

CHAPTER XVI

PROGRAM DESIGN

“A well adjusted person is one who makes the same mistake twice without getting nervous.”

— JANE HEARD

CHAPTER XV

PROGRAM DESIGN CHAPTER

INTRODUCTION

Efforts dedicated to the development of programs and the provision of services for youth around ages 14 to 25 with emotional and behavioral difficulties who are in transition, either from the children's system to the adult system, the children's system to the community, or the community to the adult system, are relatively recent. Policies which have provided for Transition Age Youth (TAY) programs and services have been primarily the result of advocacy from family members, researchers, and service providers who demanded that social policies address the under-serving of the transition needs of youth with emotional and behavioral difficulties (Clark and Davis, 2000). Government agencies have only minimally led the charge in developing TAY policy. Clark and Davis (2000) offer five legislative efforts which have produced this response, namely: 1) the Individuals with Disabilities Education Act of 1990 and the Individuals with Disabilities Education Act Amendments of 1997; 2) the Comprehensive Community Mental Health Services for Children and Their Families Act (Section 119 [amended] of the ADAMHA Reorganization Act of 1992); 3) the John H. Chafee Foster Care Independence Program (formerly known as the Independent Living Program, the Consolidated Omnibus Budget Reconciliation Act of 1985, reauthorized, COBRA 1993, and Foster Care Independence Act of 1999); 4) Section 504 of the Rehabilitation Act of 1973 and the Rehabilitation Act Amendments of 1992; and 5) the School-to-Work Opportunities Act of 1994.

The reality is that much of this policy drive has mainly come from education, individuals with disabilities, family members, and advocacy groups. This TAY Resource Guide is a response from the California Mental Health Directors Association (CMHDA) to address California's ability to understand and meet the needs of young people with emotional and behavioral difficulties who are in transition as described above. This chapter will present a comprehensive description of the TAY population. Then the focus will move to the implications of culture and socioeconomic status on the TAY population. Next will be a brief primer on evidence-based practice to introduce the importance of a greater science base for TAY programs and practices; followed by a section covering three programmatic efforts (promising practices) presently occurring in California. These efforts are presented to better understand some of the programmatic components necessary in order to help meet the needs of young people in transition. The chapter ends with a series of recommendations for mental health systems and other human service agencies serving TAY.

TRANSITION AGE YOUTH (TAY)¹

Transition periods are a natural part of human development. What children, youth, and young adults with emotional and behavioral difficulties experience, along with their families, during any of the three forms of transition mentioned earlier are critical to understand when designing programs and services to mitigate potential systemic and organizational barriers? It is often the abilities critical to a successful transition that are compromised in these young individuals (Clark and Davis, 2000). Further, they have gone through adolescence with conditions which have affected their natural development; they have struggled with emotional, cognitive, social, and

¹ Much of the information in this section and some of the proceeding sections were adapted from Rusty B. Clark and Maryann Davis' book, *Transition to Adulthood: A Resource for Assisting Young People with Emotional or Behavioral Difficulties* (Paul H. Brookes Publishing, Baltimore, MD: 2000).

moral growth; and they have missed important social, community, and school functions because of hospitalizations, therapy sessions, or involvement with juvenile justice. In addition, rites of passage, developmental milestones, family dynamics, and community life are important factors for the transitioning young person (Clark and Davis, 2000). These areas are determined to a large extent by one's cultural experiences, which include environmental influences, and should influence the design of programs and provision of services. Spindler (1996) suggests that any intervention which disrupts or interferes with the natural learning process and development of human beings are in effect, cultural interruptions. These interruptions are generally in the form of systemic or institutional environments (e.g., schools, mental health systems, child welfare systems, etc.) and substantially effect transitioning young people.

CULTURE AND SOCIOECONOMIC STATUS

The prevalence of emotional and behavioral difficulties in young people cuts across all racial and ethnic groups, and socioeconomic levels. The United States Surgeon General (DHHS, 2001) set forth a report which focused on the provision of mental health services to culturally diverse communities, with a focus on the four primary racial and ethnic minority groups in the U.S. (African Americans, American Indians and Alaskan Natives, Hispanic/Latino Americans, and Asian Americans and Pacific Islanders); and which was intended to be a supplement to its landmark mental health report in 1999. Some emerging themes were set forth: culture mattered; diverse communities had less access and availability to mental health services; diverse communities were less likely to receive mental health services; diverse communities in treatment often received a poorer quality of mental health care when accessing services; and diverse communities were underrepresented in the mental health profession and in research, both as researchers and subjects. Additionally, the supplement reported that since 1986 nearly 10,000 participants had been included in randomized clinical trials evaluating the effectiveness of treatments for bipolar disorder, major depression, schizophrenia, and attention-deficit/hyperactivity disorder. However, only in half of the studies was race or ethnicity reported. Furthermore, of those that reported data on race or ethnicity, few minorities were included; and not one of the studies analyzed the effectiveness of treatment by race or ethnicity.

Recent research reports on mental health have demonstrated that individuals who come from families living in poverty are more likely to experience emotional and behavioral difficulties (Clark and Davis, 2000). This is not to say that families from middle and higher incomes do not have individuals who experience emotional and behavioral difficulties — they do — but that the prevalence for those living in poverty is simply higher. Davis and Vander Stoep (1997) reviewed six studies on outcomes for TAY, including three based on nationally representative samples. Across these studies, the authors found that youth with Severe Emotional Disturbance (SED) were more likely to come from families from lower Socio-Economic Status (SES). It has been common knowledge for many years that people living in poverty, whatever their race or ethnicity, have the poorest overall health and quality of life (Krieger, 1993; Adler et al., 1994; Yen and Syme, 1999). Studies have consistently demonstrated that people in the lowest strata of income, education, and occupation are about two to three times more likely than those in the highest strata to have a mental health disorder (Holzer et al., 1986; Regier et al., 1993; Muntaner et al., 1998; Adler et al., 1994; DHHS, 2001). These individuals are also more likely to have higher levels of psychological distress (Eaton and Muntaner, 1999). People who live in poverty are more likely to be exposed to stressful social environments (e.g., violence, unemployment, academic failure, etc.) and to be cushioned less by social or material resources (Dohrenwend, 1973; McLeod and Kessler, 1990). The presence of a mental health disorder takes such a toll on individual functioning and productivity that it can also lead to poverty (Dohrenwend et al., 1992).

The fact that racial and ethnic minority populations have higher percentages of young individuals living in poverty puts them at a higher vulnerability (DHHS, 1999 and 2001). This is especially significant in California given the diversity of the young people in this state. The fact is that diverse populations bare a greater burden from unmet mental health needs and subsequently suffer a greater loss of their overall health and productivity (DHHS, 2001). The programmatic implication is that when designing and implementing programs or practices for TAY efforts should be included to understand the effects and impacts of services in relation to cultural competence and SES.

