FOCAL POINT

YOUTH, YOUNG ADULTS, & MENTAL HEALTH

EVALUATION OF INNOVATIVE TRANSITION PROGRAMS

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WE INVITE OUR AUDIENCE TO SUBMIT LETTERS AND COMMENTS

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INTRODUCTION

EVALUATION OF INNOVATIVE TRANSITION PROGRAMS
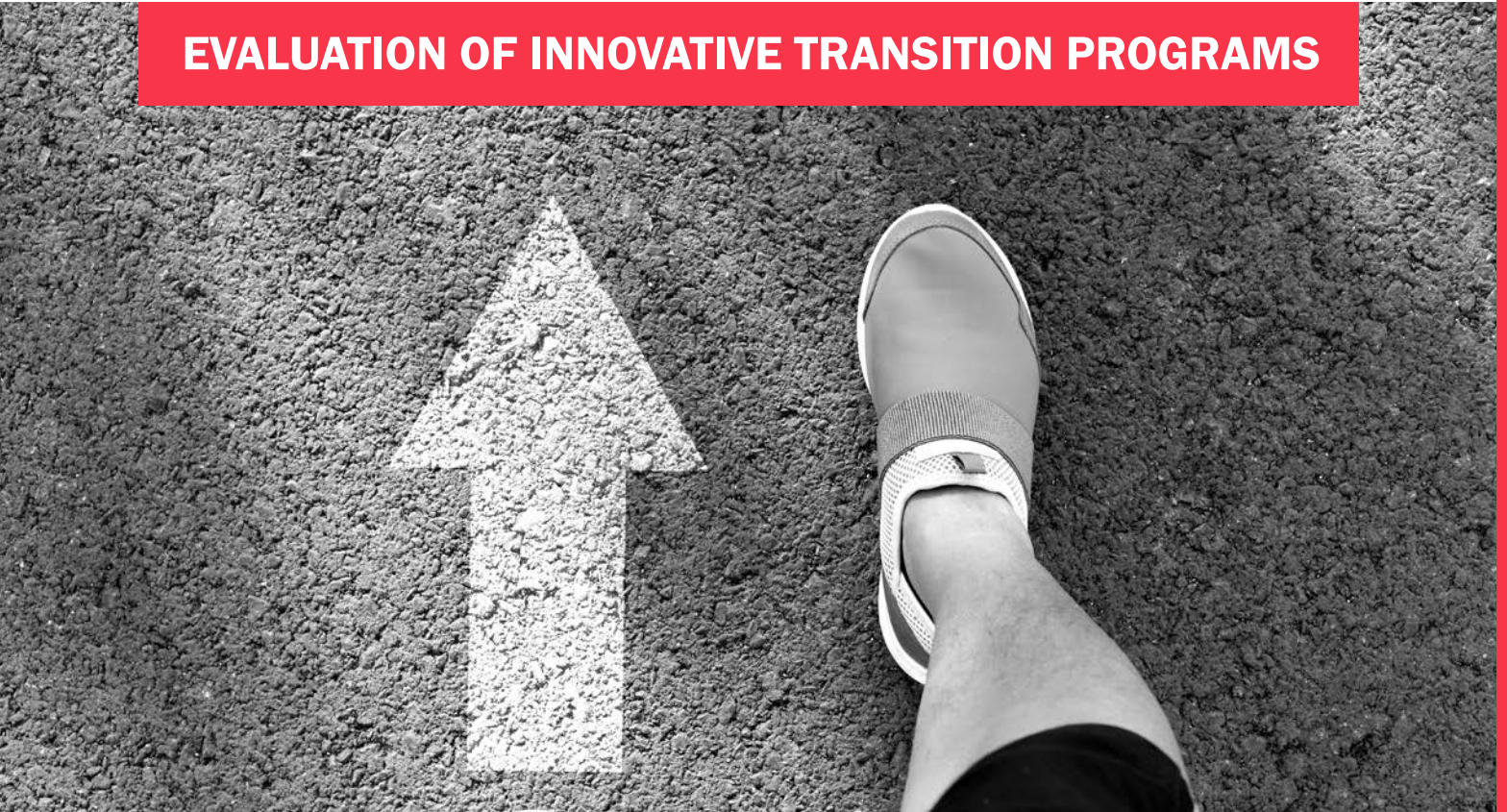
For the past 20 years, the unique needs and preferences of youth and young adults with mental health challenges have slowly been recognized and accepted by the mental health service delivery system. Since 2002 SAMHSA has funded state and local efforts to develop and test models of service delivery for this population. These grant programs were called Partnership for Youth Transition (2002–2004), Healthy Transition Initiative (2009–2014), and Healthy Transitions (2014–2019). Little has been published about findings from cross-site data collection efforts, primarily because of difficulties identifying and maintaining funding for national evaluation efforts. However, each grantee site was required to conduct a local evaluation of their own choosing. We note that young adults participated in shaping evaluation efforts in some of the programs featured in this issue, but family involvement in evaluation was not reported by the authors. The purpose of this issue of *Focal Point* is to explore the findings from the local evaluations conducted by HT grantees over the past five years as well as present evaluation findings from two other innovative programs for transition-aged youth. Taken together, these articles supply service providers and planners across the nation with an indication of the successful outcomes generated by a variety of program approaches.

The first two articles describe the important elements associated with drop-in centers and the effect of this low-barrier programming on outcomes. Massachusetts' YouForward program recorded important advances in meeting education and employment goals as well as an increase in secure housing. Kentucky reported a decrease in the number of young people indicating some period of homelessness after six months in the TAYLRD program. Kentucky's article also describes their intentional process of working with the local homeless coalition to find housing resources.

The next two articles describe ways that Wraparound can be modified to fit the needs and preferences of young adults. The OYEAH program in Milwaukee employs a practice model that mirrors Wraparound but is modified to meet the independence needs of young adults. This program reported low rates of mental health crises resulting in hospitalization or criminal justice involvement. CT STRONG has added elements of peer support

and family advocacy to their Wraparound process and demonstrated improvement in mental health symptoms, reductions in perceived stigma, and an increase in housing stability.

The following set of three articles focus on the population of young adults experiencing a first episode of psychosis (FEP). Delaware's CORE evaluation showed important differences in social connectedness for young people who had experienced a first episode of psychosis compared to those at clinical high risk for FEP. The Rhode Island Healthy Transitions project reported that after six months of services, young people with FEP indicated that they functioned better in social situations, found their symptoms less troubling, and felt more in control of their lives. The authors from Thresholds describe their approach to offering services for high-risk young adults while at the same time providing a coordinated specialty care team for young adults with FEP. Among other positive outcomes, a high proportion of Thresholds' MindStrong and Emerge Chicago-area participants enrolled in education or obtained employment after one year of services.

Each of the last three articles in this issue have a very specific focus. Wisconsin's YES! Program demonstrates how they have developed modified definitions for "positive outcomes" and "improved outcomes" and applied these to National Outcome Measures (NOMs) data. This allows them to report results that are more relevant to young adults' situations. Maryland's HT program provides in-depth academic supports that resulted in increased numbers of young adults engaged in education or training programs as well as a positive effect on their "perception of opportunity." The Florida Healthy Transition Team describes their peer-to-peer model and the employment of young adults in a variety of staff positions. They report several positive outcomes including a decrease in mental health symptoms.

The elements of each program's approach to providing services is only briefly described in each article due to space limitations. Readers may want to contact an article's authors for more details. Many thanks to all the authors who contributed to this issue of *Focal Point*.

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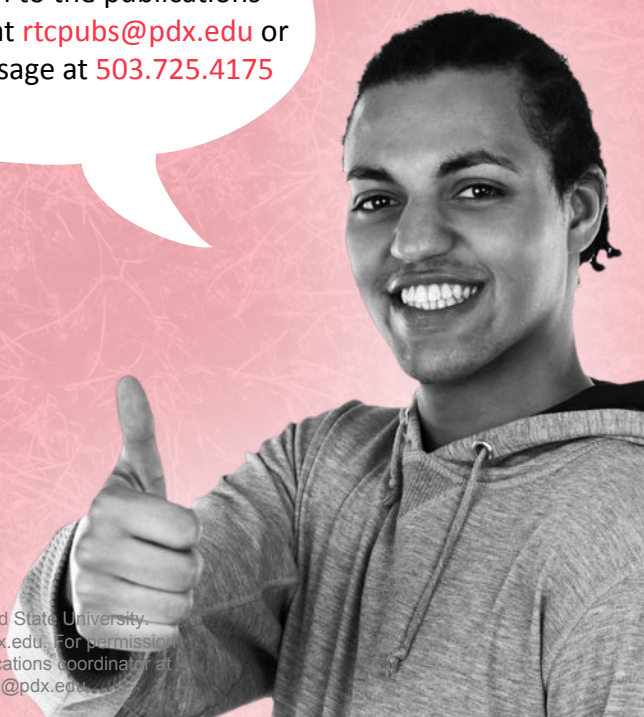
YouForward:
The Massachusetts Healthy Transitions Program

Transition-aged youth and young adults with mental health challenges are often derailed from completing school, engaging in work, and establishing adult roles. Because services specific to the needs of young people are often lacking or are poorly coordinated across child- and adult-serving programs, young adults with mental health challenges often "fall through the cracks" in the system at this critical stage of life.[1] The Massachusetts (MA) Now-is-the-Time Healthy Transitions project, *YouForward* (www.youforward.org), began serving young adults in two diverse communities in northeastern MA in late 2015. Managed by the MA Department of Mental Health in partnership with both child- and adult-serving agencies, YouForward represents an innovative model that bridges the child and adult systems. YouForward staff represent the local communities, which have large Latinx populations. Through strong relationships with other community youth-serving organizations, YouForward engages vulnerable, hard-to-reach young adults by offering low-barrier pathways into services and supports. Specific outreach efforts have brought a number of young adults who identify as LGBTQ, as well as those without stable housing, into the program.

Two *Drop-in Centers* (DICs) that opened in late 2016 are key to YouForward's low-barrier approach. DICs are available to young adults without any requirement to participate in other services. There are no screening or enrollment processes to enter the DICs; young adults are encouraged to "just walk right in." DICs provide basic amenities such as food and showers, offering young adults a place to meet basic needs and a portal to community resources. DICs also offer young adults an opportunity to join a community, build positive relationships, be inspired by peers, share their voice, and assume leadership roles. For many young adults, DICs are the gateway to other YouForward services.

YouForward's *core services* include team-based Wraparound services enhanced with the Achieve My Plan (AMP) approach,[2] the Transition to Independence Process (TIP),[3] Gathering and Inspiring Future Talent (GIFT; a resiliency-focused job training for people with mental health challenges), and access to young adult Peer Mentors.[4] YouForward also offers *expedited pathways* to quickly and easily connect young adults to housing, education, employment, health care, and other services and supports in the community.

YOUFORWARD PARTICIPANTS

To date, YouForward has served over 200 young adults, ages 16 to 25; 53% male, 45% female and 2% non-binary. A number of YouForward young adults identify as LGBTQ. In addition, young parents have found their way to the program. Almost 60% of the young adults identify their race/ethnicity as Latino, 24% as White, and 7% as Black/African American. About one-quarter of young adults are bilingual English/Spanish; 64% speak only English, and 11% speak only Spanish.

Services Make a Difference

"What they do is they sit down and talk about your goal, they talk about what they can do for you, and then you set up a plan."

"The biggest thing that my Peer Mentor did was help me get out of what was borderline homelessness."

"My TIP Facilitator has helped me with like everything. I got my GED... I attended the program, they helped me learn what I needed to, I took the test. I got my permit... was able to schedule my road test."

"I had a terrible relationship with my family... it was bad... my TIP Facilitator and Peer Mentor would give me advice... my relationship with my family has gotten a lot better since starting YouForward."

ASSESSING YOUFORWARD IMPACTS

We use a mixed-method approach to assess YouForward's impacts, including tracking outcomes achieved by young adults in important areas and conducting focus groups with young adults to understand their perceptions of the program.

Tracking Young Adult Outcomes

Beginning in 2017, we used REDCap,[5] a secure web-based application, to build an easy-to-use tracking tool to capture young adults' baseline status and quarterly outcomes in key areas, including education, employment and housing. Data for those enrolled in core services are recorded quarterly in regularly scheduled team meetings.

To date, baseline and outcome data on 68 young adults show gains in education, employment, and housing. At baseline, 43% of young adults were enrolled in school and the majority (81%) had an education goal; typical goals were to complete school or a GED. As of the most recent quarter, 42% of young adults with an education goal had completed it. Also, at baseline, 38% of young adults were working or in a volunteer job; 71% had an employment-related goal. As of the most recent quarter, 51% were working or volunteering. Finally, at baseline, while 68% lived in secure housing, primarily with family, 32% of young adults were living in insecure or temporary housing, and thus were either homeless or at risk for homelessness. At the most recent quarter, 50% of young adults in insecure/temporary housing at baseline had moved into secure housing.

Young Adult Focus Groups

To give voice to their perspectives of the program, two focus groups were conducted with YouForward young adults. Groups took place at one DIC and were facilitated by young adults with lived experience of mental health services; no YouForward staff were present. Twenty-one young adults participated in the groups; 75% had been involved with YouForward for 6 months or more.

During the focus groups, the facilitators emphasized the voluntary and confidential nature of the discussion. Facilitators asked the participating young adults to share their perceptions of the DICs, core services/other activities, and the program overall, and encouraged them to share their opinions openly. Groups were audio-recorded and each young adult received $25 to thank them

for participating. Audio-recordings were transcribed verbatim and transcripts were analyzed thematically. Data from the focus groups clustered into five core themes illuminating young adults' perceptions of You-Forward: *Services Make a Difference*; *YouForward Has Changed Our Lives*; *The Staff Care About and Teach Us; I'm Accepted for Who I Am*; and *I'm Treated with Respect and My Input Matters*.

