring and practice opportunities to develop these skills. Agency and staff should provide the resources to help young people gain and use the leadership skills. For more information, please see *Additional Resources VIII (Youth Culture)*.

XI. Resources

A. Just for Youth website, http://justforyouth.utah.gov/
B. Utah Yellow Pages for Youth – University of Utah, https://yellowpagesforyouth.ucjc.utah.edu/ucjc/yellowpages/

Appendix I

Stages of Psychosocial Development in Adolescence and Young Adulthood[1]

Stage of Development	Highlights of each stage	Consequences of developmental delay & potential additional challenges for those with serious mental health conditions
Cognitive Development	Increased capacities for • Thinking abstractly • Thinking hypothetically (if X, then Y) • Having insight or self-awareness • Simultaneous consideration of multiple ideas • Future planning • Calibrating risks and rewards • Regulating undue peer influence on judgment	• Delays can impede abilities to: ○ develop & execute plans ○ weigh pros and cons of actions ○ make changes based on self-awareness ○ regulate peer influence on judgment • Additional challenges; High rates of co-occurring learning disabilities and developmental disorders, which challenge cognitive development & learning
Social Development	• Friendships become more complex, involving mutuality, intimacy and loyalty • Increased perspective taking • Influence of peer relationships peak, then decline into adulthood • Social context shifts from lots of daily contact with many classmates to smaller social networks and work social settings	• Delays can impede abilities to: ○ Participate in the increasingly complex peer relationships ○ Put themselves in others' shoes ○ Think hypothetically about social actions (i.e. plan and anticipate consequences) ○ Negotiate the nuances of workplace social rules • Combination of social immaturity and symptoms can inhibit quality and quantity of relationships across settings (e.g. school, work, family) • Social repercussions can produce emotional pain
Moral Development	• Increased ownership of own set of rights & wrongs • More able to understand "mitigating circumstances" of moral rules • More empathic responses/use of Golden Rule • Ability to see and act on rationale for sacrifice for the greater good	• Delays in understanding and acting on the nuances of peers' social rules and society's moral standards may contribute to: ○ Compromised success in school or work ○ Increased criminal behavior ○ Reduced quality and quantity of friendships
Social-Sexual Development	• Provides new forms of emotional intimacy • Skills to negotiate sexual relationships typically on par with social development • Sexual behavior can impact roles in peer groups • Sexual orientation and gender identity resolves	• Delays can impede abilities to: ○ Have healthy sexual relationships ○ Practice safe sex • Sexual abuse histories can additionally impede abilities to form healthy sexual relationships • Individuals who have alternative gender identities or sexual orientation are at greater risk of physical abuse, homelessness, and suicide
Identity Formation	• Seeking answers the question…Who am I? • Is a prerequisite for feeling unique while feeling connected to others • Produces boundary pushing • Some experimentation needed to try out aspects of identify • Rejection of authority facilitates ownership of identity choices	• Delays can contribute to: ○ Prolonged experimentation and rejection of authority beyond typical ages ○ Difficulty making role choices; occupation, friend, spouse ○ Undue influence of others on self evaluation (not sufficiently distinct from others) • Self-image is often poor

[1] Davis, M., Sabella, K., Smith, L. M, & Costa, A. (2011) *Becoming an Adult: Challenges for Those with Mental Health Conditions.* Transitions RTC. Brief 3. Worcester, MA: UMMS, Dept. of Psychiatry, CMHSR, Transitions RTC.

Appendix II

Stages of the Family Life Cycle[2]

Stage	Family Features	Changes	Potential additional challenges families of children with serious mental health conditions face
Families with adolescents	Increasing flexibility of family boundaries for child's independence and grandparent frailties	• Parent/child relationships shift to permit adolescents' dependence to wax and wane • Refocus on midlife marital and career issues • Shift toward caring for an older generation	• Stresses of raising a child with a chronic health condition or special needs • Many youth involved with public systems have been in out-of-home care, which typically restricts parental roles during the time away, if not implicitly communicating parental incompetence • Higher family rates of: ○ Single parent household ○ Poverty ○ Mental health conditions ○ Substance use ○ Incarceration • Challenges can impede successful "launch" during transition years
Launching children and moving on	Accepting a multitude of exits from and entries into the family system (i.e., birth of grandchildren, passing of elders)	• Renegotiation of marital system as dyad • Children and parents develop adult-to-adult relationships • Inclusion of in-laws and grandchildren • Loss of senior generation	

[2] Davis, M., Sabella, K., Smith, L. M, & Costa, A. (2011) *Becoming an Adult: Challenges for Those with Mental Health Conditions.* Transitions RTC. Brief 3. Worcester, MA: UMMS, Dept. of Psychiatry, CMHSR, Transitions RTC.