ENVIRONMENTAL FACTORS

There are other factors important to explore regarding TAY notably familial roles, prevalence of specific types of emotional and behavioral difficulties, and multi-system impacts. Families are the front line for many young people in transition. They have lovingly raised and supported their children who have struggled with emotional and behavioral difficulties and sought the support of systems which have only minimally addressed their needs. The transition period for these young people is further complicated by the lack of coordinated services among children's mental health, child welfare, educational, adult mental health, drug and alcohol treatment, juvenile justice, and rehabilitation sectors (Clark, 1998).² In addition, having parents actively involved in the planning process is highly beneficial in including important familial priorities. Clark and Davis (2000) stated that families with TAY may actually reduce their extra-familial contacts and roles. This is significant in that many policies and legislative acts designed to address the needs of TAY focus on the provision of services to individuals, rather than the familial systems in which they live and the cultural characteristics that comprise their social and self-identities. Sometimes caregivers of young adults with emotional and behavior difficulties understandably attempt to hold these young people back from adult activities to protect them, as they may not be ready for adulthood (Clark and Davis, 2000). However, this inevitably leads to conflicts, acting out, and often destructive acts such as running away or homelessness. It is important to note that programs which provide services to TAY are limited by funding sources that limit eligibility and in many cases ends or changes eligibility when young people reach certain ages, placing a further strain of families.

Research on young people has demonstrated that in general about 18% to 21% of children and their families living in communities meet the diagnostic criteria for a psychiatric disorder and the prevalence increases with a child's age (Clark and Davis, 2000). The prevalence of SED has been estimated to be at least 5% to 9% nationally. In 1997, it was estimated that 6.5 million individuals of transition age had a psychiatric disorder (Clark and Davis, 2000). In one study, less than 33% of youth who had both a psychiatric disorder and a significant functional impairment received mental health services. Other studies have found that less than 20% of children and adolescents who need mental health treatment actually receive such treatment (See Clark and Davis, 2000). Another study found that the most common forms of mental illness for 16 to 17 year olds with psychiatric disorders living in households in communities was disruptive behavior disorders (12%), substance-related disorders (9%), anxiety disorders (6%), and depressive disorders (4%). Still another study found that for 17 to 25 year olds with SED who received treatment as children

² See Transition to Independence Process (TIP): TIP System Development and Operations Manual Hewitt B. "Rusty" Clark, Ph.D. Louis de la Parte Florida Mental Health Institute University of South Florida Tampa, Florida Copyright (c) 1995, Revised 1998, H.B. Clark Subsequent Printings: June 1999; January 2000; January 2001; and March 2002.

found their most common diagnosis to be substance-related disorders (43% to 49%), anxiety disorders (34% to 36%), and depressive disorders (10% to 18%). Additionally, another study found that half of all adolescents who met the criteria for any psychiatric disorder met the criteria for two or more disorders.

Males and individuals from racial and ethnic minorities are overrepresented in special education classrooms, residential treatment facilities, psychiatric hospitals, and juvenile correction centers. Youth who are African American, Asian American, Hispanic/Latino American, and Native American are underrepresented in receiving mental health services in general. Middle and lower-income youth with emotional and behavioral difficulties and those living in rural areas are less likely than other youth to receive mental health treatment. Various surveys have demonstrated that TAY with emotional and behavioral difficulties when compared to the general same-age population were: 14 times more likely not to complete school; 4 times more likely at age 18 to 21 not to be in college, in vocational school, or employed; 3 times more likely to engage in criminal activity; and 6 times more likely to be involved in a pregnancy (Clark and Davis, 2000).

TAY experience cultural, socioeconomic, and environmental factors that greatly affect their experience in mental health programs and services. They often come from loving families struggling to deal with their child's emotional and behavioral difficulties. These mental health difficulties may or may not be lifelong conditions and do not necessarily end when someone reaches a particular age. In fact, many programs that provide services to TAY are limited by funding sources which limit eligibility when these young people reach the ages of 18 to 22. Our systems, especially children's systems, are limited by these types of fiscal policies and mandates. Inevitably, some other entity has to pick up the ball and the bill. Transition is an ongoing need, which is determined and defined by young people and their families; and should be mitigated by the systems that serve them, programmatically and fiscally.

EVIDENCE-BASED PRACTICE³

Evidence-based practices are gaining in popularity. Proponents of various treatment approaches understand that practices can be promoted by describing them as *evidence-based*. As a result, the term has been used to describe an expansive and increasing number of practices with very different levels of scientific evidence. The National Institute of Medicine (2003) defined evidence-based practices as *the integration of the best research evidence with clinical expertise and patient values*. The definition makes it clear that evidence-based practices involve the incorporation of research *with*, and not in lieu of, clinical expertise and experience and the values of TAY and their families. Evidence-based practices are based on the application of proven approaches, as demonstrated through controlled research. However, these practices rely on clinical practices and TAY and family choices in their selection and use with any individual TAY. There are two important implications associated with the definition above. First, the strength of a program or practice to predictably achieve positive outcomes for TAY varies with the strength of the research on which it is based. Second, evidence-based practices do not replace clinical expertise or experience, or limit TAY choice, but build upon this expertise and offer a variety of alternative proven approaches. An example of an evidence-based practice for TAY is Clark's (1998) *Transition to Independence Process (TIP) system*, which prepares and supports

³ Much of this information was adapted from the California Institute for Mental Health report: *Toward Effective Mental Health Practices: A Strategic Work Plan to Develop Organizational Capacity for Incorporating Values and Science Into Mental Health Practices*. (2003).

young people as they transition into adult roles through an individualized process that teaches community-relevant skills, encourages completion of secondary education, provides exposure to community life experiences, promotes movements into post-school employment, educational opportunities, living situation, and community life; and transcends the age barriers typical of child versus adult services, and respects the self-determination of young persons.

In general, the level of research which supports a practice can vary. The strongest research involves controlled experimental designs that are replicated by independent researchers across diverse groups of individuals and families. Controlled experimental designs would include such features as random assignment of individuals into treatment and control groups, reliable application of the treatment approach, application of the appropriate statistical analysis, and a comprehensive analysis of the results. However, there are other less rigorous, but credible research levels including quasi-experimental research, case studies, and anecdotal observations, to name a few. Evidence-based practices can be classified by the level of research that has been used to establish the practice's efficacy or effectiveness. Higher levels of research evidence support greater confidence in the treatments efficacy or effectiveness and greater likelihood that if replicated in a similar manner with a similar group of individuals, that good outcomes would result. Not all practices are equally effective for treatment of all mental health conditions. There is growing evidence for the support of treatment specificity (DHHS, 2001; Sue and Sue, 2003). Research on efficacy and effectiveness of various mental health treatments has found that some practices predictably result in improved outcomes, some promote minimal change, and some practices result in bad outcomes. A hierarchy of scientific evidence can be used to describe important levels of effectiveness. The following hierarchy is useful in better understanding the next section in this chapter of efforts in California for TAY.⁴