CONCLUSION

Programs like YouForward that offer a flexible, low-barrier approach can help young adults struggling with mental health conditions who otherwise have not engaged in services to access the supports they need. The youth-driven practices offered by YouForward and other Healthy Transitions programs allow young adults to make real gains in important areas, such as education, employment, and housing. Such programs provide an opportunity to intervene early during a critical stage and can offer young adults a platform for successful transition to adult life.

REFERENCES

1. Davis, M., Koroloff, N., Sabella, M., & Sarkis, M. (2018). Crossing the age divide: Cross-age collaboration between programs serving transition-age youth. *Journal of Behavioral Health Services & Research, 45*, 356–369.

The Staff Care About and Teach Us

"The other thing about the staff here, they don't see it like a job."

"It's almost as if they want it as bad as we, like they want our success as bad as we do."

"They're like... our temple... the more that we see the staff handle our situations, maturity and everything... we can learn from it. Unconsciously, but we end up changing our habits."

YouForward Has Changed Our Lives

"It's gotten us out of ... risk, troubles, like dangerous persons, and it's gotten us to do good risks. Like achieve our goals and everything. It's scary but we do it."

If YouForward wasn't around:

"We'd all be in trouble;" "I feel like I would be super depressed... at home, doing nothing;" "I'd probably be dead, like I probably would have committed suicide;" "I'd be in jail."

I'm Accepted for Who I Am

"[DIC] is a really comfortable area where I can just be… myself and hang out with everybody. And can talk to people casually and not be nervous about it."

"[DIC] itself makes you kind of realize that you're not the only one, going through the same issues like everybody else."

"YouForward is so… open and willing to start an LGBT group… I fell in love with this place, just because they were able to provide me with a safe place to talk to people who are like me."

2. Walker, J. S., Seibel, C., & Jackson, S. (2017). Increasing youth's participation in team-based treatment planning: The Achieve My Plan enhancement for Wraparound. *Journal of Child and Family Studies, 26*, 2090–2100.

3. Unruh, D. K., & Clark, H. B. (2009). Futures focus: Practice, programs, system, policy and research. In H. B. Clark & D. K. Unruh (Eds.), *Transition of youth and young adults with emotional or behavioral difficulties: An evidence-supported handbook* (pp. 325–344). Baltimore, MD: Brookes Publishing.

4. Delman, J., & Klodnick V. V. (2017). Factors supporting the employment of young adult peer providers: Perspectives of peers and supervisors. *Community Mental Health Journal, 53*, 811–822.

5. Harris, P. A., Taylor, R., Theilke, R., Payne, J., Gonzalez, N., & Conde, J. G. (2009). Research electronic data capture (REDCap) – A metadata-driven methodology and workflow process for providing

"They sit down and talk about your goal, they talk about what they can do for you, and then you set up a plan."

I'm Treated with Respect and My Input Matters

"The thing is… with YouForward and the DIC they have patience with us. Other people… they don't have that patience."

"Here they're very understanding… rather than freak-out they'd be like 'calm yourself down and let's talk about it.' They don't bring in security guards."

"…when you have to go through a process of signing papers and stuff like that, you realize this is a professional relationship… these people don't actually have an interest in me. Places like [DIC] gives you… a sense of… importance because we have a big part in everything."

translational research informatics support. *Journal of Biomedical Informatics, 42*, 377–381. Retrieved from https://www.sciencedirect.com/science/article/pii/S1532046408001226

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Drop–In Centers & Local Collaboration Lead to

Improved Housing Outcomes in Kentucky

Homelessness and housing instability present serious challenges to young people and their development. Young people experiencing homelessness face intense levels of stress to find options for safety and survival,[1] which often overshadow a young person's ability to explore other essential decisions that adulthood presents, such as employment and higher education. With approximately 4,025 people in Kentucky experiencing homelessness any given night,[2] homelessness and housing instability is a significant issue for the population of transition-aged youth and young adults served by Kentucky's Healthy Transitions grant program – Transition Age Youth Launching Realized Dreams (TAYLRD). Youth drop-in centers established as part of the grant provide an important engagement environment where transition-aged youth can access an array of developmentally-appropriate behavioral health and related services and supports. The TAYLRD Drop-In Centers and the services and supports they provide have played an important role in improving housing and mental health outcomes for the youth and young adults they serve.

Transition-aged youth and young adults were involved in the design of the TAYLRD Drop-In Centers to ensure that they are engaging, comfortable, and safe spaces where youth can access services and supports to meet their life goals. The drop-in centers provide access to peer support, case management, employment/education support, therapy, and medication services, as well as assistance with setting personal goals and connecting to resources such as housing. To help connect and engage young people the drop-in centers also have computer labs, snacks, board games, pool tables, and video games. A young person can choose to become a TAYLRD Drop-In Center member after three visits. As a part of the membership process, peer support specialists assist young people in identifying life goals and connecting with services and supports that best match their interests and needs. A young person who identifies as being homeless or precariously housed is connected to case management and local housing services.

In 2015, when the TAYLRD Drop-In Center opened in Louisville, Kentucky's largest city, the number of young people coming to the center who were experiencing homelessness was higher than anticipated. As a result, the staff quickly established a more intentional and coordinated approach to helping young people find housing. The drop-in center became a part of the local Coalition for the Homeless, a group of leaders and staff from 30 member agencies that work collectively to serve homeless people in the community. As a part of the Coalition, TAYLRD was able to learn about and connect youth to other organizations that provide housing services and supports.

In 2017, the TAYLRD Louisville Drop-In Center director worked with the Coalition and other leaders to implement the 100-day Challenge, with the goal of providing housing supports to 100 youth in 100 days. The goal was exceeded and within 100 days, 112 youth

were provided housing and support services.[3] The 100-day challenge collaboration increased the TAYLRD staff's understanding and awareness of housing programs and eligibility requirements. These local partnerships helped to increase the ability of staff to connect young people to housing programs more effectively and efficiently. It also provided staff an opportunity to advocate for young people at the local system level. Concurrent with referring young people to housing services, the drop-in center staff connect the young person with other services and supports, such as mental health and substance use services, case management, job skills, and peer and

> *"...it came together quickly. Like, I probably was waiting two to three months max, so I would say it was fast, and their system, I guess. I was surprised. Being a youth that's had a couple of apartments and then felt some glory, and then lived in his car and living with people on the side too, and then getting housed was kind of a big deal to me because going from zero to hero kind of meant a lot, because when you get your own keys to your spot it's kind of a step toward independence."*
>
> **– TAYLRD youth who got housed**

community supports. The drop-in center also empowers young people to advocate for themselves by providing independent living skills. Often, young adults who were experiencing homelessness sought Louisville Drop-In Center services after learning through word of mouth that the drop-in center was youth-friendly, helpful, and able to connect them to needed resources.

In order to explore the impact of the drop-in center services on youth homelessness, the National Outcome Measures system (NOMs) dataset was used.[4] The measurement tool collects data on various life domains, including housing. The NOMs is administered by the TAYLRD Youth Coordinator at baseline, every six months, and discharge. For the purposes of this examination, only NOMs from the Louisville TAYLRD Drop-In Center were included in the analysis because it was the region

that had an overwhelming proportion of its members reported to be homeless at baseline and it was the drop-in center that established specific partnerships to address housing needs. It should be noted that only data from youth who responded to *Stability in Housing* questions at both baseline and six months were included in the analysis.

At baseline, most youth at the Louisville Drop-In Center identified as male (62%), while fewer respondents identified as female (36%), gender-neutral or transgender (2%). Two questions from the NOMs were included in the analysis of housing conditions. The answer options to the questions provided not only the number of homeless nights spent, but also the types of housing (e.g. owned, rented, foster care, hospital, detox, correctional facility, shelter, street). Overall, 12.8% of the 39 youth answering the questions at baseline reported living in an owned or rented house/apartment /trailer/room. At six months, this proportion increased to 30.8% and the number of youth selecting "homeless" decreased by 25.6%.

Thirty-five young people answered the question "In the past 30 days, how many nights have you been homeless?" At baseline, 7 youth reported that they spent 1 to 9 days homeless, 2 youth reported 10 to 19 days homeless, and 19 youth reported 20 to 30 days homeless. At the 6-month reassessment, the number of youth who spent 20 to 30 days homeless and the number of youth who spent 1 to 9 days homeless decreased, while the number of youth who spent 10 to 19 days homeless increased. Sixteen youth reported a reduced number of homeless days after 6 months; 8 of these went to "0 days" (5 of whom had been at 30 days of homelessness prior to baseline). Of the 16 youth who indicated at baseline they had spent 30 days homeless in the past 30 days, only 4 reported they had spent 30 days homeless in the past 30 days at 6 months. Ten youth experienced more homeless days than they had prior to baseline; 5 of these youth were homeless for 30 days. Overall, the average number of homeless days per youth decreased from 21.6 to 19.2. Initial analysis also showed positive improvements in some mental health and social connectedness outcome measures. At baseline only 24% of young people reported that they did not feel or rarely felt restless, and at 6 months this number increased to 40%. At baseline 58% of youth reported that they had a feeling of belonging; at 6 months that increased to 69%.

Preliminary analysis indicates that drop-in center services, when coupled with strong partnerships with

housing and related agencies, help improve housing conditions for youth and decrease the number of days spent homeless by a young person. These results indicate that a tight-knit partnership and coordination among agencies at the local level, coupled with youth-friendly services, greatly facilitate the engagement of youth experiencing homelessness and connect them to housing services and supports. It should be noted that because of the small sample size, the findings of the study should be cautiously interpreted. Future studies will focus on youth perspectives on how the services and supports available at TAYLRD Drop-In Centers helped them find jobs or housing.

REFERENCES

1. Hauwiller, R. I. (2014). *Young adult experiences of homelessness: Retrospective explorations of strengths and resilience*. Retrieved from https://sophia.stkate.edu/msw_papers/326

2. National Alliance to End Homelessness. (2017). *Kentucky Statewide Statistics*. Retrieved from https://endhomelessness.org/homelessness-in-america/homelessness-statistics/state-of-homelessness-report/kentucky

3. WAVE 3 News. (2017). *Louisville houses 112 homeless youths in 100 days*. Retrieved from http://www.wave3.com/story/36807468/louisville-houses-112-homeless-youths-in-100-days

4. Substance Abuse and Mental Health Services Administration, US Department of Health & Human Services. (2010). *National Outcome Measures*. Retrieved from https://www.samhsa.gov/grants/gpra-measurement-tools

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Often young adults who were experiencing homelessness sought Louisville Drop–In Center services after learning through word of mouth that the drop–in center was youth–friendly, helpful, and able to connect them to needed resources.

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FOCAL POINT   11

OYEAH: A WRAPAROUND COMMUNITY-BASED PROGRAM FOR TRANSITION-AGED YOUTH AND YOUNG ADULTS

OYEAH (Older Youth and Emerging Adult Heroes) has served transition-aged youth and young adults in Milwaukee, Wisconsin for over 10 years. From July 2015 through June 2018, the program served 314 youth/young adults ranging in age from 16.5 to 24.0 years with an average age of 21.0 years. The most prevalent diagnoses among those served are mood disorder, attention deficit hyperactivity disorder, PTSD, and conduct disorder.

The OYEAH practice model mirrors the Wraparound process, maintaining the same values and principles with minor modifications to accommodate the independence of the young adult. The practice model is comprised of four phases: (1) Relationship Formation, (2) Planning, (3) Action and (4) Transfer of Learning and Leading, providing young adults with behavioral or mental health needs *access to*, a *voice in*, and *ownership of*, planning and directing their future.

MONITORING RELATIONSHIP FORMATION AND PLANNING

As identified by Jivanjee and her collaborators,[1] the first two core competencies of providers are *Engaging and Building Trust* and *Partnering with Youth and Young Adults*. OYEAH incorporates these core competencies in Phases 1 and 2 as the program's cornerstone. OYEAH monitors this relationship in 6-month intervals using a modified form of the Engagement and Planning Survey.[2] This survey measures the young adults' perceptions of the relationship they maintain with their Transition Coordinator and their involvement in planning and developing their personal Domain-Based Plan. From July 2015 to June 2018, the outcomes reveal an overall average engagement score of 4.46 on a 5-point Likert scale (n = 179). There has been little variance in average scores since instituting this measurement tool. Comparing responses to questions related to Planning and those related to Engagement reveals higher, but not significantly different, scores for Engagement (4.47) than those for Planning (4.08). Further analysis reveals that specific questions consistently receive the highest and lowest ratings. Major strengths are *My Transition Coordinator listens to me* (4.53) and *My Transition Coordinator encourages me to take responsibility for how I live my life* (4.58). The lowest ratings relate to cultural understanding and independent decision-making: *My Transition Coordinator is sensitive to my cultural background* (4.07) and *I make final decisions on my treatment goals* (4.08). The supervisors review the outcome data with Transition Coordinators to provide specific feedback about their engagement and planning styles with young adults and to address those few individuals who do not appear to be engaging well.

MONITORING ACTION

In Phase 3 (Action), OYEAH incorporates the third and fourth core competencies: *Promoting Wellness* and *Meeting Needs in Keys Areas of Life*.[1] These competencies require volition and action by the young adult with

ongoing support of the Transition Coordinator, providers, and other team members. Organized around 10 developmental domains, young adults determine their priority needs.

Upon leaving the program, three factors of the Disenrollment Level of Progress are calculated: (1) Completing the Program, (2) the Youth Disenrollment Progress Report Score, and (3) the Needs Met per the Final Domain-Based Plan. The average score for young adults who either completed the program, or have chosen to leave the program after at least one year, is 59/100. While OYEAH's processes supporting transition are well established, implementing them can be challenging.

