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V. 24



TRANSITIONS TO ADULTHOOD



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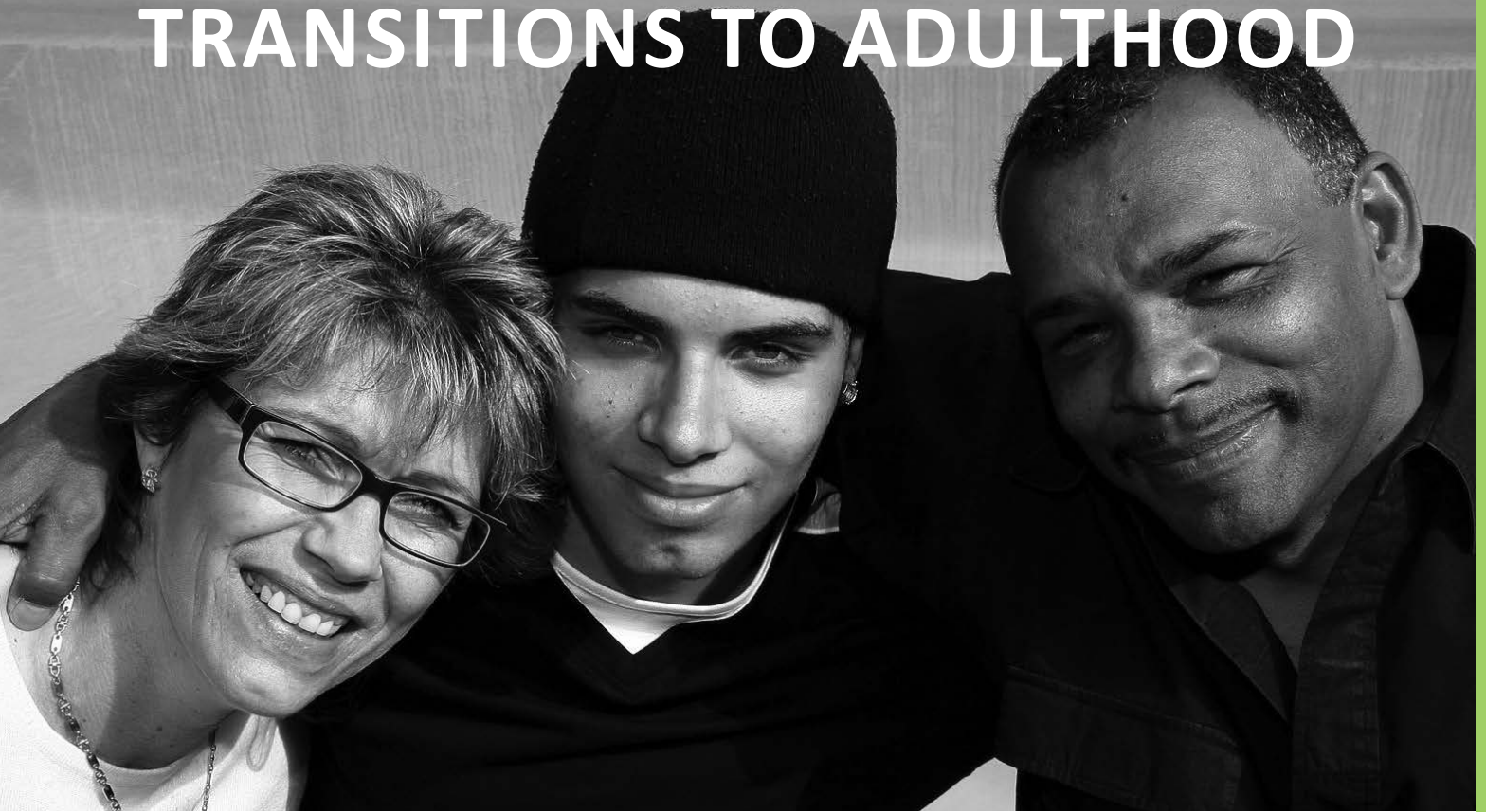
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INTRODUCTION

TRANSITIONS TO ADULthood



The new “look” that is apparent in this issue of *Focal Point* signals more than a shift in visual style and layout. Instead, it represents a deeper and larger transition in the mission and activities of the Research and Training Centers (RTCs) at Portland State University. Like many transitions, the transition experienced by the RTCs is not only an exciting beginning to a new phase, but also a bittersweet ending to what had gone before. And, again as is true in many transitions, alongside change there is also continuity. In the case of the RTCs, this continuity has many aspects, but is most obvious in the values and commitments that are being carried forward into new work.

For 25 years—from 1984 through 2009—the Research and Training Center on Family Support and Children’s Mental Health was in continuous existence. At the conclusion of each 5-year grant cycle, the RTC had successfully competed for further funding. In 2009, however, no further funding was offered for Research and Training Centers focused on children’s mental health, and the RTC at Portland State began to wind down its operations. The RTC for Children’s Mental Health at the University of South Florida, which had been funded under the same grant program, also began to close down.

At the same time, however, a competition for two new RTCs was announced by the funders. The new competition was for RTCs that focused on improving outcomes for youth

and young adults aged 14-30 with serious mental health conditions. Researchers at Portland State University, working with young adults who had experience with mental health, child welfare, and other systems, put together an ambitious proposal that included eight research projects and an array of training, dissemination, and technical assistance activities. This new RTC on Pathways to Positive Futures received funding last September and launched immediately into its new work. A second RTC, focused on the same population and goals, was funded at the University of Massachusetts Medical School.

The RTC on Pathways to Positive Futures carries forward the spirit and values that were integral to the work of the previous RTC, particularly the commitment to empowering the voices and perspectives of the young people and families who receive services. Staff members are energized and excited about the new work and invite you to learn more about the Pathways RTC by visiting the website (see box on next page). The website of the previous RTC will remain online, and access to resources—including back issues of *Focal Point*—will be maintained.

Given the new focus of our research, *Focal Point* will no longer be subtitled “Research, Policy, & Practice in Children’s Mental Health,” but instead take on the task of covering a broad range of topics related to “Youth, Young Adults, and Mental Health.” The articles included in this inaugural issue of the “new” *Focal Point* exemplify both the new work and

the continuing ethos of the previous issues of *Focal Point* and the previous RTC. This issue addresses “Transitions to Adulthood” from the perspectives of researchers, youth, family, and professionals. The articles included focus on two different types of transitions—developmental and institutional.¹ Developmental transitions are those that come with the natural growth and maturation of an individual, whereas institutional transitions are externally imposed changes that result from systems and policies (e.g., aging out of foster care). The articles in this issue clearly illustrate the importance of understanding these two types of transitions and how they unfold and interact in unique ways in the life of each individual young person.

The first article, written by Nancy Koroloff and Maryann Davis, two of the directors of the new Research and Training Centers, discusses the current status of the relatively new field of transition research. Following that, Jennifer Tanner challenges those working with transition-aged youth to consider how developmental psychology and its concept of emerging adulthood can influence how services for youth and young adults are designed and evaluated.

This issue also features several articles highlighting specific programs designed to support youth as they transition into adulthood. Tamara Sale describes a prevention program designed to help young people with symptoms of psychosis maintain their normal life trajectories. *Data Trends*, a research summary that will be a regular feature in *Focal Point*, outlines methods and findings from a study of the effectiveness of a state-wide transition program in Connecticut. Cinda Johnson shows how three schools in Washington state are working to support the successful transitions of students with serious mental health conditions. Finally, an article by Amy Salazar addresses the particular issues experienced by older youth in the foster care system.

The “new” *Focal Point* continues its commitment to featuring the voices of youth and family members. Two young adults—one who spent time in the foster care system, and another who went off to college—will share their perspectives on becoming an adult and living more independently. And family member Sandra Spencer, Executive Director of the National Federation of Families for Children’s Mental

Health, writes about her struggles and pride as she watches her son become a responsible young man.

When we think about transitions into adulthood, we often focus on independence, but the truth is that people rarely go through significant changes alone. We hope that this inaugural issue of the “new” *Focal Point* highlights the fact that we all need support as we take on new challenges created by transitions—developmental and institutional alike.

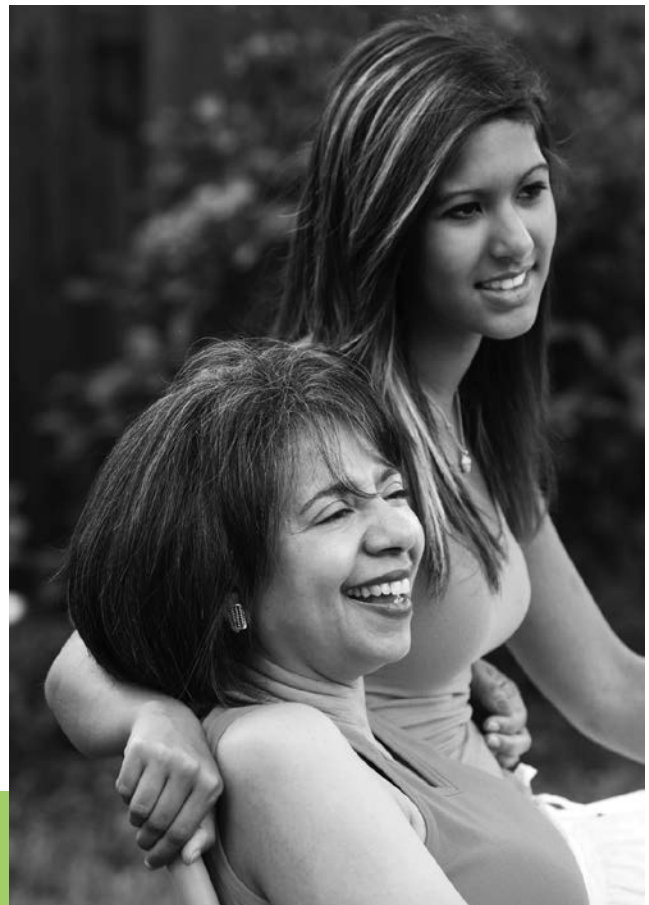
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1. The RTCs mentioned in this article are/were funded through a partnership between NIDRR (the National Institute on Disability Research and Rehabilitation, US Department of Education) and SAMHSA (the Center for Mental Health Services, which is part of the Substance Abuse and Mental Health Administration, US Department of Health and Human Services).

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MOVING THE FIELD OF TRANSITION SERVICES **FORWARD**

We are living in a period of great opportunity. Real attention is finally being paid to the challenges and preferences expressed by youth and young adults of transition age with serious mental health conditions. For years, young people and their families have complained that their voices aren't heard and their needs aren't met by either the child or adult serving systems. Each of these systems is complex, often disjointed, and there is a major chasm between systems serving children and systems serving adults. Youth previously involved in child systems often find an abrupt and difficult adjustment accessing needed services in the adult system; many young adults find that adult systems don't fit their needs. Many service providers and policy makers have also bemoaned the myriad barriers to providing good quality care for this age group, and researchers have demonstrated that existing services result in poor school completion, underemployment, substance use, pregnancy, and arrests for many in this population. As advocacy organizations and innovative service providers are currently making some progress, funders, policy makers and staff at the federal level are also convinced that youth and young adults need special services and supports and are investing in moving forward both our knowledge about how to provide services and supports, as well as the effectiveness of those services.

Many different voices and factors have come together to highlight the challenges faced by young people with mental health conditions as they move into adult life. There is an increasing understanding of the developmental trajectory of young adults, including the benchmarks and challenges typically faced by individuals as they move into adulthood.^{1,2} Our understanding of the barriers and challenges that young people with serious mental health con-



ditions face as well as their preferences for how services are structured and delivered continues to sharpen and focus. This is particularly true with regard to the problems related to building a successful adult life, such as pursuing higher education and finding a career, and, for young people in foster care and other residential settings, the need to achieve independence with limited adult support. At the state and federal levels, there is recognition of the limits placed on the ability to support young adults by policies and funding mechanisms that make moving from child serving systems into adult serving systems difficult. Increasingly, young people are becoming involved in identifying challenges and creating solutions that they find acceptable and developmentally appropriate. Their voice is growing louder as both national organizations (e.g., Youth Move National) and state and local organizations of young people gain strength. The leadership of federal divisions such as SAMHSA, Department of Education, Department of Labor, as well as the Children's Bureau and OJJDP are collaborating in federal partnerships to develop solutions that cross federal bureaus and deploy federal resources most efficiently.