- *Effective* — refers to a program or practice, applied in a usual care setting that has been evaluated using a strong research design, including random assignment into treatment and no treatment/control group(s), and found to achieve positive outcomes. This level of research supports high confidence that the practice will be effective when used with fidelity in a similar usual care setting.
- *Efficacious* — refers to a program or practice, applied in a controlled setting that has been evaluated using a strong research design, including random assignment into treatment and no treatment/control group(s), and found to achieve positive outcomes. This level of research supports high confidence in the effectiveness of the practice, but has not yet been tested in usual care settings. The effectiveness of the practice may be diminished when transported to a usual care setting.
- *Promising* — refers to a practice that has been evaluated using less rigorous quasi-experimental designs or case studies and found to achieve positive outcomes. Alternatively, the strength of the practice may be based on strong theory and expert consensus. In either case, this level of research supports optimism, but not high confidence.
- *Emerging* — refers to a practice that has distinguishing characteristics that can be defined and appear reasonable or has face validity. This level of research supports cautious optimism. Additional research is needed to verify the practice's merit.
- *Not Effective* — refers to a practice, applied in either a usual care or controlled setting using a strong research design and found to result in no or adverse outcomes. This level

⁴ This information was adapted from the California Institute for Mental Health 2003 report, *Toward Effective Mental Health Practices: A Strategic Work Plan to Develop Organizational Capacity for Incorporating Values and Science into Mental Health Practices*.

of research supports high confidence in the lack of effectiveness of the practice when used in a similar manner with similar targeted populations.

It is important to note that early applications of efficacious practices in usual care settings revealed challenges around conducting the practice with strong adherence to its model and in achieving comparable outcomes. Effectiveness research focuses on the outcomes achieved in usual care settings with typical diverse clientele. Related to the issue of effectiveness is fidelity. The high level of confidence associated with evidence-based practice assumes that the practice is being implemented with strong fidelity, meaning the implementation strongly follows the practice's defining features as determined by the developers of the treatment approach. Moving away from the practice's defining characteristics could jeopardize or even negate the effectiveness of the practice when applied. However, cultural evaluation will be a necessary element to this process, and resulting adaptations will allow the practice to be more fully scrutinized when implemented with targeted populations different from those in the original research design. The U.S. Surgeon General (DHHS, 1999) found that despite strong and consistent evidence of effectiveness, evidence-based treatments were not being translated into community settings and were not being provided to everyone who came in for services. In addition, it was suggested that there were many reasons which explained the gap between research and practice. The most significant explanations were service provider's lack of knowledge of research results, the lag time between reporting of results and translating them into practice, and the cost of introducing innovative services into existing systems.

TAY PROMISING PRACTICES IN CALIFORNIA

As we now present three efforts currently underway in California, we are reminded that the *best* work for TAY is still only in its infancy and that much is owed to the committed and caring individuals, families, and organizations in California and across the country who strive on a daily basis to meet the needs of TAY. The first effort is a promising practice called *The Village Transitional Age Youth Program* which is administered by the National Mental Health Association of Greater Los Angeles and is nationally recognized practice. The second effort is another promising practice called *The Young Adult Transition Team (YATT)* run by the Santa Clara County Mental Health Department and which continues to demonstrate good outcomes for TAY. The third effort is an emerging program in one of California's small counties, Mendocino County Mental Health, which is significant because of the collaborations involved and the good outcomes achieved for TAY. We are hopeful that these efforts will provide practical information that could be applied or learned from across mental health and other human services systems.

**NATIONAL MENTAL HEALTH ASSOCIATION OF GREATER LOS ANGELES
THE VILLAGE TRANSITIONAL AGE YOUTH PROGRAM**

INTRODUCTION

In 1999, the California Legislature passed AB34 (Steinberg) which targeted people who have a severe mental illness and are homeless and/or incarcerated. AB34 programs were required to provide intensive supports and services designed to achieve such outcomes as reduced homelessness, incarceration and hospitalization, as well as increased employment and education.

In 2000, Steinberg sought to capitalize on the very positive outcomes demonstrated in AB34 programs (Pilon) and passed follow-up legislation (AB2034) that significantly expanded the number of homeless mentally ill served on a state-wide basis. In addition, AB2034 specified sub-populations to be served by these newly funded programs. One of these targeted sub-populations was identified as “severely mentally ill young adults 25 years of age or younger who are homeless.” Most AB34 service-providers elected to blend this group in with the general AB34 population by offering the same programming, while a few, including The Village, chose to focus on developing a more specialized approach. This decision was based on the expectation that effective services to this emerging population of Transition Age Youth (TAY) would require significant adaptations to the established, adult-oriented Village recovery model.

MEMBER STORY

In 2001, “Edward” was referred to the Village by the Department of Family and Children’s Services when he was 19 and had “aged out” of the foster care system. He had been in multiple, out-of-home placements since the age of 4 when he had been removed due to physical and sexual abuse. Edward had also been diagnosed with bi-polar disorder and mild mental retardation.

Edward was initially housed in a Board and Care facility in Long Beach where the process of engagement (building a relationship) was first begun. This period of time proved to be quite difficult as Edward stayed in bed, was mostly non-responsive to staff’s daily visits and invitations to go out, and refused to shower or brush his teeth. His eyes seemed lifeless, as he appeared to struggle with a crushing depression and hopelessness.

After about six months of routine, relentless encouragement, behavior modification techniques and medication therapy, Edward began to stir. He made his first ventures out into the community and began dropping in at The Village. But then something very disturbing happened.

Edward was reported by a neighbor for coming over to their front porch and killing their pet canaries. It was also noted that during this time, Edward had been reading a book on serial murderers. Staff was alarmed; staff was worried; some staff was frightened. We immediately began identifying and calling experts in the field who could hopefully give us guidance on what kinds of treatment would be indicated, how the risks could be best managed. One expert gave us very stark and sobering advice: “Discharge him immediately, he’ll do something terrible and bring your whole program down.”

We didn't discharge him. First of all, it is counter to our no-fail, unconditional commitment philosophy and secondly there were no acceptable alternatives. We increased our support and tried to keep a closer eye on Edward's activities.

In the next two years, Edward tried work three times. His first job in maintenance lasted three hours; he felt it was too demanding. Edward tried again several weeks later and was able to work for over two weeks with intensive support and cheerleading. The Village practices an approach we call "continuous opportunity" and Edward was hired for a third time and has kept the job for the last several months.

Edward has been determined to get his GED and was connected to the local community college. He was making good progress but was kicked out for staring at campus co-eds for uncomfortable lengths of time. Another adult school was located and Edward has attended sporadically but has yet to achieve this goal.

For housing, Edward eventually chose to go into the Village's "TAY House," a transitional residential option specifically designed to teach independent living skills to this population. Edward didn't know how to operate a can opener or washing machine, was unfamiliar with public transportation, and resisted the concept of paying rent on a monthly basis. He was evicted twice from the house for refusing or being unable to meet the requirement of being active in the community (school, work, groups, volunteering etc.) for at least 20 hours per week or completing his assigned chores. When he returned to the Board and Care settings where his meals and laundry were done for him, he soon complained of being bored and asked to return to the TAY House. He graduated from TAY House last month into his own apartment.