There are two domains that young adults must view as priorities and be motivated to address: *Mental Health,* focusing on emotional stability; and *Transition to Adulthood,* focusing on skill development. Challenges in their living situation frequently distract them from implementing their plans. Comparing the level of need (*high need – no need*) across all 10 domains of young adults who completed the program to those who have chosen to leave reveals a greater intensity of need across the domains for those that chose to leave (see Figure 1).

The duration of time in the program of those who chose to leave ranges from 2 to 28 months with an average stay of 18 months. The combination of so many *high* to *medium* needs in key domains (mental health, employment, education, and living situation) may appear insurmountable to the young person and could result in emotional despair, possible homelessness, and disenrollment. However, among the young adults who have enrolled in OYEAH from the onset of the program (2009), 5% (38/713) have re-enrolled, which suggests that each young adult has his/her own process and some feel sufficiently comfortable to return when they are ready.

MONITORING TRANSFER OF LEARNING AND LEADING

The fifth core competency, *Facilitating Young People's Empowerment to Take Charge of their Own Wellness*[1] is incorporated into the fourth phase of the OYEAH Practice Model. Change in progress across time is monitored every six months using the Domain Appraisal Tool (DAT; adapted from National Outcome Measures, 2010)[3] for all youth who have formally left the program, either by completion or by choosing to disenroll.

According to the DAT outcomes, the greatest change attributed to the young adult's participation in OYEAH is in the positive change in *Internal Feelings* about oneself, which shows an average increase of 27%. This was substantiated through interviews with six young adults who had completed the program in which they all expressed feeling more confident, less anxious, and more worthy. When asked what animal represented them as an adult, 100% of them independently reported a lion because "a lion is adaptable, a leader, and powerful." Improvement in their *Everyday Living* situation including work, school, family relations, and especially housing also contributed to feeling better, with an average improvement of 8.1%. In interviews, all of the young adults expressed concerns with housing. They talked about their struggle while in OYEAH to obtain housing, and its tenuousness. They understood the connection between education/training, employment, and having a safe place to live. One young adult reported, "It's all grouped together and it's like pulling a string from a sweater... It can fall apart."

Social Connectedness is the most challenging area when functioning independently without the ongoing supportive interactions that OYEAH provides (percent of change -5%). In addition, support from family ebbs and flows and therefore, no generalization can be made, as

FIGURE 1. DOMAIN RATING OF TOTAL NEEDS
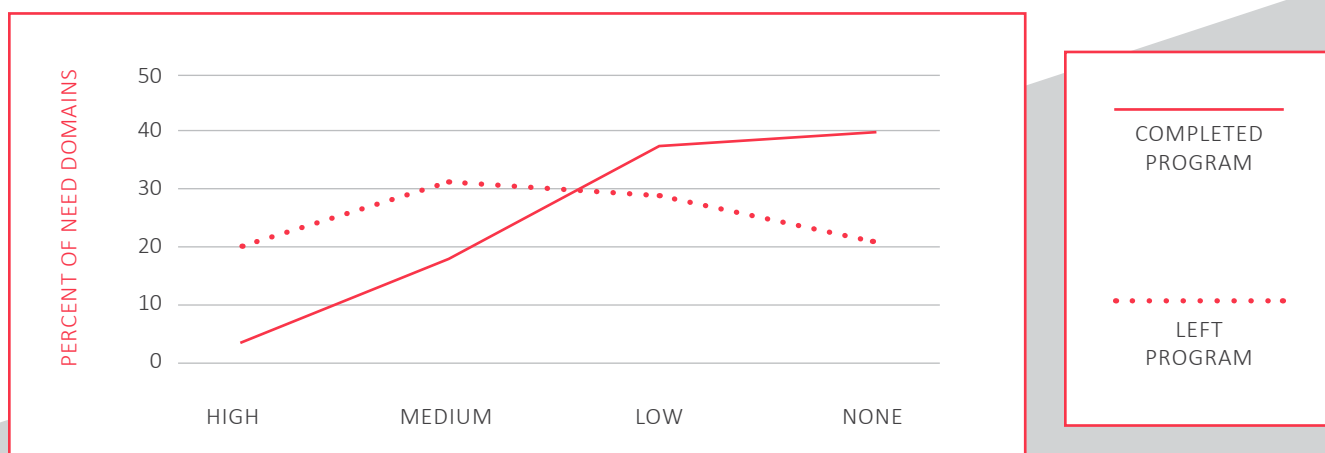
each situation is unique. The sense of feeling a part of a greater community is hard to achieve.

Lastly, monitoring negative symptoms (hospitalization and incarceration) provides additional indicators of how well young adults are functioning in the program. According to the Wisconsin Office of Children's Mental Health Annual Report (2017),[4] the number of teens admitted on an Emergency Detention to a State run mental health facility increased from 350 to close to 800 from 2011 to 2016. Furthermore, the young adult (19-25) admissions have doubled in the last three years (250 to 500 per year). For young adults in OYEAH, the average rate of hospitalization from July 2015 to June 2018 was only 4% (14/314).

The Wisconsin Department of Corrections-Division of Juvenile Corrections (2015)[5,6] recently reported the statewide recidivism rate is at 61% and the re-incarceration rate in the adult population is 15%. The state's general incarcerated population's demographics are 61% African American and 62% have mental health issues. While OYEAH's young adults all have mental health challenges and have a similar racial profile, from July 2015 to June 2018, only 8% (25/314) of program participants were incarcerated.

Young adults served by OYEAH have low rates of hospitalization and incarceration in a state with increasing rates of hospitalization for youth and young adults and high rates of recidivism. In addition, the program instills in young adults a greater sense of empowerment, self-esteem, and confidence. This process is summed up by the voices of the Transition Coordinators and the young adults who both reported "finding and believing in oneself" to be the most challenging obstacle to independence. Young adults stated that they received the most significant help in addressing these feelings of inadequacy. As reported by a Transition Coordinator, success is measured not solely by the completion of goals but rather "how resilient (they are) and how often the young adult comes back to try again." OYEAH, in partnership with young adults, builds the foundation that supports and provides direction to the desired goals.

REFERENCES

1. Jivanjee, P., Brennan, E., Grover, L., Sellmaier, C., Roser, E., Pathways Transition Training Collaborative, Youth M.O.V.E. National, & Pathways Transition Partners. (2018). *Transition mental health service provider core competencies*. Portland, OR: Research and Training Center for Pathways to Positive Futures, Portland State University.

2. Walker, J. S., & Powers, L. E. (2007). *Introduction to the Youth Self-efficacy Scale/Mental Health and the Youth Participation in Planning Scale*. Portland, OR: Research and Training Center on Family Support and Children's Mental Health, Portland State University.

3. Substance Abuse and Mental Health Services Administration, US Department of Health & Human Services. (2010). *National Outcome Measures*. Retrieved from https://www.samhsa.gov/grants/gpra-measurement-tools

4. Wisconsin Office of Children's Mental Health. (2017). *FACT SHEET: Youth psychiatric hospitalizations, readmissions, and emergency detentions*. Madison, WI: Office of Children's Mental Health.

5. State of Wisconsin Department of Corrections. (2016). *Recidivism & re-incarceration*. Retrieved from https://doc.wi.gov/Pages/DataResearch/DataAndReports.aspx

6. State of Wisconsin Department of Corrections, Division of Juvenile Corrections. (2015). *2014 Annual Report*. Madison, WI: Department of Corrections, Division of Juvenile Corrections.

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THE PROGRAM INSTILLS IN YOUNG ADULTS A GREATER SENSE OF EMPOWERMENT, SELF-ESTEEM, AND CONFIDENCE.

Preliminary Outcomes in CT STRONG:
A Youth and Young Adult Wraparound Program

Over the past four years, youth and young adults have been participating in the CT STRONG program, Connecticut's Healthy Transitions project. CT STRONG (Seamless Transition and Recovery Opportunities through Network Growth) involves a Wraparound model utilizing peer support and family advocacy and serves a population of transition-aged youth and young adults, ages 16 to 25, who have, or are at risk for, behavioral health disorders and who live in three Connecticut towns. The program engages and connects them to high-quality behavioral health services and supports. CT STRONG utilizes innovative approaches while implementing the key principles of the Wraparound approach, but is very flexible to meet the needs and preferences of young people.

EVALUATION METHODS

The evaluation of the program involves both quantitative and qualitative components in order to capture both outcome and process measures:

1. **Staff-Client Activity Logs:** A log of staff activities is used to record client-related contacts and types of assistance offered on a weekly basis.

2. **Client Interviews:** Clients are interviewed at three time intervals: intake/baseline, 6 months, and 12 months after intake. Scales of Special Interest – The client interviews include all of the data required by SAMHSA's GPRA instrument.[1] The CT STRONG team added items focused on variables of special interest; namely, youth empowerment, late adolescent connectedness, and stigma.[2-5] The evaluators and young adults with lived experience developed these measures by selecting and modifying items from existing scales.

3. **Focus Groups:** Several focus groups were held with clients and program staff to identify key program components as well as barriers to and facilitators of implementation, and to better understand the quantitative findings.

PRELIMINARY RESULTS

The evaluation is ongoing, so all results should be considered preliminary.

I. Weekly Logs

The CT STRONG team uses weekly activity log data to describe the frequency, intensity, and types of services being provided by staff, which reflect what the greatest needs are for the clients. To date, they have received 3,279 logs for 299 clients.

FIGURE 1. MENTAL HEALTH AND STIGMA: PERCENT CHANGE FROM BASELINE TO 6 MONTHS
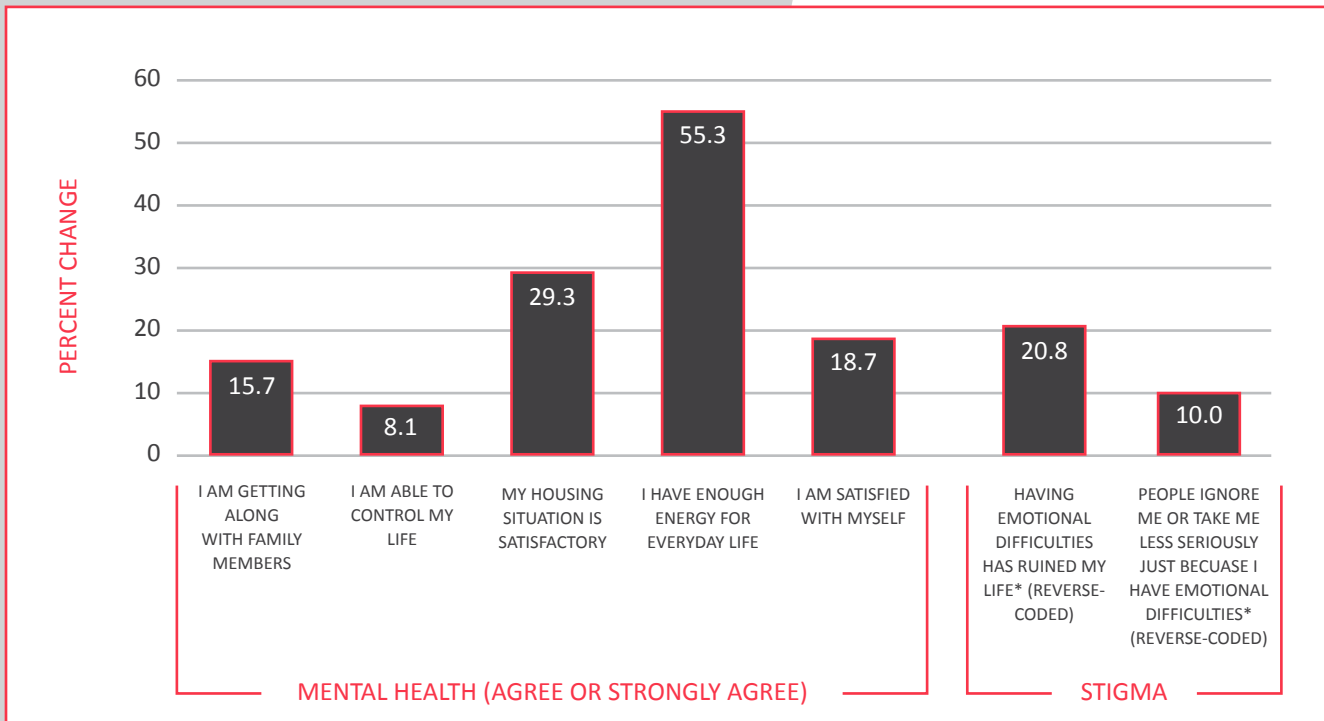
The top activities reported include emotional support for clients and families; advocacy; peer support; crisis management; and engagement in treatment planning. Over a third of the clients have been referred to formal mental health services.

Another frequent activity is teaching transitional life skills, of which vocational and money management skills are the most common. Program staff have provided emotional and parenting support for about a third of the family members of CT STRONG clients. Occasionally, staff have also helped family members apply for benefits or obtain community services.

Transportation is the fifth most common weekly activity that staff provide or help arrange for, and is often reported as a need for the clients.

Program staff also assist clients with benefit and ID applications. Assistance with housing subsidies, Medicaid, driver's licenses, and SNAP benefits were most commonly reported. In addition, CT STRONG clients received help obtaining a variety of basic needs, including personal care items, food and clothing.

II. Interview Data

A total of 193 baseline, 109 6-month, and 78 12-month interviews were completed at the time of this analysis. Some significant limitations to the completeness of the interview data given by young people include

a higher refusal rate for participating in interviews than most adult populations. (The 6-month follow-up rate has been approximately 66% in recent months.) Nevertheless, given the large number of interviews available, some preliminary observations can now be noted.