Within the mental health field, there is an increase in the number of demonstrations or pilot programs that are underway. The Center for Mental Health Services within SAMHSA has funded two waves of demonstration projects, the Partnership for Youth Transition (2002-2006), and more recently the Healthy Transitions Initiative (2009-2013). These projects have and will continue to develop innovative ways of working with and for youth and young adults as they leave the child mental health service system. Similar demonstrations have been funded in child welfare and in education. There is increasing interest in conducting research focused on young adults; at the 2010 Child Mental Health Research Conference, there were two symposia highlighting studies focused on services for transition-aged youth, and several additional papers and posters. In 2008 the *Journal of Behavioral Health Services and Research* published a special issue on research related to services for transition-aged youth, and in 2009 a second edited book was released from Brooks Publishing Inc. titled, *Transition of Youth and Young Adults with Emotional or Behavioral Difficulties*. Perhaps most prestigious for the research community, is the fact that NIMH has now funded six research projects specifically investigating mental health services and interventions for this age group, with a variety of additional studies that shed light on service or treatment needs. All of this suggests that the field is poised to move rapidly forward toward a service system that is evidence-based, developmentally appropriate and acceptable to young people.

With all of this activity, stakeholders are faced with the dilemma of how to synthesize the information resulting from these activities, and how to prioritize their efforts. In our view, there are four streams of information and experience that need to come together and inform each other:

1. *Information from youth and young adults about their experiences and preferences.* With the increased number of youth and young adult advocacy organizations comes easier access to their voices and experiences that can help inform policy and practice. Many of these organizations have gathered the stories of their members and published them in various media. These organizations can also form associations with each of the three additional sources of information (following this paragraph), to inform their efforts. Youth and young adult voice products can be found, most commonly, on web sites or in the unpublished reports of organizations. (See, for example, www.pathwaysrtc.pdx.edu/speakout/somain.php and www.cqi-mass.org/youthProject.aspx.)
2. *Information from individual programs that are doing innovative programming.* These programs are often small in scale but they generate utilization data about the services offered, and information about the demographics of the young people involved. These projects generate good information about implementation issues and the preferences of young people, although information about outcomes is often anecdotal. These programs often lay the groundwork for developing formalized models of treatment that can be experimentally evaluated. One of the challenges in taking advantage of the knowledge gained through innovative programs is accessing

that knowledge. Programs such as these are usually not published in the peer review literature, nor is information about them available in any accessible format (web, annual report etc.). There is also currently no “index” for locating innovative transition support programs. However, once located, learning from program staff, clients, and family members can yield rich and useful knowledge. (Examples of these programs can be found at www.umassmed.edu/uploadedFiles/cmhsr/TAY/PreviouslyPublishedWork.pdf.)

3. *Information from demonstration projects.* These projects are almost always tasked with creating and testing innovative programming and often collect high quality evaluation data. Demonstration projects frequently form partnerships with local universities and usually generate reliable data about program outcomes. Since demonstration projects are commonly funded in several states, they often allow for an intervention to be implemented in diverse communities across the country. This helps to expand the knowledge base about what works in different settings. Summaries of these programs and their evaluation findings can often be located either on the web or in reports. Program outcomes may also be published in professional journals or presented at professional conferences. (Examples can be found at www.gucchdgeorgetown.net/data/issues/2009/0709_article.html and www.nnyt.fmhi.usf.edu/.)
4. *Information from research projects funded to conduct rigorous research.* More rigorous research projects include several being conducted by the two new RTCs on the transition to adulthood as well as some projects funded by NIMH, other federal funders, and private foundations. These projects often study the effectiveness of a manualized intervention and include data from a comparison or control group. Rigorous research projects



that are needed to establish an evidence base are expensive, and are thus less common than demonstration projects or innovative programs. The information yielded is most definitive with regard to the effectiveness of a program but also may be more restricted regarding the characteristics of young people deemed eligible for study participation; thus the generalizability of the findings is not always warranted. Other more intensive research may describe population or policy characteristics that have implications for the development of interventions. Research findings from these projects are typically published in professional journals and at professional conferences, but they are also often available online. (Descriptions of some of these studies can be found at www.pathwaysrtc.pdx.edu/research.shtml and www.umassmed.edu/cmhsr/TransitionsRTCresearch.aspx?linkidentifier=id&itemid=93336.)

Each of these streams of information has its strengths and limitations, and all four are needed to develop a well-rounded view of what works best for diverse groups of transition-aged youth and young adults.

Both of the transition-related RTCs (Transition RTC at UMASS and Pathways RTC at PSU) are committed to producing research that will support more effective services for young people as well as facilitating the synthesis of information from a variety of projects and sources. This includes promoting collaboration among academic researchers, providers and young people and their families. The field of transition services is in its infancy with regard to solid empirical evidence to guide program development and clinical practice with young people with serious mental health conditions. Not only do we need evidence about mental health services, we also need evidence-based practices that will guide employment services, housing approaches and ways to increase recreational opportunities, independent living skills, and peer supports.

While there is currently unprecedented attention on young people with serious mental health conditions and in-

terventions that support them, there is also much work to be done to obtain the necessary knowledge to craft effective and appealing interventions that address this diverse population's needs and to ensure that these interventions are widely available and accessible. Youth and young adult advocacy organizations need to exist in more locations. These organizations also need strong ties among each other and all levels of the system (i.e., providers, local policy makers/administrators, state level policy makers/administrators, and the federal level), and to researchers and evaluators. Providers and evaluators of innovative programs need easy linkage to one another and to new developments in the field. More research and more researchers dedicated to conducting studies that inform this field and its practices are needed. The Pathways and Transitions RTCs are dedicated to fostering such connections and the exchange of knowledge that facilitates better practices and further knowledge.

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IS THERE A DEVELOPMENTALIST IN THE HOUSE? Using Developmental Theory to Understand the Service Needs of Emerging Adults



note of shifts and changes in the transition to adulthood. In 2000, Dr. Jeffrey Arnett, a developmental psychologist, published a scientific theory contesting the traditional definition of the transition to adulthood, arguing that graduating, getting a job, getting married, and having a child before reaching one's mid-twenties no longer reflected the most common experiences of 18 to 29 year-olds.¹ Rather, he recognized that global economic and cultural forces shifted enough from the 1950s to the new millennium to affect the way young people made transitions to adulthood. As a result, between

adolescence and young adulthood an intermediate stage of development arose—emerging adulthood.

According to Arnett, emerging adults represent a unique stage of development. He sees this age group as distinct because its constituents are so very different from each other: some are in school, others are not; some live with their parents, others do not; some are married, others are not; and some are parents, while others are not. Thus, it is their lack of shared situations that make them different from adolescents and adults. Teens are more similar to each other—most live with their parents, go to school, and are unlikely to have full-time careers, marriages, or children. And then again, after emerging adulthood, when people enter their 30s, there is a homogeneity that describes adults—almost all have moved out of the parental home and are no longer in school; the majority have careers, partners, and families of their own.

Interviewing over 300 emerging adults, Arnett described the way emerging adults experience these years.² The shared experiences of this group led him to conclude that emerging adulthood is an age of feeling “in-between,” experiencing instability, exploring identity, believing in possibilities, and engaging in self-focus. Emerging adults spend these years finding out who they are and where they want to go with their lives. Arnett’s survey research^{3,4} supports his conclusion that becoming adult is more about the process than the outcome. Across numerous studies and di-

There is growing interest in identifying and addressing the unique needs of young people who are making the transition to adulthood. Parents and young people themselves are concerned about the challenges that seem to accompany the long and winding, often difficult pathways youth take from adolescence into adulthood, which can even create a “quarterlife crisis” for some. Concern is particularly focused on the additional challenges facing vulnerable groups—homeless youth, youth in foster care, those involved in the juvenile justice system, youth with disabilities, and/or those with mental health conditions.

Recent developmental theory detailing the experiences of this age period provides a useful model for understanding the “new” transition to adulthood. Translating theory into applied models can be a first step in designing policies and programs that help young people who are coming-of-age in different ways from their parents. The lens that we use to design services for this age group will play an important role for determining who has access to services, how services are designed, what the objectives will be, and how we will evaluate success.

ADVANCES IN DEVELOPMENTAL THEORY

Late in the 20th century, social scientists began to take

verse samples (i.e., in terms of age, income groups, and cultures worldwide), the most commonly endorsed markers of “adulthood” are: taking responsibility for oneself, making independent decisions, and becoming financially independent.

Tanner’s developmental model of recentring⁵ accepts that emerging adulthood is an essential stage of the transition to adulthood. Complementing one another, Arnett’s framework describes what occurs during emerging adulthood; Tanner’s work explains what happens as individuals move through this stage. A person is challenged with the primary task of recentring—shifting away from letting others direct his or her life, and gaining agency directing one’s pathway.

To recentre, young people, typically between ages 18 and 29, navigate three stages (see figure 1). In stage 1, adolescents are challenged to renegotiate their relationships with their families and other contexts that supported their dependence. Stage 2, emerging adulthood, involves exploring new ways of connecting with others and roles. Through temporary commitments in work and love, the emerging adult gains first-hand knowledge of how well the reality of choices “fit” their expectations and goals. Last, individuals transition into young adulthood in stage 3 when they make commitments to careers, mortgages, partners, and children. From empirical studies we know that the roads these transitions follow are not always linear; and, some people stop and restart their engines along the way.⁶

IN-BETWEEN BEGETS A RESOURCE GAP

Distinguishing, recognizing, and accepting that there is a stage of development between adolescence and young adulthood has implications for the way we think about the needs of 18- to 29-year-olds. The fact is that services and systems (i.e., schools, community mental health centers, psychiatric treatment programs, social service organizations, juvenile justice programs, and primary health care organizations) were designed mid-20th century to serve youth and adults separately. These bifurcated services were not planned to meet the needs of those “in between.”

Aging out of youth services, emerging adults encounter a “resource gap” due to a lack of services and programs designed to fit their distinct needs. The resource gap is particularly pronounced in terms of health care. As youth turn age 18, in many states, they are no longer eligible for their parents’ employer-sponsored health care; youth who are eligible for state or federally-funded health care programs for low-income families also become ineligible based on age. As a result, one-third of emerging adults are uninsured.⁷ The most profound effect may be in terms of their mental health. While emerging adults are relatively physically healthy, they have high rates of mental health problems. Approximately 50% of emerging adults meet criteria for at least one disorder. Despite this, their use of mental health services drops precipitously, in half, after age 17.⁸

RESPONDING TO THE NEEDS OF EMERGING ADULTS: MULTIPLE PERSPECTIVES

Different approaches to reducing vulnerability during emerging adulthood have distinct advantages. The social service perspective is rooted in the sociological definition of the transition to adulthood, measured by the length of time to and sequencing of commitments to adult roles. Alternatively, the developmental perspective is rooted in theories of human development that are concerned with facilitating and optimizing normal maturation and adaptation. The different perspectives suggest different ways of identifying “at risk” groups, designing programs, setting goals and objectives, and measuring the outcomes of efforts designed to help 18- to 29-year-olds make successful transitions to adulthood.



DEFINING THE POPULATION OF INTEREST

Assuming that targeting and tailoring resources to benefit those who are most vulnerable is of interest to all, identifying those most in need is essential. Therefore, how we define “at risk” or vulnerable groups is of primary concern. Social service programs designed for transition-aged youth identify “at risk” groups based on youth-era risk factors known to predict poor outcomes in terms of establishing independence in adulthood. Programs have been designed for youth involved in: foster care, the juvenile justice system, and programs for youth with disabilities and serious mental health problems. The overarching goal of these programs is to implement a “safety net” to keep them connected to resources and deter the likelihood that they will be disconnected from resources.

The developmental perspective recognizes the plasticity, resilience, and multidimensionality of developmental adaptation. Therefore, identification of individuals as “at risk” prior to emerging adulthood may lead to both under-

FIGURE 1. THE RECENTERING PROCESS⁵

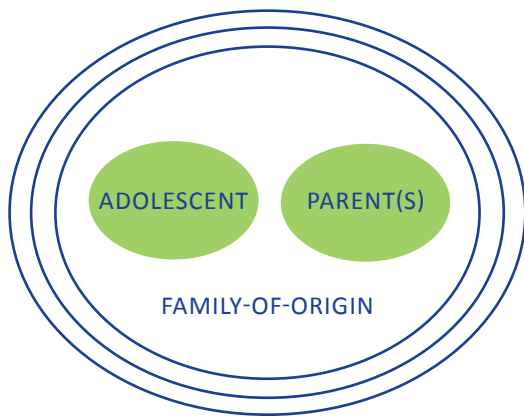


FIGURE 1A: STAGE 1.