In April 2004, something amazing took place. Edward was selected for special honors at the "Golden Ducky Awards" – an annual Academy Awards style celebration that recognizes Village member's many accomplishments. He bounded onto the stage in his rented Zoot Suit, while basking in the applause of over 400 supporters. He spoke to the audience excitedly about his plans to go to college, get his apartment and get a higher paying job. Edward's eyes sparkled with promise and possibilities.

But the road of discovery is seldom a smooth one. Edward is currently struggling. He interpreted the goal of graduation as requiring him to go off his medications, despite staff's attempts to educate him otherwise. His work hours have been reduced to one hour per day. The light has dulled in his eyes again. We will continue to stand by Edward and await the next breakthrough.

TARGET POPULATION

The TAY member (clients are referred to as members) probably differs from other non-AB34 mental health consumers in the same age range (18-25). The AB34 TAY member frequently presents to the mental health providers with an overwhelming array of needs such as no established income, no family or natural supports, no housing and no clue on how to get basic, survival needs met. Due to the inclusion of homelessness and/or incarceration (jail referred) as eligibility criteria, the typical AB34 TAY member likely has a higher incidence of:

- Background of foster care and out-of-home placements
- Involvement with juvenile justice
- Extreme poverty and no insurance
- Non-completion of secondary education

- Exposure to multiple traumas including abuse, abandonment, violence and homelessness
- Unclear psychiatric diagnoses. A large percentage does not probably have neurochemically based brain disorders such as schizophrenia and bi-polar disease.
- Non-involvement of family members and other supportive adults

PROGRAM DESCRIPTION

The MHA/Village TAY program offers a comprehensive array of integrated services and supports including:

- Supported housing continuum
- Supported education
- Supported employment
- Income/benefits advocacy – money management
- Social programming/outdoor adventures
- Dual diagnosis services
- Psychiatric/medication counseling and education
- Life-coaching

The MHA/Village TAY program adopts a no-fail approach and conceptualizes its mission as a “diversion” of members away from the mental health system whenever possible. The program serves 50 young adults and is staffed with 1 Director, 3 service-coordinators (case-managers), ½ psychiatrist, 1 education/employment coordinator and 1 ½ “TAY House” managers.

METHODOLOGY

As with all AB34 programs, outcomes are collected in nine quality of life domains. The outcome tracking system is designed to provide programs with data regarding their effectiveness in helping members to make significant changes in the objective quality of their lives. It does this by documenting “real-time” changes in the member’s objective status in a number of different quality of life domains. These include:

1. Residential (What is the member’s living situation?)
2. Employment (What is the member’s involvement in paid and unpaid work?)
3. Educational (What is the member’s involvement in school or training?)
4. Legal (What is the extent of the member’s contact with criminal justice, i.e. citations, arrests, etc?)
5. Income (What are member’s financial assets?)
6. Conservatorship (Does the member have control over basic life decisions?)
7. Payeeship (Does the member have control over his/her money?)
8. Incarceration (To what extent has the member been incarcerated?)
9. Hospitalization (To what extent has the member been hospitalized?)

The evaluation methodology for these programs employs a “before and after” approach to analyzing both client and system outcomes including cost effectiveness. The AB34 programs collect twelve months of pre-enrollment historical data on every consumer enrolled in the program. The comparison of the consumer’s pre-enrollment data to the data generated after the member’s enrollment in the program is the primary means used to evaluate program effectiveness. For example, if a consumer had 4 hospitalizations averaging 15 days per hospitalization in the year prior to enrollment, she would have a total of 4 hospitalizations and a total of 60 hospital days prior to enrollment. If in the first year following enrollment in the AB34

program the same member had 2 hospitalizations and each hospitalization lasted 10 days, she would have 2 hospitalizations for a total of 20 days. In this example, this would be reported as a 50% decrease in the number of hospitalizations (from 4 to 2) and a 67% decrease in the number of hospital days used by the consumer (from 60 to 20).

Of course, few members have been in the program for exactly one year. They may have been in the program anywhere from 1 day to more than 4 years, depending on their date of admission. To complicate things even more, on a program level this is changing with every new enrollment and disenrollment and with every passing day. This fact of varying lengths of program tenure requires that post-enrollment data be corrected by “annualizing” the data to make them comparable to the standard 1 year of pre-enrollment data.

GUIDING PRINCIPLES

The MHA/Village TAY program has struggled since its inception to transform its well established adult-oriented recovery services to reflect a more developmentally appropriate “discovery” model. The recovery model focuses attention on adults regaining lost roles, lost relationships and lost functioning. A discovery paradigm emphasizes the initial teaching, habilitation and exposure of TAY members to more normative learning environments.

The 1990 census reports that the average age when young adults leave home for the last time is 28. This statistic provided a helpful context to The Village/TAY program in developing its services. It suggests a prolonged period of transition that, in optimum conditions, requires intensive levels of financial and emotional support for even non-disabled American youth to successfully establish self-sufficient lives. This was comforting to harried staff hoping to produce results within a six month service plan. This statistic may also be indicative of the period of time that Erik Erikson described as a “psychosocial moratorium,” when young adults experiment with different roles and activities in their quest to form a viable, adult identity. For the evolving Village/TAY program this promoted the inclusion of continual exposures that support explorations and avoid pathologizing normative behaviors or stigmatize failures.

Hewitt B. “Rusty” Clark has developed a comprehensive framework to guide efforts to serve this population. The Transition to Independence Process: TIP System Development and Operations Manual (1995, Revised February 2003) has proven to be an invaluable resource in shaping the NMHA/Village TAY program. The following TIP System Guidelines are presented with related commentary on how these guidelines have been interpreted in the program. (TIP web site:<http://tip.fmhi.usf.edu>)

- 1. Engage young people through relationship development, person-centered planning and a focus on their futures.*

The emphasis on building relationships has always been a central tenet of the Village recovery philosophy and is described as forming adult to adult relationships. Expecting transitional age youth to respond as adults may be unreasonable and unfair, as they have not yet matured into adult roles in many instances. This recognition has caused Village TAY staff to modify the traditional adult to adult stance and consider the roles of mentor, teacher and, at times, parent. At the same time, staff needs to be prepared to assume the role of learner, as young adults have much to teach. Awareness of developmental delays in skills, social responsibilities and emotional competencies is essential.

This engagement effort is also facilitated by our efforts to understand and interact in ways that are sensitive to the cultural differences and orientations of our young people (e.g., ethnicity, sexual orientation, alienation from years of homelessness, poverty and/or out-of-home placements). Most of our young people do not have family members that our staff is able to locate and/or involve with the young adult. However, our staff understands, as Clark emphasizes, that we need to respect and nurture relationships that a young person might have with family and other natural and community supports that are valued and positive in the life of the individual.