Due to the lower number of 12-month interviews currently available, only baseline and 6-month data were included in the analysis. The interview data suggest some preliminary positive outcomes when comparing baseline to 6-month scores on several measures. Positive outcomes include an improvement in mental health and reduction in perceived stigma around emotional difficulties (See Figure 1).

Improvements in social relationships, self-esteem, and empowerment around managing their health and services were also noted (See Figure 2).

Positive housing outcomes are also indicated. The percentage of participants who owned or rented a house or apartment nearly doubled from baseline to 6 months (17.1% to 31.7%). The percentage of participants who reported living in an emergency shelter or in a place not meant for habitation decreased (5.7% to 1.0%).

III. Focus Group Feedback

Two of the main findings from the client focus groups were: program staff meet the clients "where they are" by first working on what clients identify as

their immediate needs and goals; and the clients are very enthusiastic about the program, want more people to know about it, and want more programs like it to be set up. Young adults appreciate the program flexibility to focus on their goals. Self-identified main needs are: jobs, education, support while in school/college, independent housing, advocacy, knowledge of rights, and help getting into services. CT STRONG has assisted them with finding jobs, getting driving permits, and looking into colleges and financial aid. One participant noted, "Yeah I think the first day I came in here, me and one of the staff – we sat down and we filled out almost ten (job) applications in the first day of being here." There was a consensus that the participants feel like they can trust the staff, with participants saying, "They keep your personal stuff personal," and "They respect you 100%."

The peer group participants generally described having had mental health problems since childhood, especially as related to trauma. Most have a history of service use and are currently in other mental health services. The young adults identified stigma as a barrier to receiving mental health services. They mentioned that the fear of stigma often prevents young people from getting help or talking about what is happening.
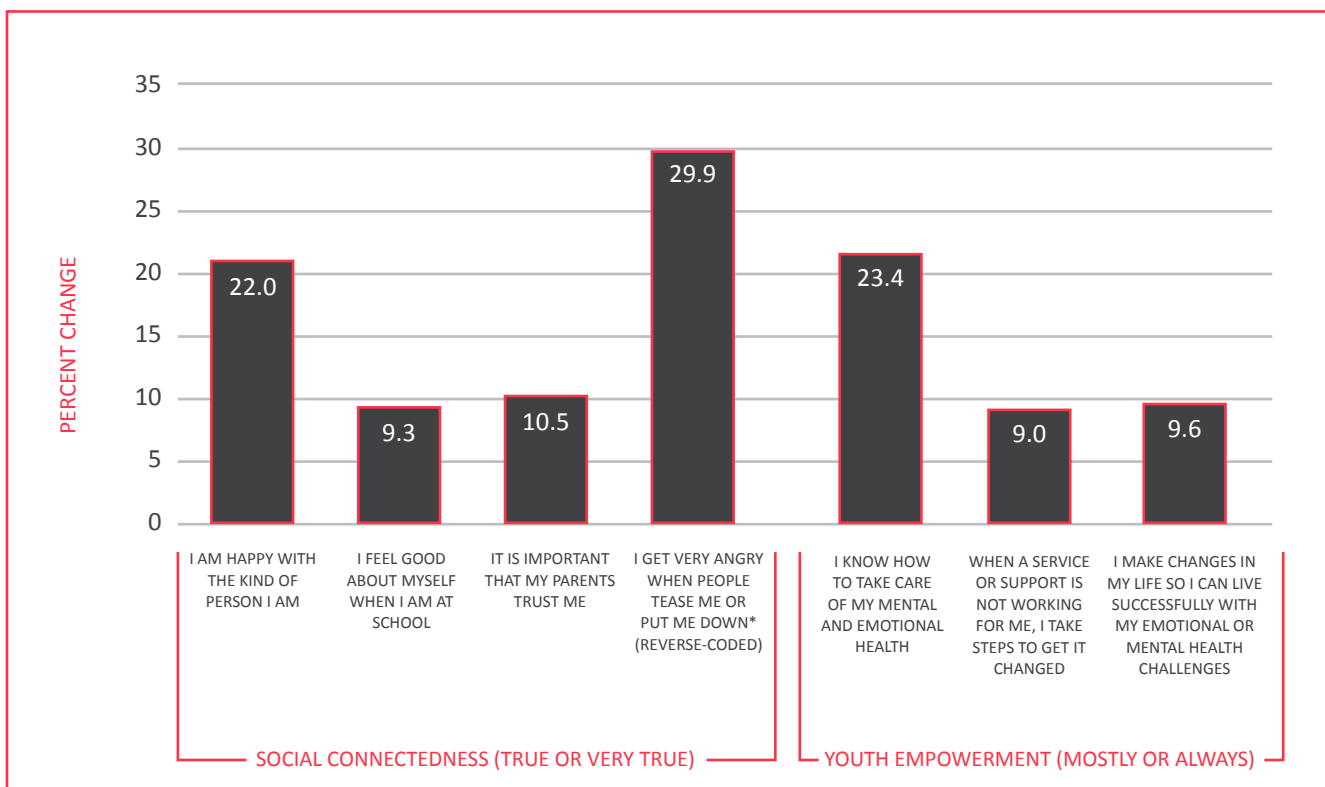
They have noticed that there is less stigma in younger generations but reported that their parents often do not understand mental illness. One participant shared, "For me, I consider my [mental illness] experience as one small chapter of my whole book."

All seemed to have had mixed experiences with mental health services, including having found some mental health professionals they trusted and others they didn't. Many expressed appreciation for receiving trauma-specific services. Generally, they wanted their preferences to be heard and solicited rather than having services based on assumptions and cookie-cutter recommendations (e.g., based solely on diagnosis). Although some found relief for their symptoms with medication, they didn't want medication to be assumed to be the best course of treatment. There was a strong preference for non-traditional/non-medical approaches such as yoga and meditation.

The young adults attending the peer support groups have found the experience to be very positive:

"We do have deep conversations about what we're going through… And we'll give words of encouragement to everybody… It's a very nice

FIGURE 2. SOCIAL CONNECTEDNESS AND YOUTH EMPOWERMENT: PERCENT CHANGE FROM BASELINE TO 6 MONTHS

Regional Research Institute for Human Services, Portland State University.
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FOCAL POINT   17

environment and it's safe for a lot of people. So I like it a lot."

"It's definitely something I look forward to in the week… it's definitely something I'd rather have more often than just once a week."

Many participants discussed making friends in the group. "Some of us hang out outside of group. I would say that a lot of people I'm pretty close with, I met in this group."

Recommendations from participants included the following: There should be more young adult support groups and parent education/training across the state. Mental health providers should not judge youths' or young adults' capabilities based on their worst days.

2. Boyd, J. E., Otilingam, P. G., & DeForge, B. R. (2014). Brief version of the Internalized Stigma of Mental Illness (ISMI) scale: Psychometric properties and relationship to depression, self-esteem, recovery orientation, empowerment, and perceived devaluation and discrimination. *Psychiatric Rehabilitation Journal, 37*(1), 17–23.

3. Karcher, M. J., & Sass, D. (2010). A multicultural assessment of adolescent connectedness: Testing measurement invariance across gender and ethnicity. *Journal of Consulting Psychology, 57*, 274–289.

4. Vogel, D. L., Wade, N. G., & Hackler, A. H. (2007). Perceived public stigma and the willingness to seek counseling: The mediating roles of self-stigma and attitudes toward counseling. *Journal of Counseling Psychology, 54*(1), 40–50.

5. Walker, J. S., Thorne, E. K., Powers, L. E., & Gaonkar, R. (2010). Development of a scale to measure the empowerment of youth consumers of mental health services. *Journal of Emotional and Behavioral Disorders, 18*(1), 51–59.

I consider my [mental illness] experience as one small chapter of my whole book.

DISCUSSION

Preliminary results suggest that peer support and a youth-centered, flexible Wraparound approach have led to improvements in the lives of individuals in the CT STRONG program. A mixed method evaluation approach is needed in order to capture a full picture of both process and outcome measures for the transition-aged youth and young adult population.

REFERENCES

1. Center for Mental Health Services (2017). *NOMs client-level measures for discretionary programs providing direct services. Services tool for adult programs. SPARS Version 2.0.* Retrieved from https://spars.samhsa.gov/sites/default/files/CMHS_Client-Level%20 Services%20Tool%20for%20Adults.pdf

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PROJECTS AND STAFF

PROJECT FUTURES: FOSTERING UNITY TOWARDS UPLIFTING RESILIENCE, EDUCATION, AND SUCCESS tests a college-based approach to enhancing self-determination and community participation to help young adults with a history of mental health challenges to build skills to navigate the university system and increase post-secondary success and engagement.

Jennifer Blakeslee, Principal Investigator; Rebecca Miller, Project Manager.

EASA CONNECTIONS brings together young adults who have been part of Oregon's early psychosis initiative to develop and test a peer-delivered series of web-based decision support tools for new individuals entering into early psychosis services.

Tamara Sale & Dora Raymaker, Co-Principal Investigators; Ryan Melton, Clinical Consultant; Christina Wall, Young Adult Coordinator; Mirah Scharer, Project Coordinator.

TEC-PD: TECHNOLOGY-ENHANCED COACHING FOR POSITIVE DEVELOPMENT tests a workforce intervention using state-of-the-art technology to implement high-quality coaching and supervision with practitioners employing the Transition to Independence Process intervention with emerging adults with serious mental health challenges.

Janet Walker, Principal Investigator; Caitlin Baird, Project Manager; Mary Beth Welch, Lead Trainer; Armand Beikzadeh and Victoria Kincaid, Student Research Assistants.

S/PAC: SYSTEM/POLICY ASSESSMENT AND CHANGE PROJECT tests a workforce intervention focused on training and coaching peer support providers who work with emerging adults with serious mental health conditions, and prepares agencies to supervise and support them.

Nancy Koroloff & Barbara Friesen, Co-Principal Investigators.

AMP+: DEVELOPING THE YOUNG ADULT PEER SUPPORT WORKFORCE tests a workforce intervention focused on training and coaching peer support providers who work with emerging adults with serious mental health conditions, and prepares agencies to supervise and support them.

Janet Walker, Principal Investigator; Caitlin Baird, Project Manager; Mary Beth Welch, Lead Trainer.

MEANINGFUL NETWORKS MODEL (MNM) is developing and pre-testing a group-based curriculum to enhance social development and well-being among young adults whose support networks are limited due to histories of out-of-home placements/system involvement.

Jennifer Blakeslee, Principal Investigator; Caitlin Baird, Project Manager; Janet Walker, Project Consultant; Armand Beikzadeh and Victoria Kincaid, Student Research Assistants.

THE PATHWAYS TRANSITION TRAINING PARTNERSHIP collaborated with service provider organizations to test the effectiveness of an online training program; surveyed service providers regarding their training needs and preferences; and has developed, and is testing, new training materials created in response to survey findings.

Eileen M. Brennan & Pauline Jivanjee, Co-Principal Investigators; Leigh Grover, Project Manager; Claudia Sellmaier, Project Collaborator.

Changes in Social Functioning in Delaware CORE

Young adults' ability to cope with new clinical information about their health relies on adequate social functioning for communicating needs and seeking social support. However, in the case of psychosis, social functioning or how one maintains relationships can be impaired before or during an episode.[1] In fact, difficulties with social functioning may be both a risk factor for and consequence of psychotic development.[2]

Unfortunately, the evidence for effective promotion and recovery of social functioning in people who have psychosis is not consistently strong.[3] Measurement of social functioning may vary depending on whether clinicians or clients are the reporter.[4] There also is initial evidence that individuals who have had a first episode of psychosis (FEP), compared to those at clinical high risk (CHR) for an episode, may exhibit more recovery of social functioning after treatment.[5] Another possibility is that perceived support may contribute to improved social functioning, as one study found family treatment involvement associated with improved social functioning.[6] Together, inconsistencies of treatment impact on social functioning may be attributed to how social functioning is measured, stage of psychosis onset, and perceived support.

PRESENT STUDY

Delaware Community Outreach, Referral, and Early Intervention Program (CORE) is an early intervention program for Delawareans ages 12 to 25 with FEP or CHR. CORE utilizes a coordinated specialty care model. A multidisciplinary team (comprised of a prescriber, occupational therapist, supported education and employment specialist, and clinician) works together with the client to address symptom management, social functioning, and educational and/or occupational functioning. The program is modeled after the Portland Identification and Early Referral (PIER) program developed by Dr. William McFarlane.[7] CORE provides education about psychosis not only to the client, but also to family members. Clients and family members are invited to attend multifamily groups where they engage in collaborative problem solving and have opportunities to build a supportive social network. These activities are based on the theorized importance of social support for reducing stress and improving overall outcomes.[7]

The present sub-study of Delaware CORE examined program impact on social functioning, as reported by both clinicians and clients. It was expected that clinician and client report would differ, although the direction of that difference was unclear based on the literature. Researchers also hypothesized that risk status (i.e.,

enrollment as FEP or CHR) and clients' perception of social connectedness would change the effect of CORE on social function. Based on the results of one study, we expected that persons with FEP would show greater improvement over time. We also expected that participants with greater social support would benefit more from CORE than those endorsing less social support.

STUDY METHODS AND RESULTS

Participants and their assigned clinicians rated participants' social functioning at enrollment, and at 6- and 12-months post-enrollment. Participants were categorized as either CHR or FEP according to the results from the Structured Interview of Prodromal Syndromes (SIPS).[8] Clinicians rated participants using the MIRECC Global Assessment of Functioning (GAF) social subscale, which ranges from 0 (no information available) to 70 (average functioning) to 100 (superior functioning). On the National Outcome Measures (NOMs),[9] participants rated their agreement (from 0 [strongly disagree] to 4 [strongly agree]) with two statements: "I do well in social situations," and "In a crisis, I would have the support I need from family or friends." The latter item served as a proxy for perceived social support, and correlated positively with other NOMs items that measure social connectedness (e.g., belonging to a community).