Launching position: Adolescent transitions from dependent status into emerging adulthood

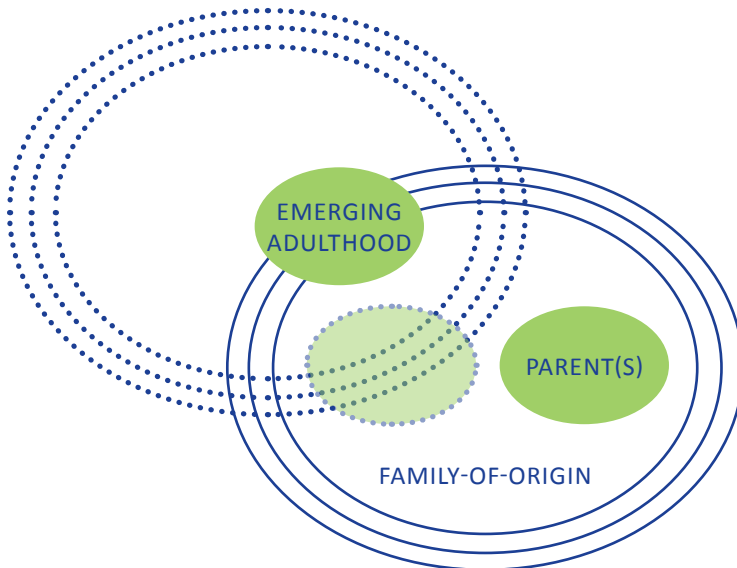


FIGURE 1B: STAGE 2.

Emerging Adulthood proper: The emerging adult is peripherally tied to identities and roles of childhood/adolescence; and, simultaneously, is committed to temporary identities and roles of adulthood

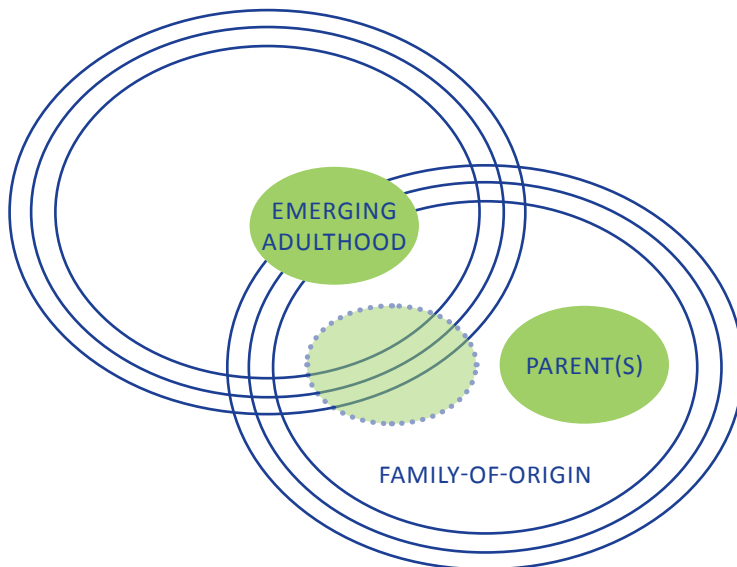


FIGURE 1C: STAGE 3.

Young Adulthood: The emerging adult exits stage 2 via permanent identity and role commitments

and over-allocation of scarce capital. Not all “at risk” youth are identified or receive adequate resources. It is estimated that 80% of children and adolescents who need mental health services receive no or inadequate treatment for their problems.⁹ Thus the majority of youth who need services do not get them, which forecasts, for this group, a double-risk of being under-served in adolescence and again, under-served in adulthood. It is also the case that some “at risk” youth will not be at risk in emerging adulthood. Resilient adolescents continue to be resilient in emerging adulthood and some youth become resilient.¹⁰ In these cases, “targeted” resources may be allocated for those who do not need them.

PROGRAM PLANNING: HARNESSING NATURAL STRENGTHS

The community model has been used to design many of the social services on which youth and adults rely. This same model has been used to design programs for transition-age youth. These services are designed to bridge services and reduce the likelihood that “at risk” youth will “age out” and disconnect from resources that provide help with education, careers, housing, and health care.

From the developmental perspective, there is reason to question the community-based program model. Emerging adulthood is different from other age periods in that tenuous connections to systems provides an opportunity for exploration. Optimally this exploration is self-focused and allows young people to find commitments that “fit” with their goals, values, and lifestyle expectations. When emerging adults fail to explore, or when they get stuck in the exploratory stage, it is important that we be able to see them experiencing these difficulties and understand that they need help. This is the same notion behind the need to let beginning walkers explore and take a few tumbles; falling down teaches lessons and provides the opportunity to learn how to get back up.

DEFINING PROGRAM GOALS: PROCESS VS. OUTCOME

Program objectives are written according to a specified, guiding theoretical framework. The objectives of social services, regardless of age, are to connect individuals to needed resources. This remains the objective of social service programs designed to meet the needs of “at risk” emerging adults. For example, Transition Plans are mandated through the Individuals with Disabilities Education Act (IDEA), Section 300.18. Beginning at age 14, these plans include, but are not limited to: academic, community, related services, independent living, and employment-related goals pertaining to the post-secondary life of the student.

But, programs designed to meet developmentally informed objectives will focus on supporting developmental maturation and adaptation. Objectives will focus on supporting processes, not outcomes. Such programs will need to consider ways of supporting relatively long and non-linear pathways from adolescence to adulthood. Programs may include objectives to facilitate responsibility for oneself, exploring and identifying one’s own belief and value

system, and establishing a plan to achieve financial independence.

Program objectives that do not encourage exploration may further disadvantage already vulnerable populations. Why? Objectives that focus on commitments to careers and lifestyles may cut-short or disallow the exploration that is normative. Peers who are encouraged to take advantage of the exploratory stage before they make commitments are benefitted by this “break” before they take on adult responsibilities. In terms of identity development, for example, research shows that emerging adults who explore before they make commitments scored higher on measures of self-esteem and self-reflection, and lower in depressive symptoms, anxiety symptoms, and self-rumination than their peers who do not explore and fail to make commitments, and also better than their peers who commit without having explored.¹¹

Objectives, by definition, define the criteria used to measure outcomes. Social services help youth stay connected to services. Developmentally-informed programs would focus on facilitating explorations and teaching emerging adults how to connect with services on their own. The former defines success in terms of the outcomes that are achieved (e.g., securing employment); the latter defines success in terms of building skills that are known to predict better outcomes (e.g., learning how to job-seek). The approaches also differ with respect to the age at which successful outcomes can be expected. Because social services seek to bridge adolescence and adulthood, anticipated gains are expected in emerging adulthood. The developmental approach expects that gains in emerging adulthood should have both short- and long-term benefits to one’s health and adaptation.

CONCLUSION

Along with changes in the way that young people make the transition to adulthood, we gain an opportunity to learn how to best invest in their futures. Applied developmental models are new to the scene in terms of policy and program design. But there is great promise in integrating and applying developmental theories. Some may argue that developmentalists and social service perspectives are really talking apples and oranges. Perhaps developmentalists put too little emphasis on the power of risk in some cases. It may also be the case that social service approaches underestimate the dynamic ways that humans can adapt and adjust. At the very least, it is important to talk about the ways that the two can work together. What we agree on is that 18- to 29-year-olds have aged into a new stage of life without a road-map and with few resources allocated to their needs. In this respect, we are fortunate that we have identified a way to work together to help.

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PROJECTS AND STAFF:

CAREER VISIONS tests an approach to career planning and employment for young adults, ages 21-25, who are receiving SSE or extended special education services.

Jo-Ann Sowers and Heidi Herinckx, Co-Principal Investigators; Michael Parker, Graduate Research Assistant.

BETTER FUTURES tests a comprehensive intervention to assist young people in foster care with serious mental health conditions to prepare to participate in post-secondary education.

Sarah Geenan and Laurie Powers, Co-Principal Investigators; Pauline Jivanjee, Project Advisor; Lee Ann Phillips, Project Manager; Amy Salazar, Graduate Research Assistant; Adrienne Croskey and Zoe Brown, Student Research Assistants.

ACHIEVE MY PLAN studies the efficacy of an intervention to increase young people's participation and engagement in their mental health treatment planning teams, and to build organizational capacity to support youth engagement.

Janet S. Walker and Laurie Powers, Co-Principal Investigators; Liz Thorne, Project Coordinator; Daniel Donohoe and Adrienne Croskey, Student Research Assistants.

TRANSITION POLICY CONSORTIUM will develop an inventory that assesses the level of community support for transition services with a specific emphasis on measuring collaboration and continuity of care between the child and adult mental health systems.

Nancy Koroloff and Janet Walker: Co-Principal Investigators; Barbara Friesen, Project Advisor; Liz Thorne, Project Coordinator; Aakrati Mathur, Graduate Research Assistant.

FINDING OUR WAY furthers the development of a culturally specific self-assessment tool for American Indian/Alaskan Native young people. Developed for youth ages 13-19, the tool will be modified to include issues relevant to transition.

Barbara Friesen and Terry Cross: Co-Principal Investigators; L. Kris Gowen, Project Manager; Abby Bandurraga, Student Research Assistant.

EHEALTH LITERACY is a developmental project that will contribute to a knowledge base about the ways youth and young adults use the internet to find information about mental health care, conditions, symptoms, or medications. The information will be used to develop and test an eHealth literacy curriculum.

L. Kris Gowen, Principal Investigator; Matthew Deschaine, Graduate Research Assistant.

RECOVERY OUTCOMES is a secondary analysis of large national data sets. This project will analyze data from the System of Care National Evaluation related to young people's recovery outcomes.

Eileen Brennan, Principal Investigator.

MEDIATORS OF STIGMATIZATION will analyze data from nationally representative samples of youth and young adults, and use this information to identify potentially effective anti-stigmatization strategies.

Janet Walker, Principal Investigator.

TRANSITION TRAINING COLLABORATIVE will develop graduate and undergraduate course modules appropriate for individuals who plan to work with transition-aged youth, as well as modules for in-service delivery.

Eileen Brennan and Pauline Jivanjee, Co-Principal Investigators; Eliz Roser, Graduate Research Assistant.

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Transitioning to Independence



I grew up in a world of confusion.

I never knew my parents, and as I grew up I remember being very rebellious. When I was 14, I started learning my own coping skills that helped me get through the day. I learned to take deep breaths and listen to music to help me remember my past—both the good parts and the bad. I have spent a long time learning how to cope and manage my life day-to-day.

I am now eighteen years old and I can finally say I'm a lot more put together than I used to be. I bring up my age because I believe that age is a step toward maturity. To me, being 18 means you have to start experiencing adult things. But it also means following rules that you set for yourself and that others set for you. For instance, I need to take my medication on my own, and I also need to live up to expectations others set for me like going to work and carrying out my tasks there. It means being responsible, and that's not always easy. Many adults supported me and helped me learn to become responsible for myself. My teachers, my team, my case worker, and my foster parents all helped me learn the things I need to become an adult.

When I do what I'm supposed to in order to prove myself to myself, I find life easier. Even though it's hard at times, I understand that I need to keep taking my medications and go to school and work. Doing all of these things helps me to earn more trust from all the adults in my life that support me. This is what it takes to be independent.

I think my school is where all my independence started. I show maturity by helping other students with their work, and by being a positive role model that other peers look up to. It's a great feeling and I love helping people. In the



future, I would like to be a mentor for kids.

I'm now at the stage where I'm transitioning to adulthood. I'm graduating June 24th and to top it all off, I'm getting my very own apartment. I'm nervous so I'm taking renting classes to prepare myself for living independently.

I've been accepted to be on SSI (Social Security Income). SSI is a program that is paying for my rent. You can get in this program if you have a disability. I am diagnosed with bipolar disorder. For me, it is like always being on the go. I never have time to sleep and my mood swings are more frequent than normal. I've learned to cope with bipolar disorder because I don't want to hurt myself or those around me. One of the ways I cope is by listening to music. It calms my nerves.

I'm proud to say I've learned something as I have grown older, and that is not struggling against those who try to help me. My caseworker, case manager, therapist, teachers and friends have all helped me to grow and become more independent. You might take my recommendation; I know it's not easy to hear others' advice. All I'm saying is, it's OK to make mistakes as long as you learn from them. Avoid holding grudges on others. Then you will find yourself taking steps toward independence.

AUTHOR

Heidi Piercey is a foster care alum and currently volunteers to help feed homebound seniors.