2. *Tailor services and supports to be accessible coordinated, developmentally appropriate, and built on strengths to enable the young people to pursue their goals in all transition domains.*

The concept of developmentally appropriate services has been an important guide in recognizing that while the chronological age range of TAY members is 18 – 25, developmentally most of the Village TAY members seem 12 –18. Understanding the common backgrounds of most of these members coming from the foster care system with horrific experiences of abandonment and abuse; as well as the lack of consistent, caring adults indicates the need for more specialized interventions. More age appropriate outcome measures will need to be developed that are better attuned to the incremental learning and normative benchmarks that are reflective of this transitional period. Other challenges include: performing meaningful, trauma sensitive, developmental assessments and recognizing implicit, adult oriented assumptions (e.g., the making and keeping of appointments).

3. *Acknowledge and develop personal choice and social responsibility with young people.*

The importance of choice is seen as a key element of the Village recovery model and a helpful empowerment strategy. However, for many TAY members, especially those “aging-out” from the foster care system, the idea of choice presumes that they have had sufficient life experience on which to base meaningful choices. The Boston University approach to supported employment of choose/get/keep has been modified accordingly to include: expose/choose/get/keep. This approach can also be applied fruitfully to education, housing and community/recreational activities.

4. *Ensure that a safety-net of support is provided by a young person’s team, parents and other natural supports.*

Clark discusses the art of striking a balance between maximizing the chances for member success while allowing for the potent learning of natural consequences to take place. Finding this balance is as difficult as it is often gut-wrenching. Should a 19 year-old youth go homeless because he fails to pay rent? Should a 20 year-old youth go hungry because she quits her job? The Village recovery model espouses a “high-risk – high support” position, it acknowledges that true growth and success is not possible in an environment that protects people from trying and failing. But when is it more appropriate to shield and buffer this more vulnerable age group from some of life’s harsher realities? A consistent message of unconditional commitment and caring, accessible relationships seems imperative to promote resiliency in young adults.

5. *Enhance young person’s competencies to assist them in achieving greater self-sufficiency and confidence.*

Village TAY staff have recognized that case-managing is not the same as teaching and coaching basic life-skills. The emphasis on teaching requires staff to be ever alert for teachable moments and to be prepared to train members in the natural environment where the competency is needed. This “side-by-side” style of teaching necessitates staff to ride buses, go grocery shopping and give flirting tips at the coffee-house. Overall, the teaching/coaching approach is more time-intensive than a case-management orientation.

Continuous efforts to uncover and discover strengths and interests are also important. One process that has been found useful is known as the “core-gift” approach. The member is engaged in an interview designed to elicit enthusiasms and passions, questions such as “when do you feel most alive,” and “If we invited people from all parts of your life into the same room together, what is one thing they would all agree you were good at?” Annual outdoor, camping activities and rope courses have also been beneficial in building confidence.

6. *Maintain an outcome focus in the TIP system at the young person, program, and system levels.*

See previous description of NMHA/Village outcome tracking system in section V.

1. *Involve young people, parents, and other natural and community partners in the system at the practice, program, and system levels.*

One of the most challenging and least developed areas in the Village TAY program has been in sustaining community involvement. Efforts to locate and nurture “places of belonging” for TAY members have produced discouraging results thus far. The pervasive stigmas against disabilities, youth and poverty have combined to limit opportunities for TAY members to meet others and form relationships. There is a growing recognition, however, that for the Village TAY program to fulfill its mission of diverting members from the adult mental health system, we cannot retreat from the goal of community integration.

PROMISING PRACTICES

According to the National Registry of Effective Practices and Programs (NREPP) a promising practice is defined as “programs that have been implemented and evaluated so as to be scientifically defensible and produce positive outcomes – but lack sufficient support to meet effective or model program status.” Three discovery-oriented, developmentally appropriate Village TAY practices will be described and their respective outcomes shared. These three promising practices are supported housing, supported education and supported employment.

1. Supported Housing

Through many trials and much error the Village TAY program has learned that most TAY members (especially 18 –21) are not prepared to live by themselves in their own apartments. Independent apartments don’t appear to be developmentally appropriate, and it is unlikely that this is where most 18 to 25 year olds reside in California.

However, adult residential facilities (Board and Care homes) do not seem to be acceptable alternatives for young adults because large groups of severely mentally ill adults congregate there with little sense of support or direction. Most Village TAY members have not yet had sufficient life experience to learn how to manage the many visitors that often besiege their new place or how to budget and take on the demanding new responsibility of paying rent. Responsible adult supervision is essential to try to assure basic safety and to teach the many complex, independent living skills that are new to most of them.

Taking these issues into account has required the Village TAY program to develop a transitional “teaching” facility with high levels of staff support. A college dorm setting has been suggested as the appropriate, normative learning environment where many young adults engage in high-risk, experimental behaviors and learn from the experiences. While possession of drugs and alcohol are prohibited on the premises, those members who choose to use elsewhere are held accountable solely on the basis of their behaviors (no violence, threats or destruction of property), not on the basis of whether they’re under the influence. Members are routinely exposed to the natural consequences of rule violations (i.e., “exited” from the facility), but in accordance with the no fail approach, they are offered the opportunity to return with a plan to address the problem behaviors.

Housing appears to be one of the program’s greatest successes, with fully 95.8% of the program’s members (46 of 48 consumers) maintaining some form of housing as of April 30, 2004 and 23 of these members living independently (47.9%).

Chapter 1 HOMELESSNESS*

NUMBER OF CONSUMERS HOMELESS AT ENROLLMENT	NUMBER OF CONSUMERS CURRENTLY NOT MAINTAINING HOUSING	PERCENT CHANGE	NUMBER OF HOMELESS DAYS IN THE 12 MONTHS PRIOR TO ENROLLMENT	NUMBER OF HOMELESS DAYS SINCE ENROLLMENT	PERCENT CHANGE
15	2	-86.7%	4,084	1,686	-83.2%

2. Supported Education

Supported education should probably be the centerpiece of any effective TAY program. The role of student is often the most developmentally appropriate one. A vigorous and relentless effort to engage and expose TAY members to educational opportunities is seen as imperative. Most Village TAY members have had interrupted and discouraging experiences with the educational system and have had multiple failures.

Several strategies have been employed in attempt to overcome the pervasive sense of disconnect and hopelessness commonly expressed by TAY members. Establishing a relationship with our local community college’s (Long Beach City College) Disabled Students Programs and Services (DSPS) has been a significant step forward in the evolving Village TAY program. This crucial partnership has enabled the TAY program to provide on-campus support, welcoming, and navigational assistance to its members. The accurate assessment of learning disabilities, as well as various learning styles has

enhanced chances for success and retention. TAY staff and members becoming familiar with the many educational options including self-contained classrooms; brief 3-class introductions to various subjects; for credit “transitional classes” (i.e., Transition to College), are some examples of less daunting ways to re-connect with the member’s educational goals. In addition, Village TAY members are offered housing subsidies called “scholarships” based on maintaining their educational status.