At the time of this report, two or more assessments were collected on 44 (81%) clients who were enrolled for at least 1 year. Average age at enrollment was 17.7-years-old (range 14- 24-years-old), with a majority of the sample describing themselves as male (~64%), and non-Latino Caucasian (~55%). About 55% of the sample qualified as CHR. Most of the clients with FEP resided

FIGURE 1. TREATMENT CHANGES IN SOCIAL FUNCTIONING BY ENROLLMENT STATUS
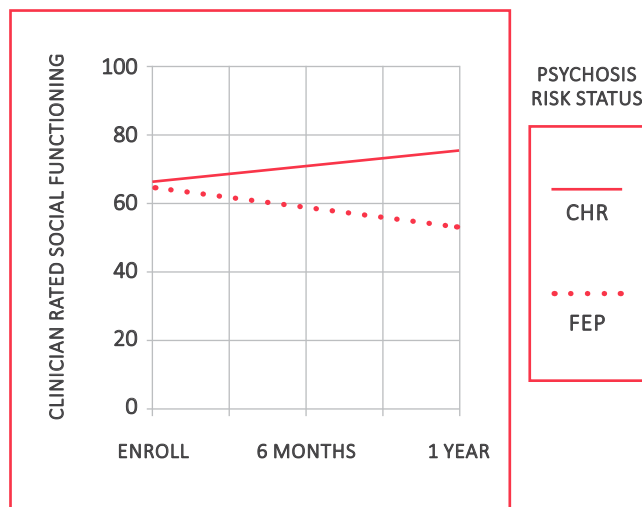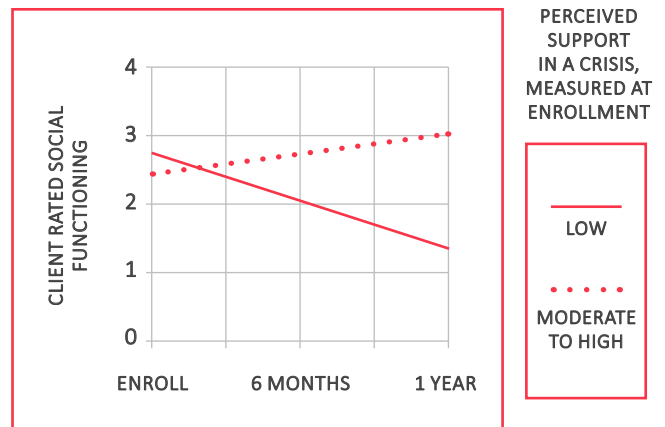

FIGURE 2. TREATMENT CHANGES IN SOCIAL FUNCTIONING BY PERCEIVED SUPPORT IN A CRISIS

in New Castle County, the most populated, urban, and culturally diverse of the state's three counties.

At enrollment, participants did not differ by their enrollment status of CHR or FEP on clinician or participant ratings of social functioning. Moreover, there was no significant correlation among clinicians' social rating on the MIRECC and clients' ratings of social well-being or support in a crisis.

Analyses revealed that not all CORE participants improved their social functioning. Instead, treatment-related changes in social functioning depended on other factors and varied by reporter.

Per *clinician report*, FEP social functioning declined during treatment, whereas CHR improved after a year of treatment; see Figure 1.

Figure 2 shows that clients endorsing higher levels of support in a crisis reported improvements in their social functioning; whereas, those endorsing lower levels declined.

LESSONS LEARNED

The findings highlight the importance of *rater* perspective. Clients did not report similar social functioning to clinicians – rating themselves with lower levels of social impairment. Differences between reports may be the result of low awareness, lack of comfort in reporting, or an artifact of clinicians' classification of participants as CHR or FEP.

These results emphasize the importance of accessing services early, even before youth and young adults experience a first episode of psychosis. Those with CHR may respond better to treatment of social functioning. Other strategies may be needed to support the social skills of those with FEP.

Clients' perceived support in times of crisis affected changes in self-reported social functioning over time. Those who reported low levels of support reported a decline in social functioning; those who reported higher levels reported improvements. Social support may be an important condition of social recovery. Learning of a loved one's mental health condition can be hard on family members; however, it is important that they show strength and lend support to the affected youth or young adult. Family members may even want to seek their own support from friends, family, religious organizations, or other groups.

A few considerations about these results are worth noting. These results are preliminary, and may change as Delaware CORE collects more data. Analyses did not include a control group, so it is unclear how participants would have done compared to a non-treatment group. Additionally, it is unclear how these results may generalize to families not enrolled in Delaware CORE. Despite these limitations, results provide evidence for the importance of capturing and promoting social functioning in young people with early psychosis.

REFERENCES

1. Addington, J., Penn, D., Woods, S. W., Addington, D., & Perkins, D. O. (2008). Social functioning in individuals at Clinical High Risk for psychosis. *Schizophrenia Research, 99*(1-3), 119–124.

2. Cornblatt, B. A., Carrion, R. E., Addington, J., Seidman, L., Walker, E. F., Cannon, T. D., … Lencz, T. (2012). Risk factors for psychosis: Impaired social and role functioning. *Schizophrenia Bulletin, 38*(6), 1247–1257.

3. Menezes, N. M., Malla, A. M., Norman, R. M., Archie, S., Roy, P., & Zipursky, R. B. (2009). A multi-site Canadian perspective: Examining the functional outcome from first-episode psychosis. *Acta Psychiatrica Scandinavica, 120*, 138–146.

4. Bastiaansen, D., Koot, H. M., Ferdinand, R. F., & Verhulst, F. C. (2004). Quality of life in children with psychiatric disorders: Self-, parent, and clinician report. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*(2), 221–230.

5. McFarlane, W. R., Levin, B., Travis, L., Lucas, F. L., Lynch, S., Verdi, M., … Cornblatt, B. (2015). Clinical and functional outcomes after 2 years in the early detection and intervention for the prevention of psychosis multisite effectiveness trial. *Schizophrenia Bulletin, 41*(1), 30–43.

6. Marino, L., Nossel, I., Choi, J.C., Nuechterlein, K., Wang, Y., Essock, S., … Dixon, L. (2015). The RAISE Connection Program for early psychosis: Secondary outcomes and mediators and moderators of improvement. *Journal of Nervous and Mental Diseases, 203*(5), 365–371.

7. McFarlane, W. R. (2002). *Multifamily groups in the treatment of severe psychiatric disorders*. New York, NY: Guilford.

8. Miller T. J., McGlashan, T. H., Rosen, J. L., Cadenhead, K., Ventura, J., McFarlane, W., … Woods S.W. (2003). Prodromal assessment with the Structured Interview for Prodromal Syndromes and the Scale of Prodromal Symptoms: Predictive validity, interrater reliability, and training to reliability. *Schizophrenia Bulletin, 29*(4), 703–715.

9. Substance Abuse and Mental Health Services Administration, US Department of Health & Human Services. (2010). *National Outcome Measures*. Retrieved from https://www.samhsa.gov/grants/gpra-measurement-tools

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Improving Life Trajectories: Outcomes from the Rhode Island Healthy Transitions Project

The transition from adolescence to adulthood is a challenging developmental period for many individuals and is significantly more so for those with serious emotional disturbance. Youth and young adults with serious emotional disturbance often struggle with adult roles and responsibilities (e.g., educational attainment, employment, housing).[1] With the continuity of care across child and adult institutions often lacking, many of these individuals lose access to important services and supports once they age out of the child mental health system and legally enter adulthood.[1] As a result, treatment and support services that effectively meet the unique needs of this population are critically necessary.

In 2015, the state of Rhode Island implemented the Healthy Transitions Project (RI HT) with support from the Substance Abuse and Mental Health Services Administration (SAMHSA) to address the needs of youth and young adults ages 16–25 with serious emotional disturbance, severe mental illness, and/or co-occurring substance use disorders. Utilizing a multidisciplinary and community-based approach, RI HT seeks to improve the behavioral health of transition-aged youth, including youth on the cusp of aging out of the child behavioral health system, to help them lead healthy and productive lives as adults.

RI HT was modeled after an evidence-based Coordinated Specialty Care (CSC) model developed and used throughout New York for transition-aged youth with first episode psychosis (FEP; see https://www.ontrackny.org, accessed 03-26-19). This CSC model uses a multidisciplinary team approach including health professionals, specialty care providers, youth and their family members working together to reach a youth's recovery goals. Each team consists of 6–8 behavioral health providers who fill the following roles: Team Leader, Clinician/ Psychotherapist, Psychiatrist, Nurse, Supported Employment and Education Specialist, Case Manager, and Recovery Coach. Treatment decision making is shared among team members, and an individualized treatment plan is developed to reflect the youth's own goals and preferences. The CSC model emphasizes outreach and engagement, and interventions typically last for two years. Wraparound services including individual and group therapy, medication management, employment and education services, intensive case management, recovery skills, suicide prevention, peer support, and family education and support are available to all participants. RI HT expanded this model to include: youth and young adults with FEP as well as other serious mental and emotional disorders, and a systematic method of tracking model fidelity across 28 indicators (e.g., maintaining staffing levels, family involvement) using electronic health records.

The state of Rhode Island partnered with two community mental health centers (CMHCs) to pilot the RI HT project. Transition-aged youth were screened in the community at a variety of locations/agencies with

connections to the participating CMHCs, such as physicians' offices and schools. Youth who screened positive were then referred to one of the CMHCs for an RI HT assessment. Those found to meet diagnostic criteria (e.g., major depression, bipolar disorder, FEP), disability criteria, and traumatic experiences criteria were offered RI HT clinical services. Preliminary outcomes were evaluated using Center for Substance Abuse Treatment (CSAT) Government Performance and Results Act (GPRA) Client Outcomes Measure for Discretionary Programs[2] data collected from 102 participants. Interviews were conducted at intake into the program and again six months later. The average age of participants was 20.8 years old. Most participants identified as White (81.4%), non-Hispanic (83.5%), and heterosexual (66.7%). Almost half of participants (49.0%) identified as male. Regarding participants' clinical presentation at intake, 29.6% reported feeling depressed most or all of the time, 74.3% reported feeling nervous all or most of the time, and 52.1% reported feeling hopeless and worthless most or all of the time. Furthermore, 51.0% reported having attempted suicide in their lifetime and 77.4% endorsed a history of trauma. Substance use was common among participants. At intake, 45.5% of participants reported alcohol use in the past 30 days, of whom 51.2% reported binge drinking at least once in the past 30 days; 40.4% reported marijuana use in the past 30 days, of whom 42.9% reported using marijuana daily; and 22.0% reported illicit drug use in the past 30 days (not including marijuana). Model fidelity was met on 68% of criteria.

Compared to intake, at 6-month follow-up assessment, youth reported significantly better functioning in social situations, feeling significantly less bothered by their symptoms, being significantly more in control of their lives, and significantly better functioning in school and/or work. Additionally, as compared to intake, at the 6-month follow-up assessment significantly fewer youth reported having spent a night in the hospital for mental health care in the past 30 days (9.3% vs 27.6% at intake); and significantly fewer participants reported having gone to an emergency room for a psychiatric or emotional problem in the past 30 days (7.1% vs. 24.6% at intake).

No differences were found from intake to 6-month follow-up assessment for participants in their reported social connectedness, substance use, or relationships with family members. This may result, in part, from the shared decision making that occurs as part of the CSC model. For example, the treatment team may not initially focus on substance use until more buy-in is obtained from the youth. In addition, it may take longer to effect change in some outcomes. For example, although youth reported improved social functioning, it may take longer to feel more connection to others. Unexpectedly, participants reported feeling depressed significantly more often at 6-month follow-up assessment compared to intake. It may be that engaging in treatment is a difficult process, and that feeling some dysphoria is to be expected, at least initially.[3]

Overall, participants reported having positive perceptions of the care they received. A large majority of participants agreed or strongly agreed that: staff believed participants can grow, change, and recover (80%); staff encouraged participants to take responsibility for how they live their lives (79.8%); staff respected participants' wishes about who is and who is not given information about their treatment (84.2%); staff were sensitive to participants' cultural background (77.9%); staff helped participants obtain information needed to take charge

of managing their illness (76.8%); and participants, not staff, decided on treatment goals (79.8%).

Preliminary results of the program evaluation are promising and suggest RI HT has demonstrated some success in improving the mental health and well-being of transition-aged youth with serious mental health concerns. Furthermore, youth reported feeling respected and empowered by the treatment model. These findings are consistent with recent research[4] and provide additional support for the effectiveness of using a CSC model to address serious mental health concerns, including FEP among transition-aged youth. More research is needed to determine program outcomes for participants over longer follow-up periods (e.g. 12 months, 18 months) and to identify participants for which RI HT may be most effective.

REFERENCES

1. Davis, M. (2003). Addressing the needs of youth in transition to adulthood. *Administration and Policy in Mental Health, 30*(6), 495–509.

2. Substance Abuse and Mental Health Services Administration. (2017). *CSAT GPRA Client Outcome Measures for Discretionary Programs*. OMB Form No. 0930-0208. Retrieved from https://www.samhsa.gov/sites/default/files/GPRA/csat_gpra_client_out-come_measures_tool_2017.pdf

3. Howes, R. (2008). Shouldn't psychotherapy make me feel good? *Psychology Today*. Retrieved from https://www.psychologytoday.com/us/blog/in-therapy/200807/shouldn-t-psychotherapy-make-me-feel-good

4. Nossel, I., Wall, M. M., Scodes, J., Marino, L. A., Zilkha, S. Bello, I., ... Dixon, L. (2018). Results of a coordinated specialty care program for early psychosis and predictors of outcomes. *Psychiatric Services, 69*(8), 863–870.