TRANSITION-AGED YOUTH, MENTAL HEALTH CHALLENGES, AND SURVIVAL SELF-RELIANCE

The transition from foster care to independence is a challenging one; youth must piece together the financial, social, academic, mental health, employment, and spiritual supports that they have in combination with their resilience and unique skill sets in order to create a place for themselves in the adult world. Transitioning out of foster care and into independence is a substantial challenge in itself, yet many of these youth are concurrently dealing with mental health challenges, which create an even more complex maze of circumstances as they transition to adulthood. While many youth are able to find success in adulthood, many more struggle to find stability.

WHAT TRANSITION MEANS TO TRANSITION-AGED YOUTH IN CARE

A study by Samuels and Pryce¹ provided an in-depth exploration of what youth approaching transition out of foster care thought about self-reliance, as well as how they felt about their development, their relationships, society's expectations about growing up, and foster care's effects on their adult lives.

The youth in this study reported feeling like they had little control over what happened to them in the child welfare system, and also felt that they had to become independent much earlier than they were prepared to. Sometimes early independence resulted in youth feeling confident that they could take care of themselves. However, early independence often resulted in youth missing out on important opportunities such as education. Some youth felt insecure as they became responsible for adult tasks before they were technically adults, but did not feel they had much choice in these circumstances. Forced independence frequently became a source of pride as well as a barrier for youth needing services, when receiving help was perceived by youth as dependence and thus weakness.

This exploration of how youth in foster care can develop "survivalist" self-reliance lends insight into why some youth may not have very successful outcomes with services, such as independent living programs, offered by child welfare. These youth reported feeling forgotten or abandoned by the system for years, becoming self-reliant in many ways, often against their will, and as a result expressed no interest in again participating in or becoming dependent on the child welfare system they felt had failed them. This study reveals additional common consequences of survivalist self-reliance, such as a reluctance to develop relationships with others or receive emotional support because of a perceived impact on one's independence.



GROUPING TRANSITION-AGED FOSTER YOUTH WITH SIMILAR EXPERIENCES

Foster youth approaching transition face a variety of challenges; each individual has a unique set of experiences, as well as a unique skill set and support system, with which to approach these challenges. While each person is different, there are some patterns among the experiences and preparedness of transition-aged foster youth that offer clues regarding how to most effectively support youth experiencing certain patterns of challenges.

In a large study of 732 youth aged 17-18 in foster care from three state child welfare systems, researchers Keller, Cusick, and Courtney² looked at a variety of factors that might be relevant for making the transition to independence, including employment, being held back in school, mental health, being a parent, exhibiting problem behaviors, placement history, and runaway history. They investigated how these factors combined to define four groups with distinct profiles reflecting transition readiness.

Group 1: Distressed and Disconnected

The members of the first group, labeled Distressed and Disconnected, had long and complicated journeys through the child welfare system. They experienced relatively higher rates of abuse and violence, a large number of placements in non-family settings, a history of behavioral problems, and struggles with employment. This group also had low lev-

els of social support and had much higher rates of mental health diagnoses such as PTSD and alcohol/substance-related disorders than youth in the other groups. This group was the largest of the four groups, comprising 42% of the sample.

Group 2: Competent and Connected

The second group, labeled Competent and Connected, comprised 39% of the sample. These youth had much more success in a variety of areas when compared to those in the Distressed and Disconnected group. Competent and Connected youth had lower rates of behavioral and school-related problems, more stable placement histories including high rates of kinship care and more substantial employment experience. These youth had considerably stronger social networks and substantially lower rates of mental health diagnoses than the Distressed and Disconnected group.

Group 3: Struggling but Staying

The third group of youth, Struggling but Staying (14% of the sample), were predominately placed in non-kinship foster care settings during late adolescence. They had lower rates of parenthood and running away, but higher rates of being held back in school and having problem behaviors when compared to youth in the other groups. They seemed to fall somewhere between the first two groups, having a bit less social support and more mental health problems than the Competent and Connected group, but generally faring better and having more positive attitudes toward the child welfare system than the Distressed and Disconnected youth.

Group 4: Hindered and Homebound

The last group was the smallest group of youth, comprising only 5% of the sample. This group had high rates of parenthood and being held back in school, low rates of employment experience, and often only experienced one placement, which tends to be kinship care. This group reported relatively high levels of social support, especially from relatives, and experienced mental health diagnoses at relatively low rates.

HOW CAN WE USE THESE GROUPINGS FOR GOOD?

Grouping youth with foster care experience based on their circumstances and personal histories allows supports

and services to be designed based on particular group characteristics to more closely meet youth needs. For example, youth having characteristics of the Distressed and Disconnected group likely need comprehensive support plans given the variety of troubles that they have undergone in addition to their lack of support. However, because they do not tend to have very positive feelings about the child welfare system, and because these youth may display survival self-reliance at rates higher than the other groups, typical services might not result in a high level of success for these youth. Youth falling into this category need to have an active and leading role in their transition planning and services so that they can feel in control of their experiences and have room to make mistakes without constantly being at risk of losing support.

The Competent and Connected group was faring rather successfully as they approached transition and may have very positive experiences with supports that serve to help them pursue their talents and dreams, such as going to college. A challenge that this group may face involves being overlooked or underserved by the child welfare system due to the fact that they are doing so well; however, these youth could still benefit greatly from and are entitled to supports related to college preparation/retention and other goals that will allow them to become not only self-sufficient but high-achieving and empowered.³

The Struggling but Staying group likely will need substantially greater transition supports than the Competent and Connected group, but because they are more amenable to the child welfare system they may have better outcomes with existing supports within the child welfare system than youth in the Distressed and Disconnected group. Struggling but Staying youth, for example, may benefit greatly from participation in independent living programs that offer social support in addition to an array of classes and services designed to prepare youth for transitioning to independence.

Finally, the Hindered and Homebound group is made up primarily of young parents and seems to struggle most with being self-sufficient apart from kinship supports, so these youth may benefit from a range of services including connections to parenting resources in the community, teen parenting classes, childcare sources, children's medical services, information on how to obtain food stamps and WIC, and securing transportation for doctor's appointments or similar responsibilities. These youth could also benefit from services that show them how they can continue their education while being a young parent.

TABLE 1. MENTAL HEALTH DIAGNOSIS RATES FOR TRANSITION-AGED YOUTH^{4,5,6}

PTSD:	Around 15% of foster youth aged 17-25 experienced PTSD at sometime in their lives; 6-8% as they approached transition
Depression:	1-10% of males and 8-25% of females approaching transition had struggled with depression within the past year
Alcohol/substance use disorders:	Almost one-fourth of males and almost 10% of females had struggled with an alcohol or substance-related disorder in the past year at age 21



MENTAL HEALTH DIAGNOSIS RATES AROUND TRANSITION TIME

Youth in the four groups outlined above tended to experience mental health issues at varying rates: those falling into the Distressed and Disconnected group seemed to have the most struggles with mental health, while youth in the Competent and Connected group seemed to be struggling the least in this area. The fact that many youth were struggling with mental health problems does not come as a surprise; it is well known that many youth preparing to age out of foster care experience mental health problems that can make the transition to independence quite challenging.

A few large studies of foster youth in their late teens and early twenties have explored how transition-aged youth are faring in terms of mental health. A study with a large sample of 373 youth in foster care who were, on average, 17 years old, found that 37% of them had symptoms and corresponding difficulties that met the criteria for a psychiatric diagnosis within the past year.⁴ Females were more likely than males to indicate diagnosable conditions—40% of females had a diagnosis within the past year compared to 33% of males. A follow-up study with the youth in the grouping study discussed previously found that, at approximately age 19, a quarter had experienced a recent diagnosis.⁵ These rates are higher than those found in the general population.⁴ Although these types of studies could not establish the causes of the mental health problems, the diagnoses are correlated with some of the difficult circumstances that youth in foster care often experience, such as maltreatment, lack of strong supports, and difficult life circumstances. Rates for specific common diagnoses are summarized in Table 1.

CONCLUSION

Youth in foster care face a variety of challenges as they approach transition; one struggle for many is dealing with mental health problems that commonly result from maltreatment and difficult foster care experiences. It seems that the youth with the highest levels of mental health problems are often the ones who have the most negative feelings toward the child welfare system and the least willingness to jeopardize their independence to receive needed help. Child welfare systems must find a way to better support these youth, and in ways that do not force the de-

velopment of survivalist self-reliance in one instance while demanding dependence on the system in the next. Simply making available services through highly structured and rule-laden programming is not an effective means of service delivery for those who need help the most. And given the high rates of mental health diagnoses still present for many youth as they approach transition, finding a solution, or not, has extensive consequences.

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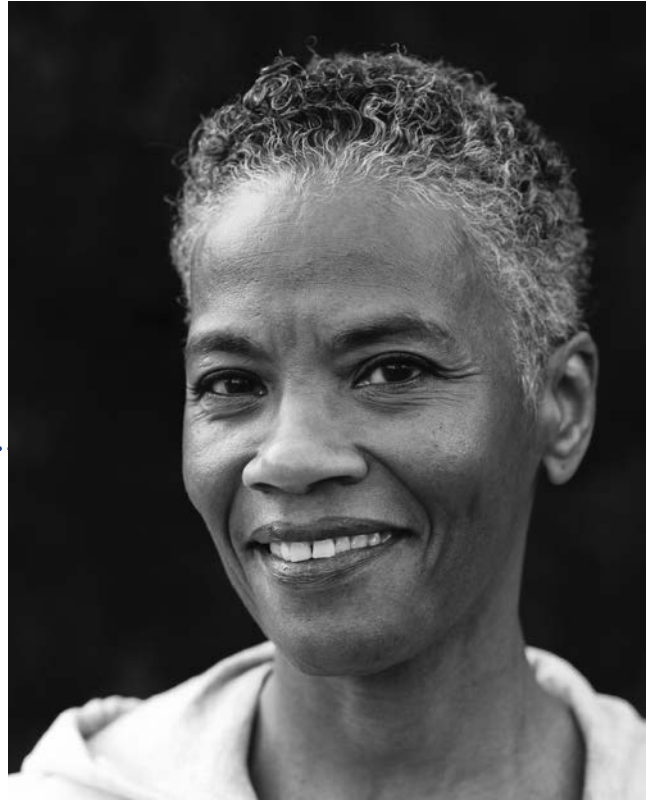


Helping Youth Transition into Adulthood: A Parent's Perspective

At the moment when that newborn baby is placed into a parent's arms, natural instincts cause us to do our first quick inspection. We want to see two soft cute arms and legs, two half open eyes, perky ears and a somewhat round head. We let out a sigh... all looks normal. As we watch them sleep, we start to dream about our future teacher, nurse, doctor, lawyer or the next President of the United States of America. After all, this baby is perfect, smart, and the sky is the limit. As time goes on, there will be many transitions in the life of this child; things from potty training to the first day of kindergarten, then middle school, and at last, high school graduation. As a parent, we strive to make these transitions as smooth and as positive as possible. While these transitions are a normal part of healthy development and growth, they are extraordinarily more difficult for the child who has a serious emotional, behavioral, or mental health disorder.

As a parent, I have grown accustomed to having to prepare in different ways for these transitions. My son was involved in multiple child-serving systems and transitions were a way of life for us. I remember my son asking the question at a child and family team meeting as we prepared to transition him back into his community school after 18 months in a residential treatment facility, "Where am I supposed to tell my friends I was for a year and a half?" This question was answered by the team in a way that, in hindsight, taught my son to be ashamed of and hide his need for mental health care and support. He was offered the following solutions: Tell them you went to stay with your grandmother in Virginia, tell them you were in boarding school, or tell them it's none of their business. I was not prepared for how this would shape the way my son handled these kinds of transitions right into adulthood.

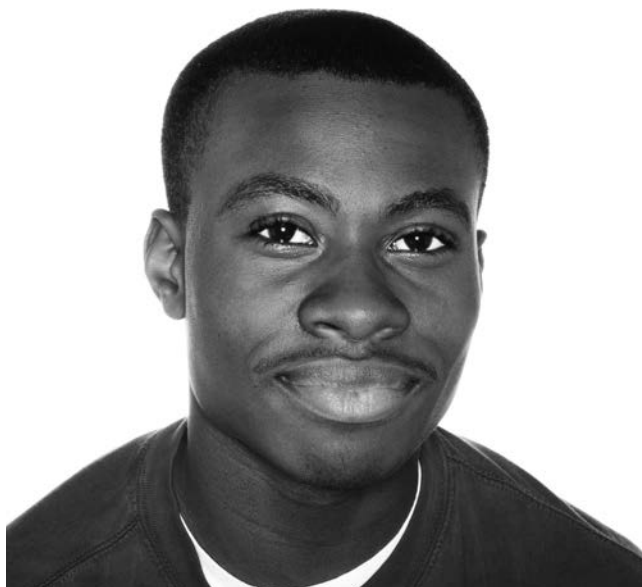
I had been my son's advocate since his first diagnosis at the age of four. I had learned to be open with people about his challenges and to ask for all the supports and services



I felt he would need to be successful. As he grew older, I often encouraged him to speak up for himself. I told him that we would need to know his hopes and dreams in order to support him in reaching them. The best thing I could do for my child was to not only be his greatest advocate, but to teach him to be his own advocate. What I was not prepared for was the anger, disappointment, and distrust he would develop for the systems he had been involved in and the amount of blame he would place on me allowing the system to "mess him up."