Appendix III

Retrieved from http://www.nmsoc.org/images/Youth%20Guided.pdf on April 10, 2014

Youth-Guided Definition

Youth Guided means that young people have the right to be empowered, educated, and given a decision making role in the care of their own lives as well as the policies and procedures governing care for all youth in the community, state and nation. This includes giving young people a sustainable voice and the focus should be towards creating a safe environment enabling a young person to gain self-sustainability in accordance to their culture and beliefs. Through the eyes of a youth guided approach we are aware that there is a continuum of power and choice that young people should have based on their understanding and maturity in this strength-based change process. Youth guided also means that this process should be fun and worthwhile.

We proposed that the process of moving from youth guided, to youth directed, to youth driven happens at 3 levels: youth involvement at the individual youth level, the community and policy making level. This list illustrates what should be happening at each stage in the process as the young person makes their transition into adulthood.
**** Youth should be young people who have experience as consumers and are or would be the youth served in a system of care community.**

Youth Guided

Youth Guided Individual	• Youth is engaged in the idea that change is possible in his or her life and the systems that serve him or her. • Youth need to feel safe, cared for, valued, useful and spiritually grounded. • The program needs to enable youth to learn and build skills that allow them to function and give back in their daily lives. • There is a development and practice of leadership and advocacy skills, and a place where equal partnership is valued. • Youth are empowered in their planning process from the beginning and have a voice in what will work for them. • Youth receive training on systems players, their right, purpose of the system and youth involvement and development opportunities.
Youth Guided Community	Community partners and stakeholders have: • An open minded viewpoint and there are decreased stereotypes about youth. • Prioritized youth involvement and input during planning and/or meetings. • A desire to involve youth. • Begun stages of partnership with youth. • Begun to use language supporting youth engagement. • Taken the youth view and opinion into account. • A minimum of one youth partner with experience and/or expertise in the systems represented. • Begun to encourage and listen to the views and opinions of the involved youth, rather than minimize their importance. • Created open and safe spaces for youth. • Youth are compensated for their work.
Youth Guided Policy	• Youth are invited to meetings. • Training and support is provided for youth on what the meeting is about . • Youth and board are beginning to understand the role of youth at the policy- making level. • Youth can speak on their experiences (even if it is not in perfect form) and talk about what's really going on with young people. • Adults value what youth have to say in an advisory capacity. • Youth have limited power in decision making. • Youth have an appointed mentor who is a regular attendee of the meetings and makes sure that the youth feels comfortable to express his or herself and clearly understands the process. • Youth are compensated for their work.

Youth Directed

Youth Directed Individual	The young person is: • Still in the learning process. • Forming relationships with people who are supporting them and are learning ways to communicate with team members. • Developing a deeper knowledge and understanding of the systems and processes. • Able to make decisions with team support in the treatment process and has an understanding of consequences. • In a place where they can share his or her story to create change. • Not in a consistent period of crisis and his or her basic needs are met.
Youth Directed Community	• Youth have positions and voting power on community boards and committees. • Youth are recruiting other youth to be involved throughout the community. • There is increased representation of youth advocates, and board and committee members throughout the community. • Everyone is responsible for encouraging youth voice and active participation. • Community members respect the autonomy of youth voice. • The community is less judgmental about the youth in their community. • Youth are compensated for their work.
Youth Directed Policy	• Youth understand the power they have to create change at a policy making level. • Youth are in a place where they understand the process behind developing policy and have experience being involved. • Youth have an enhanced skill set to direct change. • Youth have understanding of the current policy issues effecting young people and be able to articulate their opinion on the policy. • Policy makers are in a place where they respect youth opinions and make change based on their suggestions. • All parties are fully engaged in youth activities and make youth engagement a priority. • Youth receive increased training and support in their involvement. • There is increased dialogue during meetings about youth opinions and action is taken. • There is increased representation of youth and a decrease in tokenism. Equal partnership is evident. • Youth are compensated for their work.