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MindStrong and Emerge Models:

Multidisciplinary, Feasible, Effective, and Sustainable

Compared to younger youth and middle-aged and older adults, older youth and young adults (16–25 year olds) are more likely to experience serious mental health challenges, including schizophrenia, bipolar, and major depressive disorders.[1] These young people are at increased risk for high school dropout (or "pushout"), unemployment and under-employment, poverty, housing instability, homelessness, justice involvement, and suicide.[2] They are also least likely to utilize mental health services, which tend to feel stigmatizing, incongruent, and ineffective to young people. Accessible, attractive, and effective services spanning both child and adult sectors are needed to engage this unique population. To address these challenges, *Thresholds*, the largest community mental health provider in Illinois, successfully developed and implemented two multidisciplinary sister teams serving young people within a Medicaid and commercial fee-for-service insurance billing environment.

Thresholds is nationally recognized for partnering with researchers to develop and test evidence-based practices (e.g., Assertive Community Treatment, Individual Placement and Support, Supported Employment, Wellness-Management & Recovery), and for its innovative programs for older youth and young adults.

In 2013, Thresholds expanded its youth care continuum by introducing a multidisciplinary, community-based model blending child and adult evidence-based and evidence-informed practices for 18- to 26-year-olds with a variety of serious mental health conditions. This model, called *Emerge*, utilizes the Transition to Independence Process (TIP) Model[3] as its foundation and is an adapted Assertive Community Treatment model (See Figure 1). Emerge is a program without walls, where almost all services are provided in the community – wherever is relevant for learning, growth, and achieving personal goals. All participants are seen at least twice a week by their primary staff member and an additional team member. Participants build their own individualized life goals and engage in individualized in-vivo learning experiences (e.g., learning how to budget while grocery shopping or how to open a checking account with a first paycheck) with team members with a variety of disciplinary backgrounds. Therapists leverage practices from Cognitive Behavior Therapy (CBT), along with creative arts and movement-based approaches. Emerge also hosts regular, tailored social and educational meet-ups and activities in the community to foster social skills, natural peer support, and belonging.

In 2016, Thresholds added a second Emerge team, and co-located a Coordinated Specialty Care (CSC)

team (serving those with a recent onset of psychosis) with each Emerge team. This resulted in two sets of sister teams: one set in Chicago and one in the Western suburbs. *MindStrong*, Thresholds' CSC team, is similar in practice and structure to Emerge and incorporates CBT for Psychosis, Individual Resiliency Training, Family Education and Multifamily Groups.[4]

METHODS

Thresholds Youth & Young Adult Services' dedicated Evaluation, Research, and Quality Improvement (ERQI) team partners with administrators and practitioners to design feasible data collection and feedback loops. ERQI uses the Plan-Do-Study-ACT Quality Improvement Process.[5] ERQI trains, coaches, and monitors staff on real-time data collection, including employment, education, and psychiatric hospitalizations, through monthly reminders, training refreshers, and quarterly meetings in which the team examines trends in these and other outcomes. For this article, we selected all participants enrolled in MindStrong and Emerge for at least one year. First, we analyzed demographic characteristics, including age, race, ethnicity, gender, and diagnoses. Second, we examined employment and education status and history, and psychiatric hospitalization history collected during intake psychosocial assessments recorded in the Thresholds electronic health record (EHR). Third, we culled all work, school, and psychiatric hospitalization

life events from the EHR across service participants' first year of enrollment and summarized using counts and percentages.

RESULTS

A total of 263 young people enrolled across the four programs since 2014. Of these, 100 remained enrolled for at least one year. Approximately 42% were African American, 38% White, 13% Latino, and 3% other. Most (63%) were male. Approximately 75% were between ages 18 and 25. DSM-V Primary diagnoses included schizophrenia spectrum disorders (42%), bipolar disorder (27%), major depressive disorder (21%), and other mood or anxiety disorders (6%). At enrollment, 40% had a high school diploma or equivalent; 20% had some college; and 10% had an associate's or bachelor's degree or training certificate. Also, at intake approximately 24% were enrolled in school (25% for Emerge; 20% for MindStrong), and 29% were employed (31% for Emerge; 20% for MindStrong). Most (86%) had been hospitalized for treatment of psychiatric disorders prior to enrollment (92% for Emerge; 73% for MindStrong).

OUTCOMES IN FIRST YEAR ENROLLED

Overall, 66% were enrolled in school or employed within their first year of enrollment, with more employed (50%) compared to enrolled in school (28%). For Emerge, 64% were employed or enrolled in school

FIGURE 1. EMERGE MODEL
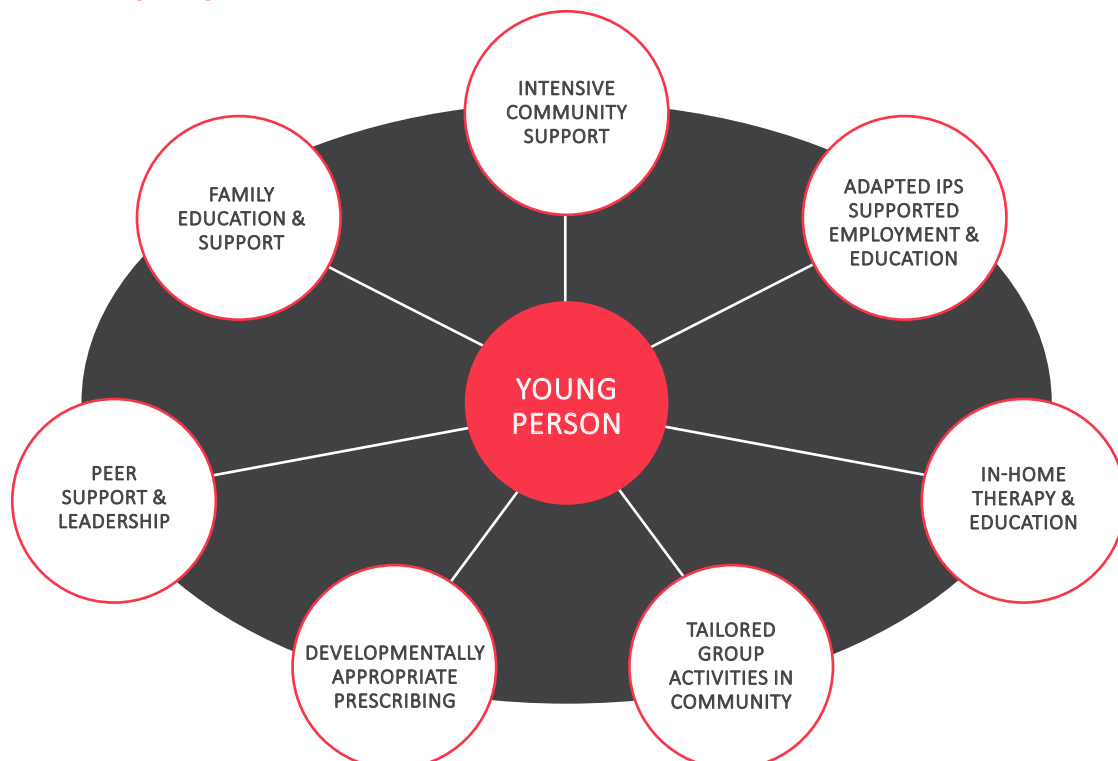
within their first year of enrollment, with specifically 51% employed and 25% enrolled in school. In MindStrong, 80% were employed or enrolled in school within their first year of enrollment; specifically 47% were employed and 47% were enrolled in school.

In their first year of enrollment, overall 64% avoided psychiatric hospitalization. For Emerge, 59% avoided psychiatric hospitalization in their first year enrolled. For MindStrong, 93% avoided psychiatric hospitalization in their first year enrolled.

DISCUSSION

The positive outcomes observed in work, school, and psychiatric hospitalizations are evidence of the positive impact of developmentally attuned multidisciplinary teams. Thresholds is an example of a real-world provider that successfully adapted, blended, and expanded practice for older youth and young adults, as well as fiscally sustained these models by knitting together funding. A number of federal initiatives, including SAMHSA's Healthy Transitions Initiatives and Mental Health Block Grant Set-Aside for recent onset of psychosis services, have paved the way for providers nationally to redesign service systems and integrate new practice models. However, many of these initiatives have not led to sustainable services because Medicaid and commercial insurance do not cover key elements of these adapted and blended models. Through robust program evaluation, service providers can demonstrate and share evidence of how adapting and blending evidence-based practice is effective for older youth and young adults. To that end, Thresholds worked with Illinois legislators to develop The Early Mental Health Act of 2018,[6] which supports coverage of key service elements not previously Medicaid Reimbursable (e.g., Supported Education, Peer Support) within team- and community-based services, such as Emerge and MindStrong.

SERVICE MODEL ADAPTATIONS

It is important for adult community mental health agencies to know that they can attract 16- to 25-year-olds to needed services, and achieve excellent outcomes by making adjustments for this unique population. Systematic adaptations to program structure, practices, standard operating procedures, the look and feel of where services are provided (if in office), and communication methods are important. To do this, agencies need internal champions paired with a strong understanding of transition-to-adulthood development and competency in youth engagement strategies. Early and ongoing engagement strategies are critical and translate into fiscal sustainability: more engagement, more billable hours. To engage, Emerge and MindStrong leverage key TIP Model principles:[3] individualizing goal planning around what matters to young people (e.g., school, work, living situation, relationships, wellness); being flexible in where, when and how services are delivered; using young person-preferred methods of communication (e.g., texting); and using in-vivo methods relevant to life skill development rather than set curriculum. Emerge and MindStrong have embedded master's levels therapists and focus on *discovery* more than *recovery*. Participants engage in and benefit

from services that help them to discover things about themselves. For instance, Thresholds' adapted Individual Placement and Support (IPS) Supported Employment values job endings as much as starts for gaining new insight into career and job preferences.

The rapid, national expansion of CSC for psychosis teams has created opportunity for providers to add sister teams like Emerge to meet the needs of those ineligible for CSC, but who would benefit from multidisciplinary team-based services. Emerge both complements Mind-Strong and serves as a referral source. The need for better understanding of how sister teams like Emerge and MindStrong blend practice and partner is immense. We aim to develop a network of providers with CSC teams and sister teams like Emerge to share practice insights and collect common outcomes to demonstrate the value of complementary and co-located teams.

REFERENCES

1. Substance Abuse and Mental Health Administration. (2018). *Age- and gender-based populations*. Retrieved from https://www.samhsa.gov/specific-populations/age-gender-based

2. Munson, M. R., Narendorf, S., Zajac, K., & Cole, A. (2015). Treating common behavioral health concerns in young adulthood. In C. Juntunen (Ed.), *Counseling across the lifespan, 2nd ed*. (pp. 259–282). Thousand Oaks, CA: Sage.

3. Clark, H. B., & Hart, K. (2009). Navigating the obstacle course: An evidence-supported community transition system. In H. B. Clark & D. K. Unruh (Eds.), *Transition of youth and young adults with emotional or behavioral difficulties: An evidence-supported handbook* (pp. 47–113). Baltimore, MD: Paul H. Brookes Publishing.

4. National Institute of Health. (2018). *What is Coordinated Specialty Care?* Retrieved from https://www.nimh.nih.gov/health/topics/schizophrenia/raise/what-is-coordinated-specialty-care-csc.shtml

5. Agency for Healthcare Research and Quality. (2013). *Plan-Do-Study-Act (PDSA) Cycle*. Retrieved from https://innovations.ahrq.gov/qualitytools/plan-do-study-act-pdsa-cycle

6. Early Mental Health Act, State of Illinois Public Act 100-1016 (2018).

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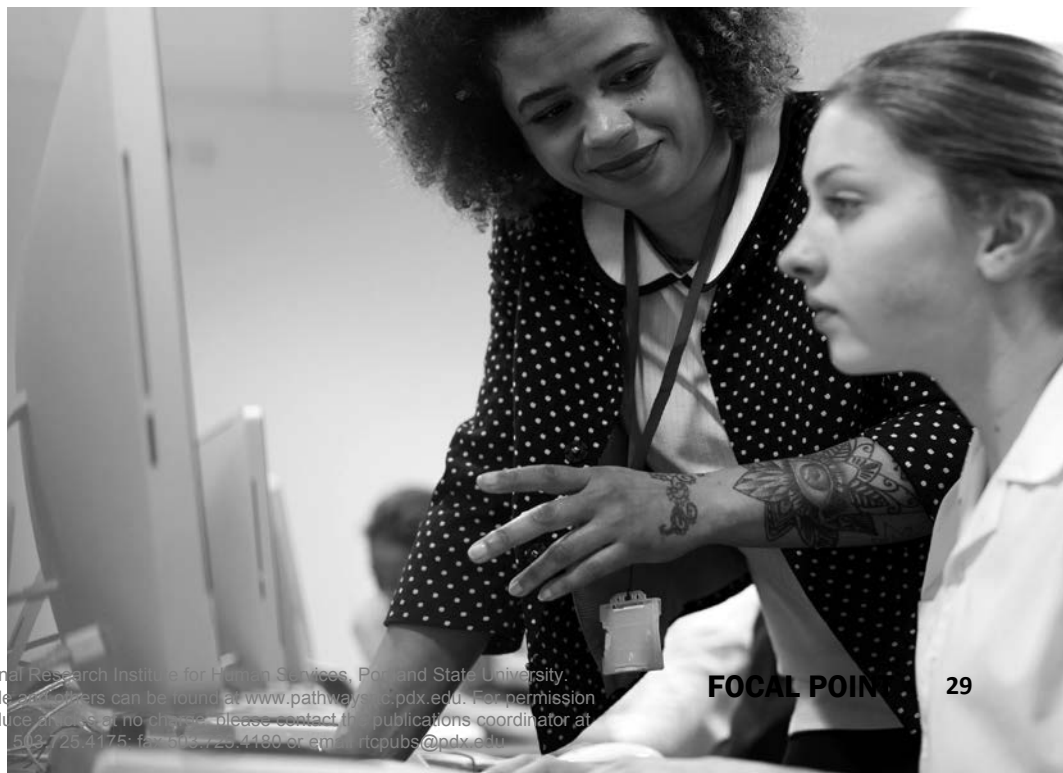
Wisconsin's Youth Empowered Solutions Monitors and Improves Participant Outcomes

Wisconsin's Youth Empowered Solutions (YES!) is administered by the Wisconsin Department of Health Services and is funded by a five-year Now is the Time – Healthy Transitions grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). Two Wisconsin counties, Jefferson County and Outagamie County have been serving youth and young adults (ages 16–25) since April 2015. YES! sites serve youth and young adults with, or at risk for, serious mental health and/or substance use conditions, and who are experiencing challenges related to poverty, high rates of psychiatric hospitalization, and unmet mental health service needs. The Wisconsin Department of Health Services contracted with the University of Wisconsin Population Health Institute (UWPHI) for the purposes of program evaluation.