The Individuals with Disabilities Education Act (IDEA 1997) mandates transition planning. My son's school did a great job with this planning. What we realized is that the best made plans will not work without the support systems and services remaining in place. My son was placed in a charter school so that he could participate in the culinary arts program in order to fulfill his desire to become a chef. He was in his senior year in high school when he entered the two-year program. He completed the first year with much success. He also completed all of his high school graduation requirements. He was given the choice of graduating with only one year of the program completed or staying in high school another year to complete the two year program. IDEA says that a student's right to a Free Appropriate Public Education (FAPE) is terminated upon graduation with a

“regular” high school diploma, but not with any other kind of graduation certificate. My son was on track to get a full high school diploma. He worked hard to stay on the graduation track. As his mother, I wanted him to stay in high school another year and come out with a high school diploma as well as a two-year certificate in culinary arts. From my perspective, this was a win-win. He would continue to have the support of the school counselor and school psychologist and would be closer to reaching his goals. On the other hand, my son was angry with the choices; or in his words, the “lack of good choices.” He could stay in school and miss graduating with his class and be viewed by his peers as fail-



ing and not graduating on time, or he could graduate now and worry about school later. He chose to graduate. The school did not feel it was the right decision and tried multiple times to change his mind. I supported my son’s decision although I really wanted him to stay in high school. I was able to see my son’s point about the “lack of good choices.” He graduated, and none of his services and supports from school followed him. Although the planning process started off in a very family-driven, youth-guided way, the regulations did not allow the process of completing the culinary program to work for my son.

Transitioning from the children’s mental health system to the adult system was a lot more challenging for me as a parent than it was for my son. When he turned 18, I immediately realized that my role in his life would have to change even more. My son’s dream was to never go from the child system to the adult system, and he wanted my support in helping him reach that goal. He wanted to be weaned from his medication and taught to manage the symptoms of his disability. I did not think this was the best thing to do. My son’s psychiatrist was willing to try taking him off of his medication and again, I realized that my role was to be supportive. I had taught him to speak up for what he wanted, but I also taught him to understand the responsibility that came with decision making. It has been over a year, and while things have not been perfect, my son is proud of the decision he made.

My son had a setback a few months ago that caused him to be placed on probation with an assigned probation officer and a new therapist. My son chose not to disclose any prior involvement in the mental health system, because of his distrust and for what this disclosure could mean. I was very afraid that without this knowledge the court system would give him a harsh sentence and not meet his mental health needs. My son was willing to take that risk just to be “treated like a normal adult.” My attempts to call his probation officer and therapist were to no avail, because he was now over 18 and I could not speak to them without his permission. I felt completely shut out of his care and treatment, although I am still responsible for the expense of his health care. I wanted to tell them his history and help them with his treatment. I am sure any parent reading this will understand my view point, and any young adult reading this is saying, “He’s grown now mom, back off!” By making his own decision, my son stepped up, took responsibility for what he had done and explained to the judge that he should have made better choices. I am very proud of the young man he has become. He also has become his own advocate, being able to speak up for himself and his needs.

As a parent, I worked hard to get the best services and supports possible for my son; although at times, my best efforts did not get him the best treatments. My son now realizes that, just as he is not always given the best choices, he has to make the decision based on what he feels is best for him. He also understands now that as his mother, I too was not always given the best choices, and I did what I thought was best for him at that time. We both realize the importance of making sure that family and youth voices are heard and supported in the service delivery process. We both agree that these are a few keys to success in the transition to adulthood for youth with serious behavioral, emotional or mental health challenges:

- having a parent or other supportive adult who believes in the youth
- parents helping the youth build their own support network
- having excellent services and supports
- having a cadre of “good choices”
- parents teaching the youth to be a self advocate
- parents supporting the youth in the decision making process

It’s a challenge for parents to know when to step in and when to let go; we need to stay tuned to the development and maturity of our youth and listen to them. I could not have waited until my son was 18 and then say, “now that you are an adult, you drive your services.” I had to allow him all along the way to be involved in treatment and service decisions. This process allowed me to be better able to support him in his decisions as a young adult.

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DATA TRENDS

SUPPORTING TRANSITION-AGED YOUTH: ONE STATE'S EFFORTS

SOURCE

Styron, T. H., et al. (2006). Troubled youth in transition: An evaluation of Connecticut's special services for individuals aging out of adolescent mental health programs. *Children and Youth Services Review*, 28, 1088-1101.



INTRODUCTION

Young adults need specialized services as they age out of children's mental health care and into adult services. Starting in 1997, Connecticut began to address this need by creating a Young Adult Services (YAS) program, designed to assist those over 18 who had moderate to severe symptoms of mental illness. YAS provides comprehensive service delivery that includes clinical, residential, case management, vocational, and social rehabilitation supports. Major principles that guide the YAS program include: (1) services must be comprehensive and integrated—focusing on one issue without supporting a young adult in other aspects of his or her life is ineffective; (2) it is challenging, yet essential, to facilitate young adults' transitions from highly supervised and structured programs into community settings in which they experience higher degrees of autonomy, and; (3) given the traumas experienced by many of these young adults, it is particularly important to provide them with opportunities to form secure attachments; therefore, YAS programs should not reject or remove clients.

The clients served by YAS have aged out of institutional settings and have complex needs: 95% have known histories of severe and sustained abuse, 95% have been in foster

and/or residential care, half have diagnosed learning disabilities, and many have been incarcerated. The purpose of this study was to identify aspects of the YAS program related to positive psychological functioning and well-being in its young adult clients.

METHOD

Participants in this evaluation were randomly selected from the young adults who received YAS services in six Connecticut locations (N=60). Average age of participants was 20 years, and 78% were male; 55% identified as Caucasian, 23% as Hispanic, and 12% as African-American. Participants had been in the program an average of 20 months (SD=12.56) and had worked an average of 3.4 days (SD=6.8) in the past 30 days.

Data were gathered through the following methods: (1) structured interviews consisting of standardized measures completed by participants; (2) surveys completed by participants' clinicians; and (3) in-depth qualitative interviews conducted with a sub-sample of participants. Youth outcomes assessed using these methods included mental health symptoms, quality of life, satisfaction with services, anger symptoms and management, overall functioning, jail

time, and hospitalizations. In addition, chart reviews were conducted to obtain information about services and five aspects of treatment planning: strengths-focused treatment planning (SFTP), incorporation of attachment style, consideration of trauma history, attention to developmental tasks, and community-focused treatment planning (CFTP). SFTP was defined as assessing a client's social and cognitive strengths, and incorporating them into the treatment plan; CFTP was defined as setting a goal of increasing client residential and community supports. Length of time in YAS and the five treatment planning variables were the independent variables in the following analyses.

RESULTS

Qualitative findings: Results from the interviews reveal that adjusting to YAS programs was difficult for participants. Many YAS clients stated that they came from environments such as residential placement settings that were highly structured and supervised; the contrasting independence of the YAS program left some with ambivalent feelings regarding this new independence. One participant said, "I've never been on my own and I didn't know what to do. People usually told me what to do" (p. 1099).

While negotiating this new independence, many clients appreciated staff support and concern. Several participants

One participant said, "I've never been on my own and I didn't know what to do. People usually told me what to do."

stated that they felt cared for, which was a new experience for them. They described staff as friends, coaches, and role models. Many clients also stated they appreciated the staff teaching them independent living skills, such as cooking and shopping.

Regarding their hopes and dreams, most participants stated that they simply wished for a "normal life" (p. 1099). From their perspectives, this meant being able to live independently, take care of their finances, have a job, and have a long-term relationship.

Quantitative findings: Three treatment variables were related to improved outcomes in this sample of young adults. After controlling for demographic variables, longer tenure in a YAS program was significantly associated with a higher quality of life, greater satisfaction with services, client reports of higher functioning, and less loneliness. After controlling for both demographic variables and time in programs, two additional characteristics of YAS predicted positive outcomes. SFTP was significantly associated with higher quality of life; CFTP was significantly associated with fewer arrests and fewer symptoms.

CONCLUSION

The qualitative portion of this study found that young adults with complex needs report a difficult time transitioning from often highly structured environments into one in which there exists a fair amount of independence. However, with the support of caring staff, these youth feel that they can work towards their goals of having productive, fulfilling lives. Accepting responsibilities for one's self and making independent decisions are two key components to transitioning to adulthood,¹ so the roles that staff seem to be filling are important to healthy development.

Regarding their hopes and dreams, most participants stated that they simply wished for a "normal life."

Quantitative analyses revealed that certain characteristics of transition services for young adults are associated with improved outcomes. More specifically, a longer time spent in a program, incorporating a client's social and cognitive strengths into the treatment plan (SFTP), and working towards increasing client residential and community supports (CFTP) were found to be associated with higher quality of life and/or better integration into the community. However, causation cannot be established. It may be possible that higher functioning young adults were more likely to stay in the program longer and receive more integrated services, accounting for the positive outcomes. However, these findings may point to the potential importance of including strengths- and community-focused treatment components in programs for young adults transitioning out of more restrictive settings into the community.

This study found encouraging results that comprehensive transition programs such as Connecticut's YAS, which not only treats problems and symptoms, but also works to build personal strengths and supports, can improve the outcomes of young people with very complex needs.

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Young Adults Value Participation, Meaningful Employment, & Unconditional Caring

Tempo Young Adult Resource Center in Framingham, Massachusetts, offers comprehensive resources to transition-aged youth (ages 16-24) in an accessible, young adult-centered environment. Tempo grew out of a participatory planning process, and in its first two years, has honed its approach through an evaluation that has measured results and informed program development. Evaluation consisted of a participatory qualitative evaluation, and a collection of quantitative data on goal completion, supported by young adults' stories compiled into a video-documentary. All three evaluation components indicate that Tempo has exceeded expectations in helping transition-aged youth with greater-than-average challenges clear the hurdles to healthy, productive adulthood.

PARTICIPATORY PLANNING PROCESS

Tempo emerged from a locally-sponsored, inclusive needs assessment in Framingham, MA, a large town with retail and industrial activity, widespread poverty, and steady growth in immigrant groups, including Brazilians and Latinos. The 2006 assessment found that coordinated supports for young adults with mental health and substance abuse conditions were severely lacking. Young adults and

family members described barriers such as: loss of mental health services at age 19, minimal outreach to non-English speakers, little attention to non-college career paths, adult services poorly suited to young adults, and few role models of successful transition to independence. Surveys of young adults verified concerns about the difficulties of finding and keeping employment at a living wage, and about the lack of behavioral health treatment oriented to young adults.

These data, along with additional young adult input, led to the establishment of Tempo. Thanks to the insights of young adults, Tempo incorporated such features as on-site laundry facilities, the use of social networking, and internships in its original design. Wayside Youth & Family Support Network (a mid-sized child welfare/mental health agency in Framingham) led four other collaborating agencies in realizing the resulting plan, funded in 2007 by the Robert Wood Johnson Foundation and a group of local partners.

WHAT IS TEMPO?

Tempo is a collaboration of five separate agencies providing resources for young adults in a single location. It is run by five Transition Facilitators who coach young adults through comprehensive planning and goal-setting and help them navigate the often confusing, fragmented community



resources. The “one-stop” site ties together resources for career exploration, work-readiness and job search supports, access to housing for young adults, substance abuse recovery groups, legal assistance, access to benefits, young parent supports, and health assessments and screenings. Tempo has expanded access to resources for youth who were excluded from existing services due to narrow eligibility criteria. Tempo houses practical help as well, including a washer and dryer, a kitchen full of donated snacks, computers and phones to share, and a van for transportation to appointments.