The TAY program appears to be successful in helping members to access educational opportunities. There has been a 55.6% increase in the number of members attending school from pre- to post enrollment. As of April 30, 2004, fully 13 of the 48 program members were currently enrolled in some type of educational activity (27.1%).

Chapter 2 EDUCATION*

NUMBER OF CONSUMERS IN SCHOOL IN 12 MONTHS PRIOR TO ENROLLMENT	NUMBER OF CONSUMERS IN SCHOOL SINCE ENROLLMENT	PERCENT CHANGE
9	14	+55.6%

3. Supported Employment

A large number of TAY members have benefited from the availability of an impressive “menu” of employment options. However, even the effective application of the robust Village employment services has demanded some innovations when dealing with the TAY members. Strategies that incorporate ways for TAY members to visit job sites and learn about qualifications and conditions are proving useful. Before many TAY members choose, let alone get a job, we attempt to expose them to as a wide variety of job settings as possible. Day labor services that offer paid work opportunities in the community provide immediate, accessible ways for TAY members to “try work for a day.” Apprenticeships have been developed as an additional employment menu option for TAY members. This arrangement usually entails the Village paying the member’s wages for a contracted period of time to gain valuable experience in a career related field.

Helping program members to find and maintain employment of program is another strength of the program, which has demonstrated a 122.2% increase in the number of members working from pre- to post-enrollment and a 52.5% increase in the number of days they worked. Not only are more members working, but they are working longer.

EMPLOYMENT*

NUMBER OF CONSUMERS EMPLOYED IN 12 MONTHS PRIOR TO ENROLLMENT	NUMBER OF CONSUMERS CURRENTLY EMPLOYED	PERCENT CHANGE	NUMBER OF DAYS EMPLOYED IN THE 12 MONTHS PRIOR TO ENROLLMENT	NUMBER OF DAYS EMPLOYED SINCE ENROLLMENT	PERCENT CHANGE

9	20	+122.2%	1,668	3,508	+52.5%
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**The preceding tables reflect the outcomes for the 48 consumers enrolled in the Village ISA TAY program as of April 30, 200. All post-enrollment data are “annualized” to take into account the average length of tenure for the 48 program participants.*

**SANTA CLARA COUNTY MENTAL HEALTH DEPARTMENT
YOUNG ADULT TRANSITION TEAM (YATT)
PROMISING PRACTICES**

INTRODUCTION

In 1998, Santa Clara County Department of Mental Health began providing mental health services which were specifically targeted toward young adults who had problems with daily functioning as a result of mental illness. The concept behind this program was two fold. First, the Young Adult Transition Team was developed to help children who were already involved in the mental health system to make the transition to adult mental health services with as little disruption in services as possible. Secondly, this team was also designed to serve the needs of young adults who required these services as a result of the recent emergence or identification of symptoms of mental illness. Whether the clients mental health service needs were of a more chronic or acute nature, the Young Adult Transition Team’s purpose was to provide the level and type of services that were necessary to help their clients achieve a high level of satisfaction with their lives and in their relationships with others, to function effectively in all domains of living and to be able respond to the challenges associated with the young adult phase of development.

MEMBER STORY

One of the clients of our YATT service team, “George” was first referred to our team in April 2003, at the age of 18 years. At that time, George was in a residential treatment program through the provisions of Chapter 26.5 (aka3632). This meant George had an emotional disturbance that was serious enough to warrant this level of intervention in order for him to benefit from his education. George was subsequently diagnosed with Major Depression with Psychotic features. He was previously hospitalized three times because of suicide attempts he had made. He said he was depressed about his family and living at home “was hell.” He reported that he had run away from home on several occasions. George indicated he was also physically abused at the time. Finally, he added that he was behind in school and his grades “weren’t that good.”

Our Family and Children Intensive Services Unit referred George to the YATT. He needed an adult residential facility because he could not return home and had nowhere else to live. He could no longer continue his placement at the residential facility because it was an adolescent treatment center and he was now legally an adult.

The YATT staff assigned to assist George was Ernie Schmidt, LCSW. He helped George transition from the adolescent facility to the Young Adult program at the Riviera facility. He also took on the role of Rep Payee to assist George with managing his Social Security Insurance (SSI) monies.

George wanted to stay out of the hospital. He still felt depressed and was living on his own for the first time in his life. He stayed at the Riviera for eight months. He felt a lot of good things happened while he was there. He was able to become more accustomed to living on his own. He had a girlfriend for a few months. However, he had difficulty with some of the program rules and received warning notices for his behavior.

During the course of this placement, George received weekly individual counseling from Ernie. George felt it was helpful to have someone to talk to at the time and he wanted to reduce his depression. He focused on this goal during his therapy with Ernie and gradually began to feel better.

George moved from the Riviera program to a rented room as part of his desire for greater independence. His therapist, Ernie, disagreed with the timing of the move but supported George's right to make that decision. The first four months went well and George continued to attend high school classes. Unfortunately, he also decided to discontinue his medication and subsequently began to hear voices and developed suicidal ideation. He was eventually hospitalized for a short period of time and began taking his medications again.

At this point, Ernie assisted George in eventually returning to the Riviera program. George participated in group and individual therapy. He continued to struggle with depression and hallucinations but gradually improved in both areas and he was ultimately successful in graduating from the Riviera program and left the program in April 2004.

He reported he completed the program in record time and this fits with his self-described tendency to be a "competitive person." He was student president of the program at one time and participated in developing the program rules.

George currently resides in a studio apartment. He completed his high school education program and hopes to take classes at a local community college. One of his academic goals is to study courses in counseling.

To assist George in his occupational goals, Ernie referred him to a Vocational Rehabilitation program. He got a job at a local shop as a food server in February 2004 and currently works 28 hours a week. He likes his job and hopes to work full time so he can get benefits. He doesn't know what he would like to pursue as a career but is considering options such as a security guard, probation officer or peer counselor. His long term goals include marriage, home ownership and a college degree.

In terms of relationships, George reported his communication with his family has improved. The family focuses on their present relations and chooses to not dwell on the past. George reports he has positive relations with his parents. Socially, George mentioned he has a small circle of friends that he met at his residential and educational placements. He recently broke up with his girlfriend through mutual agreement.

George stated that overall he is doing well, "The best I have done in my life." The YATT psychiatrist worked with George to reduce and eventually discontinue his medications. George still gets angry at times and sometimes feels lonely on the weekends. During the week "There is no time to be bored." George has not been hospitalized for almost two years now. He will soon

graduate from the YATT. He will continue to receive support from his friends and family. George knows he can call us if he needs our help again.