METHODS

As a part of the Now is the Time – Healthy Transitions grant, YES! site staff collect data using the federally-required National Outcome Measures (NOMs) tool when a participant is admitted to YES!, every six months after admission, and when a participant is discharged from YES! services.[1] As a part of the program evaluation, UWPHI staff use SAMHSA's Outcome Measure Report Guide as a framework to inform analyses conducted to monitor and report participant outcomes.[2] These analyses include participant outcomes between the intake and six-month follow-up interviews, and the intake and discharge interviews. Participant outcomes analyses are conducted and reported to state and local partners on an annual basis.

Improving participant outcomes and defining "positive outcomes" and "improved outcomes" for youth and young adults served through YES! has been a focus of the YES! initiative and evaluation. YES! staff and stakeholders have discussed this at length and considered what is appropriate and realistic for this population. This discussion and review of SAMHSA's outcome measures resulted in a modification of SAMHSA's definitions of "improved outcomes." For example, SAMHSA considered a change in drug and alcohol use to abstinence from drugs and alcohol as an improved outcome; however, YES! staff agreed that the definition of an improved outcome should include sustained abstinence and reductions in alcohol and drug use.

Similarly, SAMHSA's definition of an improved outcome for stable housing in the community includes changing housing situations to an "owned or rented house, apartment, trailer, room," and a "group home" for this population. YES! staff decided to assess changes in housing, without placing an "improved" definition on it since it varies for this population. In addition, YES! site staff began gathering separate, more in-depth, housing stability measures to document whether current housing situations are considered to be stable, as defined by YES! staff and stakeholders. For example, a 17-year-old living in a parent's house without a threat of displacement is considered to be in stable housing under this definition.

To demonstrate how our modification of the SAMHSA indicators impacted our results, we will review our analysis of the outcomes in the domain of illegal drug use. While SAMHSA defines an improved outcome as using illegal drugs within the 30 days before baseline, and then never using any illegal drugs in the 30 days prior to the second interview, YES! staff agreed that less frequent use of illegal drugs in the 30 days prior to the second interview (as compared to the baseline interview), and sustained abstinence from illegal drugs (no use in the 30 days prior to the baseline and second interview) should be included in a definition of improved outcomes. In the initial analysis of the use of illegal drugs domain according to SAMHSA's definition at six-month follow-up, 20% of our total YES! participants were abstinent from illegal drugs in the 30 days prior to the six-month follow-up interview. This was largely due to our participants not using illegal drugs within the 30 days prior to the baseline interview. When we modified SAMHSA's definition of improved outcomes and used our local definition, 64% of our total YES! participants remained abstinent and/or have improved outcomes.

TABLE 1. PARTICIPANT OUTCOMES

OUTCOME DOMAIN	IMPROVEMENT FROM BASELINE TO 6-MONTH FOLLOW-UP (N = 63)	IMPROVEMENT FROM BASELINE TO DISCHARGE (N = 33)
NO SERIOUS PSYCHOLOGICAL DISTRESS	62 % (*n* = 61)	81% (*n* = 31)
FUNCTIONING IN EVERYDAY LIFE	84% (*n* = 61)	93% (*n* = 26)
OVERALL HEALTH	83% (*n* = 61)	87% (*n* = 30)
NEVER USING ILLEGAL DRUGS	64% (*n* = 50)	58% (*n* = 26)
NOT BINGE DRINKING	85% (*n* = 60)	77% (*n* = 30)
NOT USING TOBACCO PRODUCTS	50% (*n* = 60)	42% (*n* = 31)
STABLE HOUSING IN COMMUNITY	42% (*n* = 60)	42% (*n* = 31)
RETAINED IN THE COMMUNITY	89% (*n* = 36)	79% (*n* = 19)
SOCIALLY CONNECTED	87% (*n* = 52)	89% (*n* = 27)
ATTENDING SCHOOL REGULARLY AND/OR CURRENTLY EMPLOYED	79% (*n* = 56)	56% (*n* = 27)
NO INVOLVEMENT WITH CRIMINAL JUSTICE SYSTEM	98% (*n* = 60)	94% (*n* = 31)

Outcomes analyses were conducted using the domains outlined by SAMHSA, and analyses conducted included the expanded definitions of improved outcomes defined by YES! staff and stakeholders.

RESULTS

Using the definitions developed, UWPHI evaluation staff conducted participant outcomes analyses between the intake and six-month follow-up interviews, and the intake and discharge interviews (see Table 1). These analyses were conducted based on all of the information collected by YES! site staff during the first three years of YES! implementation.

Baseline interviews were completed with 136 individuals during the first three years. At the six-month follow-up interview (n = 63), at least half of YES! participants experienced improved outcomes in 10 of the 11 outcome areas measured, with more than 75% of YES! participants reporting improved outcomes in seven of the areas.

Outcomes measured at discharge (n = 33) were similar to those reported at the six-month follow-up interview, and rates of improved outcomes in the areas of mental and physical health were higher than those at the six-month follow-up. It should also be noted that the average length of stay for YES! participants who were discharged from YES! during the first three years of implementation was 8.5 months, and 47% of those discharged were involved for nine months or longer.

LIMITATIONS

The number of individuals included in the outcomes analyses has been impacted by a series of changes in the required federal participant interview tool, as well as challenges in successfully completing the six-month follow-up and discharge interviews with participants.

A larger number of participants will be included in the six-month and discharge outcomes analyses as YES! continues to be implemented. Future analyses of other follow-up interviews (12-month, 18-month, etc.) will also be considered.

Additional information about the YES! initiative and the program evaluation can be found in the YES! Evaluation Report for Grant Years 1–3.[3]

REFERENCES

1. Substance Abuse and Mental Health Services Administration. (2017). *Center for Mental Health Services NOMs Client-Level Measures for Discretionary Programs Providing Direct Services Services Tool for Adult Programs*. Retrieved from https://www.samhsa.gov/sites/default/files/programs_campaigns/samhsa_hrsa/noms-client-level-measures.pdf

2. Substance Abuse and Mental Health Services Administration. (2017). *SAMHSA's Performance Measure Accountability Reporting System (SPARS) outcome measures report guide*. Retrieved from https://spars.samhsa.gov/sites/default/files/Ref-399_CMHS_Services%20Outcome%20Measures%20Report%20Guide_1-24-18.pdf

3. Goodrich, J., Lecoanet, R., & Dustman, D. (2018). *Youth empowered solutions (YES!) evaluation report for grant years 1-3*. Retrieved from https://uwmadison.app.box.com/s/srxhrl3ac5pah9eh485l2szkwxdddcsi

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Academic Supports and Outcomes: Maryland Healthy Transitions
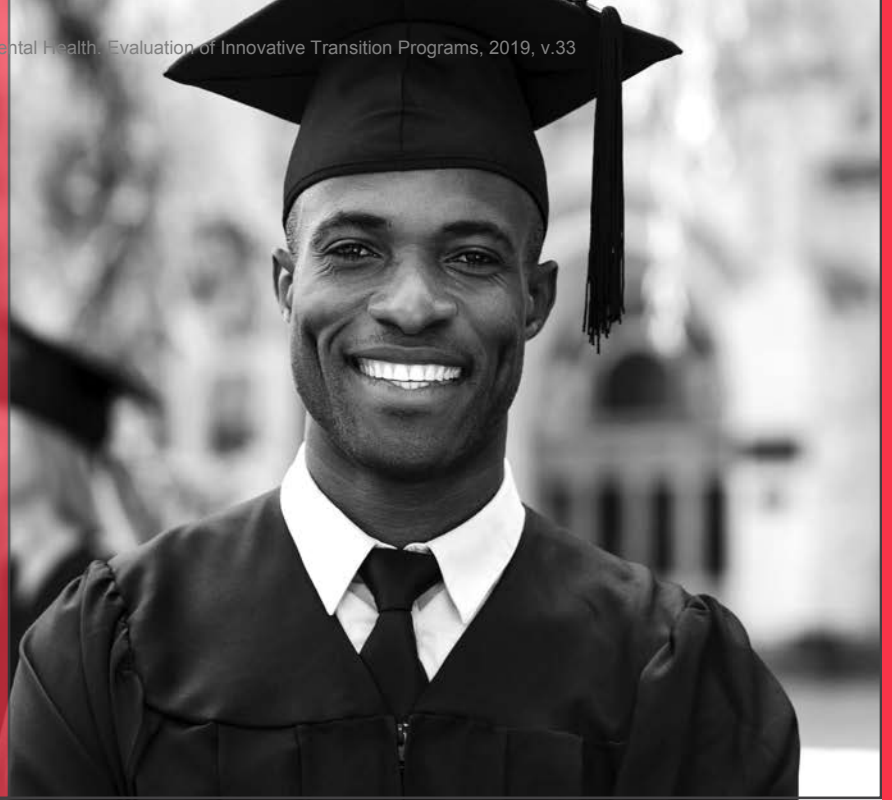
As evaluators for Maryland Healthy Transitions (MD-HT), team members from the National Center for School Mental Health at the University of Maryland School of Medicine are uniquely interested in the academic supports and services offered to young people with emotional and behavioral disorders (EBD). Attainment of education and employment are primary goals during the transition years from adolescence to adulthood. However, young people with EBD struggle to meet typical education milestones, and suffer poorer academic outcomes than their peers, such as lower grade-point averages, increased risk of drop-out, and decreased likelihood of graduating from high school and pursuing post-secondary education.[1,2] These challenges highlight the need for interventions for young people with EBD that account for the factors that impact academic success.[3]

TYPES OF ACADEMIC SUPPORTS FOR YOUNG PEOPLE

Several strategies are used to provide academic support to young people, including both informal and formal supports. Personal relationships are instrumental in the academic success of young people with EBD, as interpersonal support increases the likelihood of graduation, passing the GED, and college admission.[4,5] Supported Education programs that strategically integrate academic supports into young adult services are increasingly demonstrating positive impact. While Supported Education lags behind Supported Employment in its evidence base, researchers have defined its core components, such as assistance with applying for and enrolling in school, obtaining financial aid, and acquiring education accommodations.[6,7]

MD-HT ACADEMIC SUPPORTS

MD-HT site staff are trained to provide education supports and work one-on-one with clients to determine their academic goals. Many young people come to MD-HT directly from an alternative education program for high school students who are at risk of dropping out. These students work with MD-HT transition facilitators to create study routines, organize course materials, and connect to resources, such as tutoring, that often lead to high school graduation. Young people who had previously dropped out of high school successfully pursued a GED after enrolling in MD-HT. Given the high rates of dropout for young people with EBD, it is likely that without these academic supports, many MD-HT enrollees would not graduate from high school or obtain a GED.

In addition to helping them complete high school, MD-HT staff support young people in the pursuit of higher education. Transition facilitators use tools such as interest inventories or skill-finding questionnaires to help enrollees refine their educational goals. Some

enrollees do not enter MD-HT expressing interest in attending higher education but decide to apply after discussing their goals with their transition facilitator. Young people and transition facilitators then search together to identify appropriate academic programs.

Post-secondary program applications are often complex and lengthy, so MD-HT staff provide support and guidance. This includes completing the Free Application for Federal Student Aid (FAFSA), which involves gathering legal information from the enrollee's parent(s) or guardian(s), and applying for scholarships together. MD-HT staff write letters to institutions on behalf of the applicants. Additionally, an MD-HT site may provide direct financial support to pay for costs not covered by financial aid.

USING DATA TO INFORM EDUCATION SUPPORT FOR YOUNG PEOPLE

In the interest of understanding the academic goals and outcomes of MD-HT participants, and to shape programming, the evaluation team has collected, analyzed, and shared education data at regular intervals with program funders and implementers. A mixed methods approach (using both quantitative and qualitative data) was used and is detailed below with preliminary findings from baseline to six months after enrollment.

QUANTITATIVE FINDINGS

As part of the MD-HT evaluation process, transition facilitators collect data on the National Outcome Measures (NOMs).[8] These data include a variety of demographic and functioning items, in addition to education and employment outcomes. At baseline, the majority (61.6%) of the 198 enrollees who were over the age of 18 were not enrolled in any education or training program. However, around 60% of the 40 enrollees under the age of 18 were enrolled, as many were in high school. As transition facilitators worked with the young people to refine their academic goals and apply for appropriate programs, the biggest increases in enrollment occurred among the 82 young people who entered MD-HT with a least a high school diploma or GED. Between the baseline and six-month assessments, for the 122 young people who completed both assessments, the percentage who were not enrolled in any training or education program dropped from 78% to 70.7%, while the percentage enrolled in a program increased from 22.0% to 29.3%.