Tempo provides resources to over 300 young adults per year, a third engaged in comprehensive planning with a Transition Facilitator, the others briefly involved, usually seeking employment. Most young adults who come to Tempo are facing significant challenges, including poverty, mental illness, homelessness, substance abuse, lack of a high school diploma, unemployment, a criminal record, lack of family support, and/or single parenthood. Thirty-nine percent of

measures, such as educational attainment, employment rates, reductions in arrests, sustained self-care, and healthy community involvement. Young adults partnered with staff and outside experts in the two other evaluation components: the stories of participants’ turning points, and an interview-based qualitative evaluation.

In keeping with the participatory nature of Tempo, the YAAC decided that young adults would be engaged in all aspects of conducting the qualitative evaluation. Given their own experiences trying to access supports as they transitioned to adulthood, the young adults selected by Tempo staff to become evaluators were uniquely qualified to determine what is most critical to learn from Tempo’s young adult participants.

Consumer Quality Initiatives (CQI), a mental health consumer and family member-led behavioral health evaluation organization, was selected by Tempo to train young adults to become evaluators. Tempo management identified four young adults to participate in the evaluation training. Tem-

“No one flunks out of Tempo.”

youth who came to Tempo last year were identified as living at or below the federal poverty level; another 46% were low-income. All were facing at least one and often several barriers: 105 had dropped out of school, 102 were court-involved, 42 were pregnant or parenting, 46 were homeless, and 15 were aging out of foster care.

Though Tempo is a welcoming house (decorated by youth), more welcoming still is the commitment to treat each youth with dignity, no matter how many times he or she makes missteps. For example, staff say that “young adults come to Tempo for resources” rather than “Tempo provides services to clients,” placing young adults in the self-directed role of seeking out resources to reach their goals, rather than passively receiving help. Small changes in language represent big changes in attitude. As one young adult said about Tempo, “This is the first place that I have ever been where I wasn’t treated like a patient.”

Grounded in a positive youth development approach, Tempo builds on young people’s strengths, empowers youth to realize their potential, and puts young adults at the center of their own plans. In practice, this means providing internships where youth practice leadership skills and serve as Peer Mentors for other young adults; holding monthly meetings of the Young Adult Advisory Council, where young adults are the majority and make decisions about Tempo operations; offering community service opportunities (voter registration drives, soup kitchen, public speaking classes); and creating individual care plans that are goal-oriented and youth-driven, rather than directed by adult providers or standardized procedures.

PARTICIPATORY EVALUATION PROCESS

Tempo’s Young Adult Advisory Council (YAAC) decided on three methods for collecting information on participants’ utilization of Tempo services, outcomes, and experiences at Tempo. First, management and staff collected quantitative

po management and CQI staff carefully considered who should be trained to become evaluators. All parties agreed that it was important to hire young adults who had a stake in the success of the project, but were not Tempo participants, due to confidentiality concerns. The young evaluators joined three Tempo staff and three CQI staff as members of the evaluation team.

The evaluation process was designed to include guidance from the young adults at every step. This participatory process began with encouraging the young adults to shape a training schedule that would best meet their preferred learning styles and needs. Training consisted of both classroom training—group discussions, activities, and role plays—and extensive field training. The young adults, guided by CQI trainers and Tempo staff, created a qualitative interview guide which was used to gather young adults’ perspectives on the experience of coming to Tempo and working with a Transition Facilitator. Shared decision-making with the young adults shaped the structure and wording of the instrument, the interview process, and the analysis methodology.

Young adult evaluators and Tempo staff attempted to recruit and interview all Tempo participants who had been working with a Transition Facilitator for three to six months. Interviewing occurred in two phases, and the guide was adapted by the evaluation team for the second round of interviews. In total, 27 young adults were interviewed over the course of 18 months. The rapport that the young adults developed with interviewees and the perspectives they brought to the analysis process greatly strengthened the evaluation.

The young adult evaluators not only played integral roles in the evaluation, but also gained valuable skills. One young adult evaluator is working toward his BA in psychology and found the training to be complementary to his studies and future goal of becoming a mental health practitioner. Two young women used the skills and experience

they acquired to become more active in advocating for the needs of young adults.

KEY EVALUATION FINDINGS: EMPLOYMENT, PARTICIPATION, RELATIONSHIP

Tempo outcomes show the promise of the organization's youth-led, comprehensive approach. Of the 121 young adults engaged with Transition Facilitators, our quantitative evaluation revealed that 67% improved their educational level (earning their GED, enrolling in college or vocational training), and 92% remained clean and sober. Eighty-seven percent of young adults with housing as a goal obtained or maintained stable housing, and 99% of those on probation successfully met their requirements.

According to findings from the interviews, participants' initial impression of Tempo set it apart from other programs they had experienced, with participants finding Tempo to be very welcoming, unthreatening and open. Staff were identified as the cornerstone of participants' positive experiences. Participants described staff as friendly, relatable, non judgmental, and most of all helpful. Interview findings indicate that staff's ability to build trust with participants helped create an environment in which work could begin right away. For many young adults, results were seen immediately.

In addition to assistance from staff, participants identified practical tools, such as the computers at Tempo, as important in enabling them to work toward their goals. Interns—young adults hired at Tempo as part of their comprehensive goal planning—were seen as a powerful example that Tempo values young adult goals, competence, and ability to overcome past setbacks.

The *Tempo Rocks!* video, developed by young adults, gave a third perspective on the program. Young adults self-selected to be recorded, based on how they felt about sharing their very personal experiences. Young adults described their turning points (homelessness, family chaos, probation, mental illness crisis) that led them to seek out Tempo, and how Tempo made a difference for them. Young adults recounted, for example, how important it was to be welcomed back to Tempo by caring staff and to be encouraged to try again, even after making choices with severe consequences, such as incarceration or psychiatric hospitalization. As one participant said: "No one flunks out of Tempo." Listening to the narratives has been compelling, and has helped us clarify which program elements to fortify and what to change.

Young adults come to Tempo looking for work far more than for any other resource. By listening to and learning from young adults, we concluded that purposeful employment plays a central role in identity formation for youth. Most (87%) of the 275 job seekers who utilized Tempo services were able to make some progress, generally finding part-time or temporary work. However, young adults were frustrated by the lack of jobs available to them, and even more so by the scarcity of jobs with potential growth. Those who found meaningful work (as interns, or in jobs with a supportive, learning environment) generally became stable and successful in other ways, such as keeping their housing, staying clean and sober, and starting college. Employment

is a springboard for healthy adulthood.

The importance of employment, revealed in the data, has shaped next steps for Tempo. In the coming months, Tempo will focus on creating jobs for young adults by developing new opportunities through collaboration with local employers. For example, a collaboration with a local business, Lizzy's Ice Cream, has already begun, giving young adults employment and paid apprenticeship opportunities in a hands-on learning Career Path where young adults can master business skills (basics of spreadsheets, bookkeeping, advertizing, management).

Tempo blends employment opportunity, commitment to participatory youth development, and unconditional caring to help young adults build strong foundations for success, future productivity, civic engagement, and other widespread community benefits. Tempo staff and manage-



ment, with CQI input, are developing "tool kits" to share our experience in effective collaboration to develop resources with and for young adults.

Youth-led planning, decision-making, and evaluation were critical in the early success of the Tempo Young Adult Resource Center. Without input and feedback from Tempo users, adult and community stakeholders may have known which resources were needed but would not have known how to attract the young adults who need them. We have learned that young adults begin to thrive when offered practical resources to aid their goal development, respectful relationships with caring adults, a chance for real self-determination and meaningful employment opportunities.

AUTHORS

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Transitioning Does Not Mean Escaping

College seemed to be another escape, a new stepping stone to a young person's life. To me, college was the unfound freedom to allow myself to experience things without any limitation or censorship from parents or teachers. However, being in a different environment helped expose the internal conflicts that I tried to hide. I dove into the hectic college life, consuming many hours studying, trying to balance work and play. Nevertheless, I hit a breaking point in mid-semester. I made a suicide attempt in my college dorm.

Close friends and classmates were downstairs, laughing and playing a competitive game of beer pong while I lay in bed consumed by a deep sadness that was hard to evade. I took 46 sleeping pills with a bottle of NyQuil and woke up two days later with 12 missed calls from my friends and parents wondering where I was. I looked at my wrist and saw the deep crimson lesions I had made in my state of profound sadness. I looked at the calendar and realized that I had missed two days of classes. I went to my computer and stared at the empty computer screen that was supposed to be an email message to my professors: What was I supposed to say?

I never addressed the problems that I was dealing with then. I continued to let problems devour me, like a dark cloud over my head, blinding me to every good thing that I had to the point where I felt there was no escape. I felt as if I were jumping in front of a train. Finally, after a long talk with a close friend I found my will to get better, and I went to the counseling center in my school. At the end of the week, I was admitted to a psychiatric hospital after being diagnosed with borderline personality disorder. I felt complete and utter shock as I arrived. I saw women in their



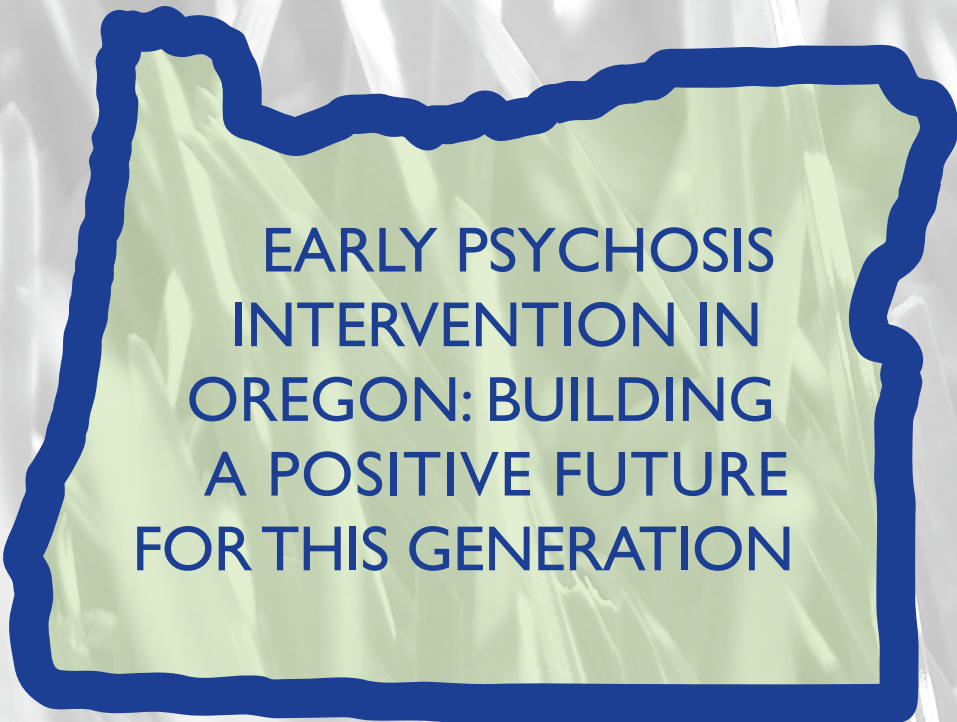
mid-forties who had tried to kill themselves, men whose houses had been foreclosed, and a soldier who still had vivid memories of the people he had killed. Initially, I felt as if I were insane. I longed to go back home, to see my friends and family. However, I slowly realized that being at that hospital was for my benefit. I needed to work on myself. After a week of intensive group therapy and medication, I felt more grounded than before. I learned techniques to help manage my emotions and develop a clear sense of self.

Upon returning to school, I felt as if I were reborn. I saw things in a new light. I felt as if the demons that had been afflicting me for months had finally disappeared.

However, I still struggled to find support. Initially, my parents and close friends did not understand what borderline personality disorder was or how to help someone who has it. Because of my experience, I wish I could see change in the mental health system through an improved understanding of mental disorders. I also want more people to know how to handle difficult situations with someone who has a mental health condition. If there were more programs that were willing to teach people about these conditions and help family members understand the illnesses that are plaguing their loved ones, that would make individuals who are struggling with the disease feel as if they have support.

AUTHOR

Anonymous attends college and is studying to become a teacher.



EARLY PSYCHOSIS INTERVENTION IN OREGON: BUILDING A POSITIVE FUTURE FOR THIS GENERATION

WHY EARLY INTERVENTION IN PSYCHOSIS MATTERS

Schizophrenia affects one in one hundred people; its onset usually begins in late adolescence or early adulthood. Symptoms include hallucinations, delusions, confused thinking, and a range of cognitive deficits. In its acute phase an individual afflicted with schizophrenia becomes unable to discern what is real from what is not, and may act on incorrect or inaccurate information about the environment. The young person often loses the ability to participate in school and work, or even to take care of basic needs. Families may mistakenly attribute the cause of these changes in a loved one to antisocial behavior or drug use. Friends drop away quickly as the person isolates or behaves strangely.