TARGET POPULATION

The Young Adult Transition Team provides mental health services to young adults who meet the criteria for medical necessity for mental health services. That is, these individuals have been diagnosed with a mental health disorder included in the Diagnostic and Statistical Manual (DSM IV) and have significant difficulty with functioning in basic areas of life, such as social and/or occupational domains. In terms of mental health disorders, the two most frequent diagnoses of our approximate 100 current clients fall under the general classification of a mood (37) or psychotic disorders (41). Of the mood disorders, the most common diagnoses are Bipolar Disorder (16) and Major Depression (12). Of the psychotic disorders, the three most prevalent diagnoses are Schizophrenia (16), Psychotic Disorder NOS (15) and Schizoaffective Disorder (10). Several of our clients have also been diagnosed as having different types of anxiety disorders, including Post Traumatic Stress Disorder (PTSD), Obsessive Compulsive Disorder (OCD), and Social Phobia. Finally, our clients often have co-morbid disorders, such as a personality and depressive disorder. It is also not uncommon for our clients to have a dual diagnosis. For example, Bipolar Disorder and substance dependence frequently co-occur as has been indicated in research in this area.

In terms of referral sources, some of our clients come to us through other mental health clinics throughout the county. Often, these youth require more intensive case management and therapeutic services than the referring parties can provide. For example, we often work with youth who have basic needs in multiple areas, such as housing, education, and vocational rehabilitation, social and emotional adjustment. When these youth have been served through the Family and Children Division of the mental health system, there is typically a high level of care provided to that child and their family prior to being referred to the YATT. For instance, these youth have often been placed in out of home settings through Chapter 26.5 or other programs. Other youth have been receiving wraparound services (intensive community based programs). These youth “age out” of the children’s system when they turn twenty-two years old or graduate from high school, whichever occurs first. These same youth often continue to need mental health support due to the difficulties they have associated with their mental illness. These difficulties are compounded by the stress that has already been placed on their families and primary support system. Moreover, young adults typically have the desire (and the encouragement of their family) to leave home and begin independent living as an adult. This is difficult enough for most young adults; it is a monumental undertaking for young adults with serious mental illness. These are the youth we serve. We continue to provide assistance until they are able to navigate the demands that are a part of young adulthood without an intensive level of support.

PROGRAM DESCRIPTION

A helpful way to look at the program description of the YATT is to first describe the disciplines of the various members who comprise the core team. This team is located at Las Plumas Mental

Health (LPMH) Center on the East Side of San Jose, California. Currently, the YATT consists of 2 Licensed Clinical Social Workers (LCSW's), 2 Licensed Marriage and Family Therapists (LMFT's), 1 Occupational Therapist (OT), and 1 adult psychiatrist (MD). In addition, each clinician supervises one to four interns who are students or graduates from the local state and private universities. These interns are an invaluable resource for increasing our capacity to provide more frequent contact and assistance for our clients.

The Occupational Therapy component of our program helps our clients' transition from adolescence to young adulthood utilizing multiple resources and treatment modalities to assist them thru this process. The OT provides 1:1 sessions, groups, home and site visits to obtain a more comprehensive evaluation of our clients' needs, skills and goals. Structured and measurable assessment tools are incorporated. Examples include Allen's Cognitive Level (ACL) evaluation through task analysis, and the Kohlman's Evaluation of Living Skills (KELS), and community re-entry training. Treatment interventions and modalities that are unique but yet common to the Team is the use of the Occupational Therapy Dog (OTD) with communication/socialization skill training, we developed our OT program in collaboration with San Jose State University Occupational Therapy Department, contract agencies and housing programs. As a result, we offer multiple mini-clinics and additional treatment groups/activities for our clients to graduate in an upward motion toward increased independence. A client who would never leave home can advance to attending a group at the clinic, receiving OT services in a residential setting, to living independently and attending a group with other young adults at the university site.

In addition to the core member team described above, each Santa Clara County Mental Health (SCCMH) Clinic has a designated staff that serves as a YATT Specialist. These staff participates in training seminars, which are designed to provide information about various community resources that can be of benefit to our clients, such as housing and vocational rehabilitation programs. As a result, the YATT Specialist is able to serve as a consultant for that particular clinic who can assist YATT clients to access resources in the local community. This type of design is helpful for clients in a number of different ways. First, Santa Clara County is a relatively large county with a significant amount of traffic congestion. Clients are sometimes unable to travel across county or may not have the means to do so. Mental Health Services at a local site can serve as a tremendous convenience to our clients. Secondly, there are two divisions in Santa Clara County – Adult Division and Family and Children Division (F&C). Youth who have been served in the F&C Division as children can sometimes continue to be seen as young adults for a period of time by the same clinical staff that worked with the individual as a child. This allows for greater continuity of care, especially at a time often associated with multiple changes in the youth's life, such as graduating from school. The transition to the core YATT can be made when more intensive case management services are required, such as the location of housing programs. The role of the YATT Specialist thereby serves a crucial function in helping the youth to make the transition to young adult services in as smooth and coordinated fashion as possible.

In addition to the YATT Specialist in the SCCMH system, several of the local agencies that contract with the county also have YATT Specialists on their teams. These Specialists attend the same training meetings and participate in our System of Care model toward coordinating services for clients that are seen at the different agencies. Some of these agencies have their own service teams that specifically serve young adults. For example, ALLIANCE for Community Care (ALLIANCE) has such a team and offers comprehensive mental health services similar to the level provided by SCCMH. This is helpful in that clients can be transferred to a team at ALLIANCE if LPMH clinician's caseloads are full. This way, clients are less inclined to have to wait for services once they are referred to the YATT.

When clients are transferred to the YATT from other agencies, the referring person completes a brief screening form that provides basic information regarding the client's needs and status (see addendum). This information is helpful in determining the specific reason for the clinician referral and whether the client is eligible for YATT services. The LPMH team is interested in client strengths and resources as well as some basic historical data regarding education, health, and so on. Also, insurance information is necessary because only Medi-cal and uninsured clients can qualify for YATT services.

If the referred client is deemed eligible for YATT services, the assigned clinician meets with the client to conduct the initial assessment. This is a very comprehensive process that helps the clinician understand the client's current needs and concerns and the goals they wish to work toward as part of their involvement with the YATT. The mental health assessment also helps the clinician gather information that pertains to basic background and current relevant areas such as family history, medications, previous treatment, cultural factors, and developmental history and so on (see appendix). Also, clinicians will conduct a traditional mental status exam, which includes inquiry regarding how areas the client identifies as their strengths.

Once the assessment process is complete, the clinician will develop a treatment plan with the client that consists of the client's current concerns or identified problems, goals, and objectives. The clinician also indicates what basic interventions and treatment modalities will be involved in helping the client achieve their goals. Treatment modalities can include individual, family and or group therapy. (Also, occupational therapy is routinely offered to LPMH clients. LPMH's OT program is described in detail in the appendix.) Finally, clients are routinely evaluated for medication needs and subsequently monitored for medication efficacy by the team psychiatrist. The entire treatment team meets at least once a week to discuss client program and adjust goals and interventions as needed.