Youth Driven

Youth Driven Individual	• The youth describes his or her vision for the future. • The youth sets goals for treatment with input from team. • The youth is aware of his or her options and is able to utilize and apply his or her knowledge of resources. • Youth fully understands his or her roles and responsibilities on the team. • The youth and all members of the treatment team are equal partners and listen and act upon youth decisions. • The youth facilitates open lines of communication and there is mutual respect between youth and adults. • The youth is able to stand on his or her own and take responsibility for his or her choices with the support of the team. • The youth knows how to communicate his or her needs. • Youth are mentors and peer advocates for other youth. • Youth are giving presentations based on personal experiences and knowledge. • The youth is making the transition into adulthood.
Youth Driven Community	• Community partners are dedicated to authentic youth involvement. • Community partners listen to youth and make changes accordingly. • Young people have a safe place to go and be heard throughout the community. • There are multiple paid positions for youth in every decision making group throughout the system of care and in the community. • Youth are compensated for their work. • Youth form and facilitate youth groups in communities. • Youth provide training in the community based on personal experiences and knowledge.

Youth Driven Policy	• Youth are calling meetings and setting agendas in the policy making arena. • Youth assign roles to collaboration members to follow through on policy. • Youth hold trainings on policy making for youth and adults. • Youth inform the public about current policies and have a position platform. • Youth lead research to drive policy change. • Youth have the knowledge and ability to educate the community on important youth issues. • Youth are able to be self advocates and peer advocates in the policy making process. • Youth are compensated for their work. • Community members and policy makers support youth to take the lead and make changes.

Youth Guided

Youth Guided means that young people have the right to be empowered, educated, and given a decision making role in the care of their own lives as well as the policies and procedures governing care for all youth in the community, state and nation. This includes giving young people a sustainable voice and the focus should be towards creating a safe environment enabling a young person to gain self-sustainability in accordance to their culture and beliefs. Through the eyes of a youth guided approach we are aware that there is a continuum of power and choice that young people should have based on their understanding and maturity in this strength based change process. Youth guided also means that this process should be fun and worthwhile.

Youth Driven

Youth, initiated, planned and executed in partnership with others
Expert level of understanding

Youth advocate for other young people

Youth Directed

Continuing with Youth Guided process
In a safe place (not in continual crisis)
Taking a more active decision making role in treatment and within the system of care (policy, etc)

Increased knowledge of services and resources
Deeper understand of the system

Youth Guided

Knowledge of services
Beginning to research and ask questions about resources
Beginning to understand the process of the system and services

Voice in identifying needs and supports
Learning how to self advocate
Articulate experience and what helps and what harms

Education	**Foundation**	**Awareness**	**Foundation**	**Resources**	**Foundation**	**Support**	**Foundation**	**Philosophies**

Additional Resources
Youth-in-Transition Service Guidelines

I. Mental Health and/or Substance Abuse Disorders ion Children and Youth

A. Children's Defense Fund Mental Health Fact Sheet, March 2010, http://www.childrensdefense.org/child-research-data-publications/data/mental-health-factsheet.pdf
B. Find Youth Info, http://findyouthinfo.gov/
C. National Alliance on Mental Illness, http://www.nami.org/
D. National Federations of Families for Children's Mental Health, https://www.ffcmh.org/
E. National Institute of Drug Abuse, http://www.drugabuse.gov/
F. National Institute of Mental Health, Child and Adolescent Mental Health, http://www.nimh.nih.gov/health/topics/child-and-adolescent-mental-health/index.shtml
G. Substance Abuse and Mental Health Services Administration, http://www.samhsa.gov/

II. Psychosocial Development

A. Brief 3, Becoming an Adult: Challenges for Those with Mental Health Conditions - http://labs.umassmed.edu/transitionsRTC/Resources/publications/brief3.pdf
B. Webinar by Jennifer L. Tanner, What's Normal? The Value of the Developmental Lens in Working with Transition-Aged Youth with Mental Health Challenges"
   Click here for presentation PDF
   Click here for webinar presentation *view in Windows Media Player*.
C. Webinars by Dr. Maryann Davis - http://labs.umassmed.edu/transitionsRTC/Resources/publications/PresentationsPosterWebinars.html#webinars
   1. Part I: How does young adult role functioning differs from adolescent and adult role functioning?
   2. Part II: Psychosocial development milestones that support adult role functioning and the need for more evidence-based practices.- to access presentation:

III. Family Cultures and Dynamics

A. Brief 3, Becoming an Adult: Challenges for Those with Mental Health Conditions http://labs.umassmed.edu/transitionsRTC/Resources/publications/brief3.pdf
B. Family Obligation and the Transition to Young Adulthood by Andrew J. Fuligni, Developmental Psychology 2002, Vol. 38, No. 5, 856-868 http://www.ccpr.ucla.edu/events/ccpr-seminars-previous-years/Sem04F%20Fuligni%20Family%20Obligation%20and%20Transition%20to.pdf

IV. Brain Development

A. Jim Casey Youth Opportunities Initiative, http://jimcaseyyouth.org/
   1. The Adolescent Brain, new research and its implications for young people transitioning from foster care http://www.aecf.org/~/media/Pubs/Topics/Health/Other/The%20AdolescentBrainNewResearchanditsImplicationsforYoungPeople/TheAdolescentBrainprepressproof.pdf
   2. Adverse Childhood Experience: the Balance of Risk and Opportunity http://jimcaseyyouth.org/adverse-childhood-experience-balance-risk-and-opportunity
   3. Understanding the Adolescent Brain and its implications for young people transitioning from foster care, http://jimcaseyyouth.org/understanding-adolescent-brain-and-its-implications-young-people-transitioning-foster-care

B. The Teen Brain: Still Under Construction, NIMH http://www.nimh.nih.gov/health/publications/the-teen-brain-still-under-construction/index.shtml?utm_source=LifeSiteNews.com+Daily+Newsletter&utm_campaign=2c0fa9560b-LifeSiteNews_com_Intl_Full_Text_12_18_2012&utm_medium=email
C. Toxic Stress, The Facts, Center on the Developing Child, Harvard University http://developingchild.harvard.edu/topics/science_of_early_childhood/toxic_stress_response/

V. Disruption in Education

A. Alliance for Excellent Education, http://all4ed.org/. For Utah data, go to http://all4ed.org/state-data/utah/?related-to=1297
B. "*Educational Outcomes for Children in the Care of the Department of Human Services and its Divisions: Preliminary Data Match Report.*" by Forsyth, N., & Dewitt, J., (2013)
C. *Recommendations for improving education outcomes for children and youth in foster care through amendments to the McKinney-Vento Act/Education reauthorization in the No Child Left Behind Act, by* Center for Law and Social Policy (CLASP). (2009). Washington, DC. http://www.clasp.org/resources-and-publications/publication-1/0355.pdf
D. The Effect of Education on Adult Health and Mortality: Evidence from Britain by Damon Clark and Heather Royer, National Bureau of Economic Research, http://www.nber.org/papers/w16013

VI. System Coordination

A. Find Youth Info, http://findyouthinfo.gov/
   1. Coordinating Systems to Support Transition Age Youth with Mental Health Needs http://findyouthinfo.gov/youth-briefs/mental-health-youth-brief-intro
   2. Map My Community, http://findyouthinfo.gov/maps/map-my-community

VII. Trauma

A. The National Center for Trauma-Informed Care, http://www.nasmhpd.org/TA/nctic.aspx
B. The National Child Traumatic Stress Network, http://www.nctsnet.org/

VIII. Youth Culture

A. Find Youth Info, http://findyouthinfo.gov/
B. Jim Casey Youth Opportunities Initiative, http://jimcaseyyouth.org/resources
C. National Resource Center for Youth Development, http://www.nrcyd.ou.edu/
   1. http://www.nrcyd.ou.edu/youth-engagement
   2. http://www.nrcyd.ou.edu/youth-engagement/positive-youth-development
   3. http://www.nrcyd.ou.edu/youth-engagement/youth-leadership-development
   4. http://www.nrcyd.ou.edu/youth-engagement/youthadult-partnerships
D. RTC 4 Pathways 2 Positive Futures, http://www.pathwaysrtc.pdx.edu/index.shtml
E. Youth M.O.V.E. National, http://www.youthmovenational.org/