The fact that schizophrenia begins during teenage and young adult years makes early intervention critical. The illness interferes with key developmental tasks, including identity formation, finishing school and beginning employment, taking on adult roles and responsibilities, and forming intimate relationships. Psychosis can impede these developmental processes in ways that will affect a person for life. The stress can lead to family dissolution and even homelessness. Unable to tell what is safe from what is not, or what is real from what is not, an afflicted person is at risk of accidental death, injury, or suicide. It is common for psychosis to lead to arrest and legal charges.

Unfortunately, these experiences are common because many people don't get the right help in the early stages of psychosis.¹ Treatment programs and providers are often untrained and unprepared to provide appropriate support.

Too often, a series of traumatizing crises and inappropriate care lead to an involuntary hospital commitment and/or entry into the federal disability system.² The longer it takes for a person to get appropriate help, the more challenging recovery becomes.

WHY AND HOW EAST/EASA WAS CREATED

Mid-Valley Behavioral Care Network (MVBCN) is an organization responsible for publicly funded mental health services across five Oregon counties. In 1999, MVBCN looked for ways to improve the typical life course of people with schizophrenia. In early 2001, The Early Assessment and Support Team (EAST) was created, modeled after the work of the Early Psychosis Prevention and Intervention Center in Melbourne, Australia,³ and practice guidelines⁴ implemented in Australia. Adaptations to EAST were made over the years, such as adopting aspects of SAMHSA's recovery toolkits. In 2007, the Oregon legislature provided funding to begin disseminating EAST statewide, and this broader effort was named the Early Assessment and Support Alliance (EASA). EASA programs were created in eleven new counties, so that today sixty percent of Oregon's population has access to an early psychosis program.

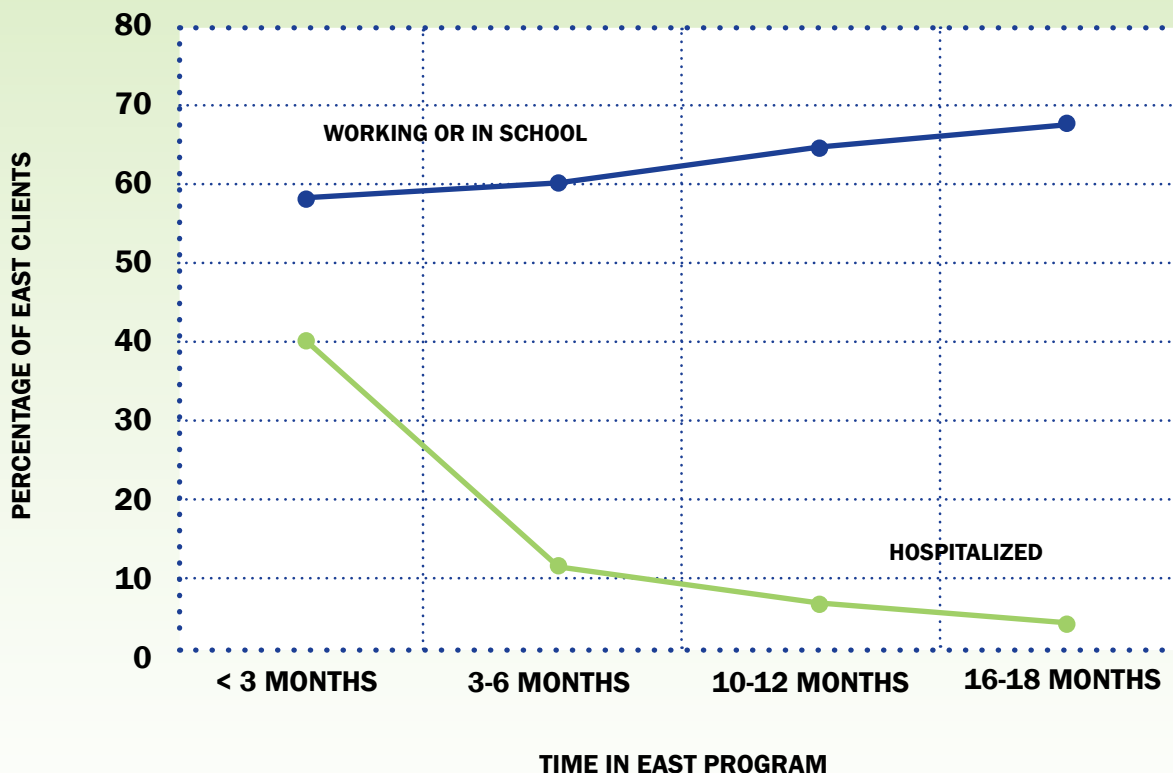
WHAT EAST AND EASA DO

The mission of EAST and EASA is to support young people and families to maintain their normal life trajectory when psychotic symptoms first occur. Most families stay with the program for two years, and then move onto a

CASE EXAMPLE: JAN

Jan is a talented singer who hopes to become an architect. During her junior year in high school she began having trouble taking notes in class and reading her textbooks. She began seeing bizarre images and hearing the sounds of someone conversing when no one was there. Distressed, she talked to her favorite teacher, who referred her to the high school guidance counselor. An EAST counselor came and met with Jan and learned about her goals, strengths, and struggles. It appeared that Jan was experiencing increased sensory sensitivity and depressed processing speed and memory. The EAST counselor also talked with Jan's parents and her primary care doctor. Jan received a comprehensive physical evaluation and started a regimen of Omega 3 fatty acids. With the help of her EAST counselor, doctor, nurse, and occupational therapist, Jan worked with her teachers to identify accommodations so she could complete the school year successfully. The family joined a multi-family group which helped prevent conflict, reduced stress and improved the family's ability to identify and resolve issues as they emerged. At one point Jan's symptoms became severe, so she chose to use an antipsychotic medication temporarily. The team continued to provide symptom monitoring, education, support and advocacy as needed. As she neared graduation, Jan applied to college, was accepted, and was able to explain what accommodations she needed to the university disability office. EAST helped her connect with on-campus supports and with a local counselor and doctor. After she left town for college, EAST continued to be a resource for Jan and her family.

TABLE I. HOSPITALIZATION, SCHOOL, AND WORK TIME IN THE EAST PROGRAM (2002-08)



planned transition into additional supports. To accomplish this, the programs consist of the following elements:

Community education and outreach: EAST/EASA representatives go out into the community to increase awareness about psychosis and encourage early referrals. These education efforts are offered to a wide range of audiences—school counselors and teachers, medical professionals, law enforcement, parents, clergy, and adolescents.

Targeted outreach to those in need: Psychosis is often frightening, and even the thought of being diagnosed with such a serious mental health condition may cause a young person to refuse to seek help. EAST/EASA team members meet the person and family at their level of readiness in order to form a relationship built on trust. Services are strengths-focused and oriented toward issues the young person finds relevant, such as getting through school, resolving conflicts, paying off debts, or regaining their proficiency in areas they have previously done well in but in which they are now struggling.

Consistent services in the transition from adolescence to adulthood: Services are provided to teens and young adults by the same team. EAST serves ages 12 to 25 and the other EASA programs serve ages 15 to 25. There is no discontinuity of care or caregiver teams just because a person “ages out” of childhood services. Teams meet twice weekly or more often to coordinate care closely.

A supported employment/education specialist: This specialist works closely with each program participant. The success of this program aspect is highlighted by the fact that the majority of young people involved with EAST/EASA do not pursue federal disability funding.

Treatment options: When it comes to treatment, the emphasis is on education and choice. Medications are used cautiously, and close attention is paid to the side effects experienced by the client. Medical staff, which includes psychiatrists and nurses, are members of the care team and collaborate in decision making.

Occupational therapists: These specialists are available to help assess and provide treatment for underlying sensory, cognitive, and functional issues.

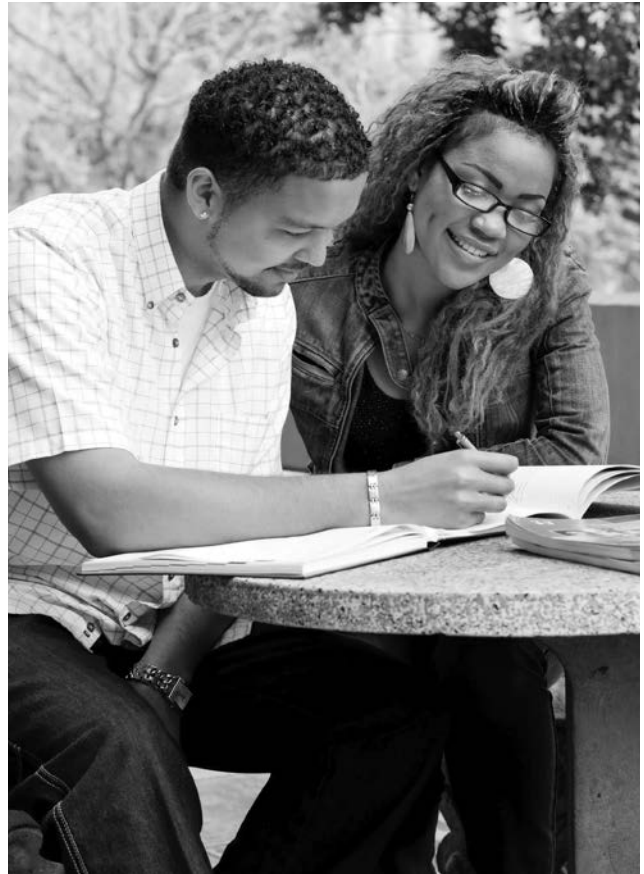
Family inclusion: Families are viewed as essential partners in the decision making process. Most families participate in evidence-based Multi-Family Psychoeducation⁵ focused on increasing knowledge and problem solving.

Commitment from systems leaders: State and regional leaders work together to develop and realign funding streams, regulations, and workplace policies in order to best serve individuals in a flexible way, without barriers such as insurance restrictions and gaps between child and adult systems.

EVALUATION

Data is routinely collected on all EAST/EASA participants, including hospitalizations, legal involvement, school/work involvement, living situation, diagnosis, and referrals. For the one-year period following EASA’s inception at the beginning of 2008, EASA served 340 families and assessed 739 referrals. The results of EAST, as well as the new EASA sites, are encouraging. EAST and EASA participants show

significant declines in hospitalizations as they participate in the program, from approximately fifty percent needing hospitalization in the three months prior to intake to ten percent requiring hospitalization in the following three months; rates continue to decline every quarter thereafter (see Table 1). Approximately seventy percent of participants are actively involved in school or work, and all but a small handful maintain an active vocational goal. EAST is now beginning to follow-up with individuals who have graduated from the program. In addition, each EASA site is involved in a fidelity review process.



WHERE WE GO FROM HERE

We hope that early psychosis intervention programs become more common, and as a result psychosis will be perceived as less frightening, and more as a common medical condition needing appropriate care. Through collaboration with research programs focusing on earlier identification of psychosis, such as The Robert Wood Johnson Foundation’s Early Detection and Identification for the Prevention of Psychosis Program (EDIPPP), EAST/EASA may be able to become more effective in early identification and support. We are on the verge of a tremendous leap forward in improving the lives of people with schizophrenia, from a time when it is viewed as a permanently disabling condition to a time when this mental health condition becomes widely known as treatable.