Transition facilitators also assess "perceptions of opportunity" among youth, including beliefs about the

importance and likelihood of achieving specific goals. While some youth were unsure of their academic and career goals upon entering MD-HT, a majority (87%) reported that graduating from college was either "very important" or "somewhat important." Of the 196 enrollees who rated graduating from college as "very important" or "somewhat important" upon enrollment, 85 (43.36%) rated their chances of doing so as "good," 84 (42.86%) selected "fair," and 27 (13.76%) selected "poor." These perceptions remained relatively stable six months into the HT program. Therefore, several HT participants who think that it is important to graduate from college perceive that they will be unable to do so.

QUALITATIVE FINDINGS

In addition to quantitative data collection, transition facilitators conducted 32 interviews with HT participants during re-assessments to further inform the impact of the education and employment supports. Interview topics included progress made with transition facilitators, perceptions of services, and education and employment goals and challenges. Most respondents said they had discussed education with their transition facilitator, and some stated they had made plans to obtain their GED, find a suitable trade school, or prepare for and apply to college. They reported that the education services were important because gaining independence, getting an education, and making money were necessary components of supporting themselves. One young adult stated that the services were important because "I would like to have my own funds and take care of myself and have a good future." Many enrollees linked their educational goals to their vocational goals, and referenced the

connectedness between getting their GED/high school diplomas, graduating from college, and finding a job they enjoy that can support them financially.

When asked about barriers to academic success, many participants listed that their mental health prevented them from succeeding in school. One student reported that, "my anxiety and depression affect my attendance and focus, and my autism affects my communication with teachers." In addition to financial needs, other barriers included dedicating time and energy to determine goals before proceeding. Most young people reported that the educational services helped them succeed in a current school, get into a new school, and improve their emotional and mental well-being. The enrollees said they felt more prepared for their futures, more confident in their abilities, and more motivated to do better for themselves. They also mentioned the amount of support received from the transition facilitators made a huge difference in their lives, with one participant stating that the services "saved my life."

CONCLUSIONS

Informal and formal academic supports are especially important for young people with EBD and can promote positive educational outcomes, including high school and post-secondary graduation. In Maryland, MD-HT staff provide an array of academic support services that align with emerging core components of Supported Education. In addition to a modest increase in education enrollment among MD-HT participants, they report that HT services and supports are critical to attaining their educational and career goals.

REFERENCES

1. Ellison, M. L., Rogers, E. S., & Costa, A. (2013). Supporting the education goals of young people with psychiatric disabilities. In M. Davis (Ed.), *Tools for system transformation for young people with psychiatric disabilities: State of the science papers*. Worcester, MA: University of Massachusetts Medical School, Department of Psychiatry, Center for Mental Health Services Research, Transitions RTC.

2. Wagner, M., & Newman, L. (2012). Longitudinal transition outcomes of youth with emotional disturbance. *Psychiatric Rehabilitation Journal, 35*(3), 199–208.

3. Maggin, D. M., Wehby, J. H., Farmer, T. W., & Brooks, D. S. (2016). Intensive interventions for students with emotional and behavioral disorders: Issues, theory, and future directions. *Journal of Emotional and Behavioral Disorders, 24*(3), 127–137.

4. Collins, M. E., Spencer, R., & Ward, R. (2010). Supporting youth in the transition from foster care: Formal and informal connections. *Child Welfare, 89*(1), 125–143.

5. Lee, C., & Berrick, J. D. (2014). Experiences of youth who transition to adulthood out of care: Developing a theoretical framework. *Children and Youth Services Review, 46*, 78–84.

6. Waghorn, G., Still, M., Chant, D., & Whiteford, H. (2004). Specialised supported education for Australians with psychotic disorders. *Australian Journal of Social Issues, 39*(4), 443–458.

7. Ringeisen, H., Langer Ellison, M., Ryder-Burge, A., Biebel, K., Alikhan, S., & Jones, E. (2017). Supported education for individuals with psychiatric disabilities: State of the practice and policy implications. *Psychiatric Rehabilitation Journal, 40*(2), 197–206.

8. Substance Abuse and Mental Health Services Administration, US Department of Health & Human Services. (2010). *National Outcome Measures*. Retrieved from https://www.samhsa.gov/grants/gpra-measurement-tools

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Florida Healthy Transitions' Peer-to-Peer Service Delivery Model

From Left to Right: Kiara Santiago, Tyler Smith, Brittany DeFiore, and Tajhah Kittling

How would services differ if providers truly understood the complex needs of young people? What if healthy relationships, education, stable employment, affordable housing, and life skills were key components of mental wellness? What if young people could connect to providers of similar age and experiences? The Florida Healthy Transitions program has aimed to do just that, and a key element of the program's success is its young adult staff. This article will explore the unique experiences and perspectives of Florida Healthy Transitions' young adult staff and describe the ways they've worked to enhance engagement with transition-aged youth and young adults. They also offer advice for young adults who may be considering careers in helping professions.

Since 2016, Florida Healthy Transitions' staff have provided 24/7 crisis intervention services to nearly 12,000 residents of Hillsborough and Pinellas counties, and facilitated Wraparound and Bent Not Broken[1] wellness groups to over 200 young people between the ages of 16 and 25.[2,3] Florida Healthy Transitions may appear to be a traditional behavioral health program. However, this program is quite unique in its approach to engaging with youth and young adults who are emotionally and behaviorally challenged. The difference is that over 80% of the program's service staff are young adults. Through its peer-to-peer model, Florida Healthy Transitions employs young adults to serve in various roles: Crisis Intervention Specialists, Crisis Care Coordinators, Peer Support Specialists, Youth Coordinators and Transitional Specialists. The staff possess first-hand knowledge of the unique needs of young people who are transitioning to and through adulthood. Ultimately, they promoted a culture that encourages both staff and participants to use their voices to enhance program outcomes, evaluation, and innovative solutions.

As evidenced by the program's baseline to six-month National Outcome Measures (NOMs)[4] comparison data for 59 participants, Florida Healthy Transitions' peer-to-peer approach has resulted in several positive outcomes, notably: 150% increase among youth and young adults whose symptoms are no longer bothersome; 83% decrease in severe depression; 59% improvement from hopeless to hopeful; 52% improvement in the ability to deal with crisis; 34% increase among youth and young adult participants who get along with their family members; and 30% increase in youth and young adult participants' sense of belonging in their communities. Additionally, at their six-month survey assessment, 97% of program participants stated they would choose Florida Healthy Transitions for services, despite having other options.

As you'll see from the contributions of some Florida Healthy Transitions young adult staff that follow, this work has its challenges, as well as rewards.

REFERENCES

1. Florida Healthy Transitions. (2018, April 17). *Bent, not broken*. [Video file]. Retrieved from https://www.youtube.com/watch?v=ktOi4WQIMcY

2. Substance Abuse and Mental Health Services Administration (2018). *SAMHSA Performance Accountability and Reporting System [SPARS]: Number of Consumers Served by Grant Year Report*, Florida Healthy Transitions [Database]. Unpublished raw data.

3. Central Florida Behavioral Health Network (2018). *Florida Healthy Transitions' Monthly Provider Reports* [Data file]. Unpublished raw data.

4. SAMHSA. (2005). *National Outcome Measures (NOMs)*. Retrieved from http://www.nationaloutcomemeasures.samhsa.gov/outcome/index.asp

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Florida Healthy Transitions

All members of the Florida Healthy Transitions team are involved in staffing, and have opportunities to provide input and offer support to one another through the collaborative, multi-disciplined approach.

*Florida's **2-1-1 Contact Centers** provide crisis intervention, suicide prevention, and community linkage services 24 hours a day, 7 days a week to local residents. The **Crisis Intervention Specialists** serve as the first responders for all texts or calls made to the 2-1-1 Contact Center and **Crisis Care Coordinators** facilitate the connection to direct services providers.*

***Peer Support Specialists**, **Youth Coordinators**, **Transitional Specialists**, and **Transitional Coordinators** provide direct services and work as a team to outreach, engage, and retain youth and young adults in services.*

Tyler Smith
Youth Coordinator

Growing up, I felt like my life would always be limited to what I could and "could not" do. Constantly battling anxiety, depression, and managing a diagnosis that I didn't fully understand, I struggled to connect with others because I felt like an outcast. It wasn't until I took full responsibility for my mental health and went through therapy/support groups that I realized my symptoms were completely manageable. My personal experience with mental health inspired me to want to make a change in the social services industry. I later graduated from the University of Central Florida with a bachelor's degree in Psychology. I'm grateful that I'm in a position where I can use both lived experiences and a degree to better serve our communities in need.

There are challenges that I've faced as a Youth Coordinator. The job requires wearing multiple hats and sometimes there's a struggle navigating, defining, and coping with those roles. When operating as a peer, you're given the freedom to use your personal experiences to help support participants and allow them to see that their diagnosis is manageable. I believe that having peers in positions like this is important to help reduce the stigma that is associated with mental illness, but there need to be adequate support systems in place to allow peers to release the emotional baggage that comes with the role.

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Brittany DeFiore
Youth Coordinator

Throughout my life, I looked at my lived experience as a burden; something that held me back, something that stole life from me, something I was going to have to hide if I ever wanted to be successful. When I joined Healthy Transitions, my lived experience was embraced. My lived experience has made me more empathic and understanding, as I know what it feels like to be misunderstood and unheard. I see the world differently because of who I am.

This job has given me the opportunity to grow professionally, but also personally. When I first started, I struggled a lot with sharing my story. I don't think I was ready to put myself out there, and I didn't understand the best way to help people through my lived experience. Since I nervously began this job, I've become more comfortable in sharing my story. I see the impact it has on the young adults I work with, and that has inspired me to continue in my journey of openness and advocacy. This job has changed my life for the better, but I had to trust myself a little to get here. My biggest piece of advice is to trust yourself and surround yourself with people who support your growth. It may seem scary to share your personal experiences with others, but know you are drawn to this field because you have what it takes to assist people who are like you, in leading better lives.

Kiara Santiago
Transitional Specialist

My lived experience allows me to be more understanding and empathetic towards others. It allows me to validate their experiences, and engage with them from a place of understanding. There is a difference between actually knowing how someone may be feeling, and saying, "I am so sorry you're going through that, but it will get better."

In my position, I have faced many challenges and obstacles. One challenge is being triggered by the experiences of others because I may have gone through something similar. A participant's story may be so relatable to yours, that it can trigger emotions tied to your own past trauma. When this occurs, you must make time to take care of yourself. For example, go to the movies, get your nails done, get a massage, eat ice cream, or work out. Do something that you enjoy, and take care of your heart and mind. Doing this type of work requires a lot of patience and understanding; it requires a nonjudgmental heart and the ability to believe that everyone deserves a second chance. If you are passionate about helping others, use your story/journey to encourage others. Do not allow your past to define who you are meant to be. Then pursue your goals with all your heart.

Tajhah Kittling
Transitional Specialist

I consider my life to be a series of events that are unique to me, uncommon to some, but relatable to most. Although my story is not the same as the youth and young adults that we work with, we often have similarities that build common ground. I have realized that finding common ground is more personal than creating rapport, and it allows for a stronger relationship to develop. My experience with frequent moves and a constant change of surroundings gives me the ability to connect with most people. Our youth and young adults want to know they're not alone, they have someone who will walk with them through difficult transitional times, and there's a light at the end of their tunnel. Through our lived experiences, wielded strategically and appropriately, we increase our ability to be effective with the young people we work with.

It's challenging to work with a young person who has a story like mine. It can feel as if I am watching myself relive a trauma. Working with someone close in age can bring up past hurts, but the reason we're in this position is to walk alongside someone else and show them there's more for them. In these moments it can be a challenge to remember my emotional boundaries, my self-care practices, and my coping skills. These are the exact things I would encourage any young person entering a helping profession to develop. In this work, we all need to find a strong network of supports and supervisors to trust, to keep our self-care tools sharpened, to practice sharing our personal stories, and practice caring deeply for ourselves.

Access Pathways Training Videos Online

Pathways Transition Training Video Briefs

Pathways has developed ten brief training videos focusing on key topics for transition service providers. The 5–7 minute video briefs feature presentations by service providers, youth advocates, and cultural experts. Each video brief is accompanied by practice-oriented discussion questions and links to relevant resources for further learning. Topics include *Trauma Informed Care*, *Working with LGBTQ Youth*, and *Promoting Family Support*.

Promoting Positive Pathways to Adulthood

Register for these free online trainings and receive Continuing Education Credits for service providers. Pathways invites service providers to participate in Promoting Positive Pathways to Adulthood, a series of ten, free, hour-long online training modules to increase skills to work effectively with young people with mental health conditions. Modules address topics such as *Increasing Cultural Awareness and Building Community Support*, and *Using Evidence-Supported Practices and Individualizing Interventions*.

To access these resources, please visit:

www.pathwaysrtc.pdx.edu/pathways-transition-training-partnership

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Community Integration: State of the Science. (2018), V. 32.

Justice and Recovery. (2017), V. 31.

TIP SHEETS AND MANUALS

Important Information for Parents and Friends of Young People Experiencing Psychosis: Lessons Learned from Young Adult Graduates of EASA. (2019).

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Supporting College Student Success Through Connections to Mentors and Campus Champions: A Strategy Brief for Campus-Based Mentors and Other Student Support Programs. (2018).

Housing and Transition: Meeting the Needs of Young Adults with Mental Health Conditions. (2018).