IX. Youth-Adult Partnership

A. Focal Point; Research, Policy, & Practice in Children' Mental Health; Research and Training Center; Portland State University. 2009, Summer. *Youth Empowerment and Participation in Mental Health Care*, *h*ttp://www.pathwaysrtc.pdx.edu/pdf/fpS09.pdf
B. Grealish/Community Partners, Inc., E. M. (n.d.). A Youth Guide to Wraparound Services: Your Life, Your Future. Retrieved April 10, 2014, from http://www.wraparoundsolutions.com/docs/Wraparound_Guidebook_-_WEB_4-27-09.pdf
C. Ministry of Youth Development, http://www.myd.govt.nz/

D. National Resource Center for Youth Development, http://www.nrcyd.ou.edu/
http://www.nrcyd.ou.edu/youth-engagement/youthadult-partnerships
E. Youth M.O.V.E. National, http://www.youthmovenational.org/

X. Transition Assessment

A. Ansell Kasey Life Skills, http://www.casey.org/Resources/Tools/cls/
B. The Praed Foundation, http://www.praedfoundation.org/About%20the%20ANSA.html

XI. Person Centered Planning

A. For people with intellectual and developmental disabilities:
   1. http://www.dol.gov/odep/pubs/fact/effectiveinteraction.htm
   2. http://www.medicaid.gov/mltss/docs/PCP-CMSdefinition04-04.pdf
   3. http://www.opwdd.ny.gov/opwdd_services_supports/person_centered_planning
   4. http://www.unitedspinal.org/pdf/DisabilityEtiquette.pdf
B. For people with behavioral health challenges
   1. Judge David L. Bazelon Center for Mental Health Law, http://www.bazelon.org/
      a. In the Driver's Seat, An Advocate's Guide to Self-Directed Mental Health Care, http://www.bazelon.org/News-Publications/Publications/CategoryID/14/List/1/Level/a/ProductID/27.aspx?SortField=ProductNumber%2cProductNumber
      b. Power in Planning, Self-Determination Through Psychiatric Advance Directives http://www.bazelon.org/News-Publications/Publications/CategoryID/14/List/1/Level/a/ProductID/28.aspx?SortField=ProductNumber%2cProductNumber

XII. Transition Supports

A. National Resource Center for Youth Development, http://www.nrcyd.ou.edu/
http://www.nrcyd.ou.edu/youth-engagement/transition-planning
   1. Engaging Women in traumas-Informed Peer Support http://www.nasmhpd.org/docs/publications/EngagingWomen/PEGTitle_and_Acknowledgement.pdf
   2. Defining Peer Support http://www.nasmhpd.org/docs/publications/docs/2008/SRBriefings/IV_1_A_MeadDefiningPeerSupport.pdf
B. Transition to Independence Process (TIP) model, http://tipstars.org/
C. Job Corps
   a. Clearfield Job Corps, http://clearfield.jobcorps.gov/home.aspx
   b. Weber Basin Job Corps, http://weberbasin.jobcorps.gov/about.aspx

XIII. Peer Support

A. Center of Excellence in Peer Support, http://www.peersupportvic.org/
B. DSAMH
   1. Certified Peer Support Specialist http://hsemployee.utah.gov/dsamh/cps/
   2. Family Resource Facilitator http://dsamh.utah.gov/provider-information/family-resource-facilitators/
C. National Association of State Mental Health Program Directors, http://www.nasmhpd.org
D. Pillars of Peer Support, http://www.pillarsofpeersupport.org/

XIV. Working with Special Population

A. Young people with intellectual or developmental disabilities
   1. http://www.dol.gov/odep/pubs/fact/effectiveinteraction.htm
   2. http://www.hsdspd.utah.gov/
   3. http://www.ncwd-youth.info/quick-reference-guide/benefits-planning
   4. http://www.schools.utah.gov/sars/DOCS/resources/taguide.aspx
   5. http://www.usor.utah.gov/

B. Young people with or at risk of developing mental health/substance use disorders
   1. National Technical Assistance Center for Children's Mental Health, Georgetown University, http://gucchd.georgetown.edu/67211.html
   2. Regional Research Institute for Human Services, Portland State University, https://www.rri.pdx.edu/
      a. Pathways to Positive Futures, http://www.pathwaysrtc.pdx.edu/
      b. Reclaiming Futures, http://www.reclaimingfutures.org/blog/
      c. National Wraparound Initiative, http://www.nwi.pdx.edu/
   3. The Institute for Innovation & Implementation, University of Maryland School of Social Work, https://theinstitute.umaryland.edu/
   4. Transitions Research and Training Center, University of Massachusetts Medical School http://labs.umassmed.edu/transitionsRTC/index.htm#sthash.b85kBFiA.dpbs