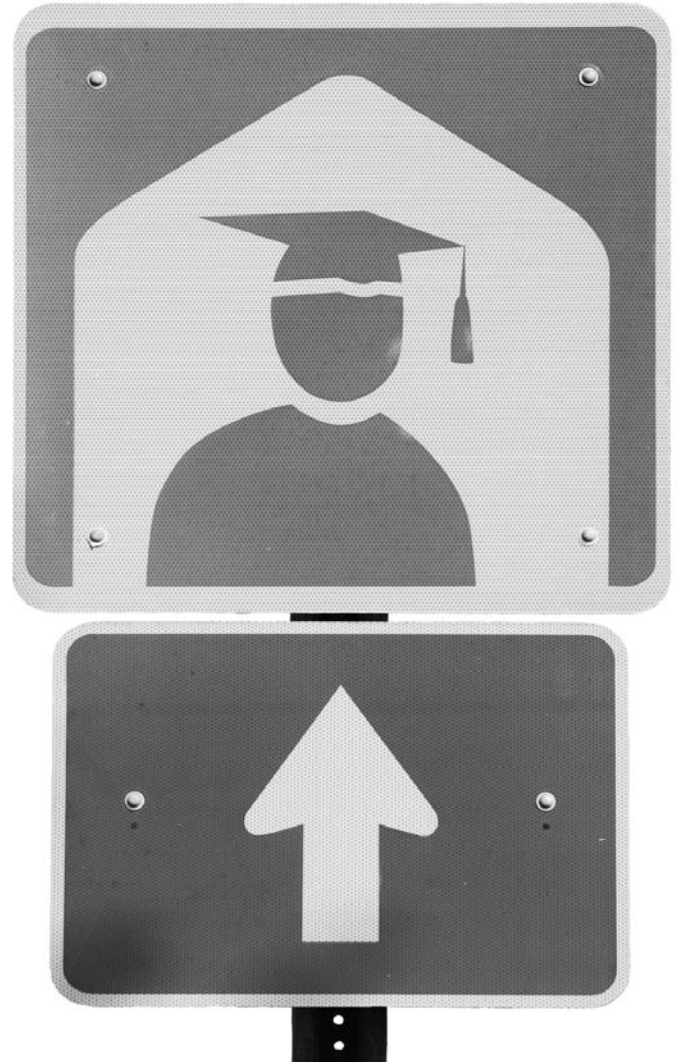
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AUTHORS

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RECOMMENDED WEBSITES

EAST's website designed for families and professionals:

www.eastcommunity.org

International Early Psychosis Association (offers free membership and journal):

www.iepa.org.au

Early Psychosis Prevention and Intervention Center at the University of Melbourne, Australia:

www.eppic.org.au

SAMHSA evidence-based practice toolkits:

www.mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits

HeadSpace (Australia's adolescent health integration program):

www.headspace.org.au

EDIPPP (Website for The Robert Wood Johnson Foundation's study entitled Early Detection and Intervention for the Prevention of Psychosis Program):

www.changemymind.com

A HOLISTIC APPROACH TO SUPPORTING THE TRANSITIONS OF HIGH SCHOOL STUDENTS WITH EMOTIONAL AND BEHAVIORAL DISABILITIES

Providing transition services for adolescents with emotional and behavioral disabilities (EBD) is a primary and vital component to supporting these young people both during and after high school. In 1990, the Individuals with Disabilities Act (IDEA) mandated transition services for all students with disabilities, including students with mental health conditions.¹ Yet despite this legislation, negative post-school outcomes for students with EBD who are served in special education programs are well-documented.

The first step in providing transition services to students with EBD is to simply keep them in school. Students with EBD exhibit the lowest graduation rate among all students with disabilities; less than half graduate from high school. According to the National Longitudinal Transition Study-2,² in 2000 only 56% of students with EBD graduated compared to 72% of all students with disabilities. Post-school outcomes for youth with EBD are also troublesome. Only 66% of youth with EBD were employed or attending college or training programs one year after leaving high school compared to 79% of youth with learning disabilities. Two years after graduating high school, 37% had been arrested, and 3 to 5 years after high school 58% had been arrested. For those who dropped out of high school, 78% had been arrested within 3 to 5 years. In the author's home state of Washington, 41.3% of youth with EBD graduated in 2008, and only 56.9% were employed or attending postsecondary education or training programs within one year of graduating or dropping out of high school.³

To address the negative post-school outcomes of students with EBD, schools must re-examine how they serve these young people and implement interventions based on research associated with positive outcomes for youth with mental health disorders. These evidence-based interventions include strategies that are youth-centered, and support the development of positive and powerful connections with adult mentors in both school and community settings. One such approach is School-Wide Positive Behavioral Interventions and Supports (SW-PBIS), a research-based strategy for providing effective transition services for young people with EBD that is specifically mentioned in IDEA.^{4,5}

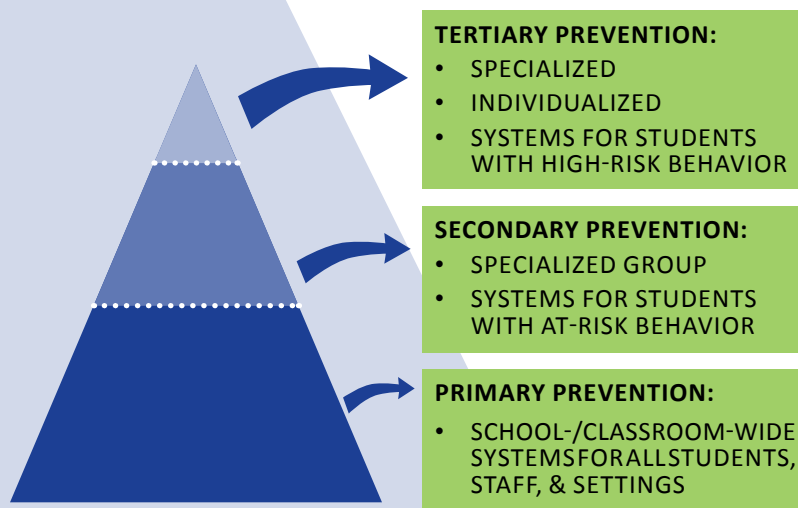
SCHOOL-WIDE POSITIVE BEHAVIORAL INTERVENTIONS AND SUPPORTS

SW-PBIS is a multi-stage, decision-making framework

that guides the implementation of evidence-based practices for improving academic and behavior outcomes for all students.⁶ Schools that implement SW-PBIS organize around a three-tiered approach. In the primary (universal) tier, all students receive support. Students with behaviors that are not responsive to school-wide outreach receive more concentrated support in the form of a group contingency (secondary tier) or a highly individualized plan (intensive tier). (See Figure 1.)

Despite the appeal of SW-PBIS as an evidence-based framework to support a school-wide plan for positive be-

FIGURE 1. CONTINUUM OF SCHOOL-WIDE AND POSITIVE BEHAVIOR SUPPORT



havior, it is often difficult to implement at the high school level due to the size of the student body and the number of students with which teachers may interact. In addition, research examining the implementation of SW-PBIS in high school populations is limited; one study found that implementation of SW-PBIS may be related to improvements in student behavior and school climate, as well as an increase in high school completion rates.⁷ Nevertheless, three high schools in Washington State have taken on the challenge of implementing SW-PBIS over the past three years. The rest of this article describes the SW-PBIS framework in more detail and highlights the efforts in Washington to implement all three SW-PBIS tiers in order to improve outcomes for students with EBD.

THE SCHOOL BUILDING: UNIVERSAL OR PRIMARY TIER OF SW-PBIS

One component linked to both high school completion and positive post-school outcomes for youth with EBD is their inclusion in general education. This inclusion is also an essential component of SW-PBIS. At the universal tier, SW-PBIS provides students with EBD support in general education classrooms. Behavioral expectations are clearly defined and taught across all school settings. Students with EBD are explicitly taught behavioral expectations and receive positive reinforcement for meeting them.

An example of how Washington schools are implementing supports at the universal tier is by identifying “guiding principles” for behavior for all students. In one school the behavior principles included: 1) respect yourself, 2) respect others, and 3) respect property. These three rules were taught to all students to ensure compliance not only in the classroom but in all areas of the school grounds.

THE CLASSROOM: SECONDARY TIER OF SW-PBIS

Students identified as needing support beyond the universal level often receive secondary supports in special education resource rooms. In addition to intensive academic and behavioral supports and interventions, components of self-determination, including goal setting and attainment, are often addressed.⁸ Research indicates that students with better self-determination skills have a greater chance of attending post-secondary education/training and obtaining employment.⁹ Students with EBD can learn self-determination skills by facilitating their own Individualized Education Program (IEP) meetings. Students meet with the school psychologist and the special education teacher to ensure understanding of the IEP process, practice role-playing their participation in the IEP meeting, develop a meeting agenda, and invite participants. These skills are not only useful for IEP planning, but are also necessary after leaving high school.

Missing school is a “red flag” for students at risk of dropping out of school. Carefully analyzing attendance, office referral, and discipline data at the school-wide level identifies students at risk of dropping out of school and prompts secondary tier interventions. An example of a secondary tier strategy used in Washington is Check and Connect (website: www.ies.ed.gov/ncee/wwc/reports/dropout/check_conn/). Teachers, including special education teachers, mentor approximately ten students each, checking in with them every morning, once during the day and once again at the end of the day. If the student is absent the teacher calls the student first thing the next morning to determine why he or she is missing school and to offer support or assistance as well as encourage school attendance. This intervention may continue at the intensive tier.

INDIVIDUAL LEVEL: INTENSIVE OR TERTIARY TIER OF SW-PBIS

Intensive supports are necessary for the school success and positive post-school outcomes of many of the students with significant mental health conditions. At the intensive/tertiary level, services are typically delivered by special education personnel and others within the special education program and often in self-contained programs or settings. Youth-centered transition plans are a critical element of this level of support. Components of these plans include: (1) providing a voice and choice for the students who are the focus of the process, (2) identifying the strengths of the students, (3) focusing on supports that occur naturally in the life of the students, (4) offering comprehensive supports that are based on the needs and preferences of the students, and (5) continued planning for additional intensive supports.¹⁰ These components can and should drive students’ transition plans as well as their IEPs in order to provide information to identify post-school goals and develop a course of study throughout his or her high school years.

Building on these components, strategies and interventions implemented at all three Washington schools at the intensive tier included a personal futures planning process which addressed all five of the components listed above. This process was implemented to help students with EBD identify their own skills, strengths, and limitations; create short and long term goals while facilitating their own IEP meetings; and develop both community connections and, perhaps most importantly, student voice.

Prior to beginning the personal futures planning, the students participated in setting classroom expectations by building on the school-wide behavioral expectations identified at the universal tier. Aligned with these principles, ground rules establishing respect and support were developed and modeled at the beginning of the personal futures planning process. Then teachers developed and shared their own personal futures plans, thereby acting as mentors and facilitators, rather than “experts.” Finally, students created their own plans. This process included reviewing the students’ personal histories, describing their lives today, identifying their strengths, identifying people in their lives who support them, identifying dreams and goals, and developing their “next steps.”

After the personal futures plans were developed, students began to implement their personal goals. Once students were clearer about their post-school goals, developing connections with community agencies and resources became more relevant. Students connected with community resources including the Division of Vocational Rehabilitation, local mental health services, and employment career centers. Through these connections, students participated in job shadowing, job sampling, and internship opportuni-



THE IMPORTANCE OF RELATIONSHIP BUILDING

The community-based activities undertaken by the students in Washington helped these young people develop active and positive relationships with adults within the schools and their communities. Relationship development is a critical component to providing transition services to students with EBD. These relationships provide a circle of support that can facilitate connections to future employers, help identify adult services including mental health treatment, and further solidify post-school goals. Trusted relationships are also important in helping adolescents and young adults manage risk behaviors. Young people who are engaged with support networks and their communities, have success in their schools, and are given assistance and support to identify and reach their personal goals are more likely to replace risky behaviors with productive activities toward their personal goals.

ties in their communities. Students each had mentors who “coached” them as they developed their goals for life after high school (See box on the importance of relationship building).

MEASURES OF SUCCESS

The students in these three schools facilitated their own IEP meetings, partnering with their teachers to develop annual goals for their IEP that were meaningful and relevant to them. They all completed the personal futures planning process and identified six- and twelve-month goals and the people, including their mentors, who could help them achieve these goals. They reached into the community with internships, job shadows, and visits to community agencies. Preliminary data show that school attendance, credit accrual and grades have increased while office discipline referrals have declined.

Although this is a small project and includes less than 100 students, it is a positive example of ways to address the critical issue of transitioning youth with EBD from a high school setting to positive outcomes in the adult world within the framework of SW-PBIS. The teachers and community partners were able to implement the secondary and intensive levels of SW-PBIS and continue to work toward full implementation of the universal level. Continual work is needed to ensure that SW-PBIS is implemented at the level of rigor intended by legislation. The goals of the SW-PBIS projects implemented in these Washington schools are for students to complete high school with academic skills and supports in place that will allow them to: make choices on whether they wish to attend postsecondary education, par-

ticipate in training programs, or attain employment; have knowledge of and access to services to support their health care needs; and have the skills to advocate for these services and supports. SW-PBIS, along with strategies including personal futures planning, community access, and positive relationships with trusted adults, are vital components in this effort and need to be provided in a deliberate and rigorous way in order to prepare youth with EBD for life after high school. The post-school outcomes and dropout rates for youth with EBD are unacceptable. It is imperative that teachers, community members, adult agency providers, and families are aware of these interventions and advocate for implementation.

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