C. Young people in foster care
   1. Jim Casey Youth Opportunities Initiative, http://jimcaseyyouth.org/resources
   2. National Resource Center for Youth Development, University of Oklahoma OUTREACH, http://www.nrcys.ou.edu/
   3. National Resource Center for Youth Development, http://www.nrcyd.ou.edu/
   4. Supporting Youth in Transition to Adulthood: Lessons Learned from Child Welfare and Juvenile Justice, http://jimcaseyyouth.org/sites/default/files/documents/Georgetown%20child%20welfare%20and%20juvenile%20justice.pdf

D. Young people with trauma histories
   1. The National Center for Trauma-Informed Care, http://www.nasmhpd.org/TA/nctic.aspx
   2. The National Child Traumatic Stress Network, http://www.nctsnet.org/

E. Young people with personality disorders or traits
   1. National Alliance on Mental Illness, http://www.nami.org/
   2. National Institute of Mental Health, mental health information, http://www.nimh.nih.gov/health/topics/index.shtml

F. Young people with Acquired Brain Injury
   1. Brain Injury Alliance of New Jersey, 2006, *Preparing for Life after High School: The Nest Steps. Living with Brain Injury*, retrieved from http://bianj.org/Websites/bianj/images/Preparing-for-Life-after-High_School-FINAL-WEB.pdf
   2. Colorado Kids with Brain Injury, www.cokidswithbraininjury.com
   3. Colorado Department of Education, *Brain Injury for Children and Youth: A Manual for Educators*, retrieved from http://cokidswithbraininjury.com/ckwbi/wp-content/uploads/2013/01/BI_Manual_Hi-Res_Final_WEB.pdf

4. Kentucky Department of Education, Technical Assistance Manual on Brain Injury, retrieved from http://dspd.utah.gov/pdf/ABI%20Training%20Manual%20Level%20II.pdf

G. Young people who are homeless
   1. National Coalition for the Homeless, http://nationalhomeless.org/
      a. LGBTQ Homelessness, http://nationalhomeless.org/issues/lgbtq/
      b. Youth Homelessness, http://nationalhomeless.org/issues/youth/
   2. Runaway and Homeless Youth Training and Technical Assistance Center, http://www.rhyttac.net/
   3. Homeless Youth Resource Center - Volunteers of America http://www.voaut.org/Services/Homeless-Outreach--Housing-Programs/Homeless-Youth-Resource-Center

H. Young people who are in the correction systems
   1. National Technical Assistance Center for Children's Mental Health, Georgetown University, http://gucchd.georgetown.edu/67211.html
   2. Jim Casey Youth Opportunities Initiative, http://jimcaseyyouth.org/resources
   3. Supporting Youth in Transition to Adulthood: Lessons Learned from Child Welfare and Juvenile Justice, http://jimcaseyyouth.org/sites/default/files/documents/Georgetown%20child%20welfare%20and%20juvenile%20justice.pdf
   4. National Institute of Justice, https://www.crimesolutions.gov/

I. Young people who are pregnant or parenting
   1. National Resource Center for Permanency and Family Connections, Pregnant and Parenting Teens, http://www.nrcpfc.org/is/pregnant-and-parenting-teens.html
   2. Pregnant and Parenting Foster Youth: Their Needs, Their Experiences, Chapin Hall at the University of Chicago, http://www.chapinhall.org/research/report/pregnant-and-parenting-foster-youth-their-needs-their-experiences

J. Young people with cultural and/or linguistic diversities
   1. National Center for Cultural Competence, http://nccc.georgetown.edu/
   2. Greene, G. (2011). *Transition planning for culturally and linguistically diverse youth*. Baltimore, Md: Paul H. Brookes Pub. Co.
   3. The National Culturally and Linguistically Appropriate Services (CLAS) Standards in Health and Health Care, http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15

XV. Social Media Policy

A. Designing Social Media Policy for Government: Eight Essential Elements http://www.ctg.albany.edu/publications/guides/social_media_policy/social_media_policy.pdf