GUIDING PRINCIPLES

Guiding principles for the YATT were defined and disseminated at the inception of the program in 1998. At that time, the YATT Specialist was initially informed what the mission statement and general goals would be for the program. These principles were established through a collaborative process involving the YATT, administrative staff, stakeholders and advocacy groups. After careful consideration of what the foundations of the program should consist of, the group established the following premises:

The Goal

The goal of the Young Adult Transition System of Care is to help young adults who are severely mentally ill to develop skills and competencies so they can graduate to a greater degree of independence in adulthood.

Core Values:

- *Young Adult Consumer Centered.* This value implies that the focus of treatment is consistent with needs, which are associated with the young adult phase of development. Youth at this age often need help with basic areas of life, such as housing and finding employment. They are generally transitioning from institutions of childhood – such as being a child in a family or a student in high school – to institutions of adulthood-which can involve college, adult education, being an adult in a family and so forth. Therefore, the clinician can be of the greatest assistance if they have knowledge and commitment to

- helping the young adult to make these transitions by providing the necessary type and amount of information and support in these areas.
- *Community based.* This value involves working with the youth in their setting as opposed to always meeting in the clinician’s office. Community-based work allows for the clinician to visit the youth at home or out in the community, to go with the youth to help make connections, such as social and occupational linkages, and to be flexible in general in terms of setting and time.
 - *Family friendly.* The clinicians work with the youth and their families to the degree that it is beneficial to the clients and to the extent that it is possible. If the clients give consent to do so, family members are invited to meetings to discuss ways to improve communication when necessary and coordinate efforts to help youth and the transitions noted above.
 - *Cultural Competence.* A central aspect of the values is to provide services, which are consistent with the cultural values and practices of the clients. Through the system of care, LPMH offer Spanish and Vietnamese speaking clinical mental health services. The team assesses client cultural beliefs and needs in the provision of psychotherapy and the coordination with other community agencies.

Core Principles:

- *Early Intervention.* We try to assist youth at the earliest point of their transition to adulthood. In many instances, the consultation and intervention occurs prior to this phase.
- *Individualized.* All the services are designed to meet the individual needs of each of the youth referred to the program. This process begins at assessment and is reflected in the youth’s treatment plan
- *Comprehensiveness.* We focus on each of the primary domains of the youth’s life, including social, occupational, education, and housing needs.
- *Smooth Transition.* As stated, the focus is on helping adolescence make a smooth transition to young adulthood. In addition, we assist young adult to transition from one level of care to another with as much support as possible.

SUPPORTED HOUSING

As Maslow indicated in his concept regarding the need for hierarchy, food and shelter are basic needs, which must be addressed before one can start to focus on growth needs. As such, we place a great deal of emphasis on identifying the type and level of housing needs of each of our clients and then providing referral and linkage to the designated program. Established YATT core principals regarding housing are this service promotes stability, learning of life skills and enhancement of consumer safety.

There are two basic set of circumstances which apply to our clients regarding housing when they enter our program- either they are transitioning from living with their families or they have already made this transition. In the former case, we will assess the youth and their family’s level of satisfaction regarding their relationship and their plan regarding the timing of the youth’s transition from home. Since housing in the Santa Clara County is quite limited, we try to plan in advance regarding housing needs whenever possible. It is not uncommon for youth to be placed on a waiting list in order to get into a Board and Care home or Transitional Housing program. Sometimes, you can continue to reside with their parents or other family members for a period of time before they transition from the home. We can provide family therapy as needed to help work out agreements between the youth and their family regarding rules and responsibilities in the

home that the youth and their family members can agree to during this final phase of living together and to assist in a smooth transition of “leaving home.”

Some of the clients transition from residential treatment centers or group home where they resided as adolescence. When this occurs we work with the providers and the youth to identify the type and level of adult placement that will be needed once the youth leaves their current placement. For example, we have ongoing meetings with our local Community Treatment Facility (CTF) to coordinate efforts to help the involved youth transition successfully from this facility to and adult placement.

There are instances where young adults require hospitalization and subsequent placement in one of our IMD’s. When this occurs, our clinicians work with the staff of the IMD, the Public Guardian, when applicable, the client and our 24-Hour Care team to transition the youth to a Crisis Residential facility when the client is ready for this change. This process often occurs when youth have a “first break” due to an emerging psychosis or a relapse attributable to mental illness.

The level of care of housing varies according to the youth’s level of functioning, the development of their independent living skills and any other individual needs or abilities, which will affect the level of support, they will require. When they are placed at higher levels of care we will identify what skills they need to acquire to transition to less restrictive placements. We than provide mental health services, medication support and occupational therapy and case management in concert with the services they receive at the facility to help the youth make the transition to lower levels of care and greater independence as so as they are ready to take this step.

One of the key components regarding housing for young adults who have been emphasized by the CMHDA and young adults pertains to the opportunity to live with other consumers who are of the same or similar age. This grouping according to developmental age provides a peer support network, positive peer mentoring and the chance to associate with peers with who are more likely to share similar interests and experiences.

To achieve this optimal condition in the area of housing, Santa Clara County partnered with one of our local adult housing programs to provide a live-in program for YATT clients. This program is called the Riviera Young Adults Program. It provides up to eight beds for our clients along with a comprehensive array of mental health services. The program goals are to help teach young adults skills toward obtaining employment, to help clients with future housing assistance and to teach clients skills to help them become more independent in basic areas of their lives (e.g., medication management, managing finances, etc). The program provides an area for young adults to room together, paid work experience on site, staff able to assist clients in the development of independent living skills, dual diagnosis groups, 24-hour supervision and security, careful monitoring for medication compliance and hygiene maintenance on a daily basis. The YATT routinely coordinates services with the Riviera program by visiting the site to provide individual, group and occupational therapy to clients as well as case management and consultation. The Riviera program has a well-established behavioral therapy approach to assist clients in achieving the above stated goals.

SUPPORTED EDUCATION

The YATT is committed to assisting youth to achieve higher education as adults when it is identified as a goal they would like to pursue. Staff encourage all youth to pursue some form of education beyond high school, whether it is enrolling in classes at a local community college or

just signing up to take a course at a nearby adult education or community center. The timing of a youth's readiness to continue this pursuit also varies considerably during the young adult phase of development. Sometimes, young adults need to prioritize work over education when their living situation necessitates earning an income. In these situations, education takes the form of learning a new job skill.

As previously mentioned, young adults who enter the YATT program have a range of strengths and needs. This range also pertains to their academic ability and performance. For example, some of our clients participated in Special Education during the course of high school. These students were frequently qualified for this form of support due to being classified by their local district school psychologist as Emotionally Disturbed. Some of these youth also received counseling support from our Family and Children team through eligibility under Chapter 26.5. When this occurs, we work with the F&C providers and the local school districts to provide the most recent school records to the youth and the local community college. Then, the college disability counselor can review the student Individualized Education Plan (IEP) and work with the student to design a program to include the appropriate accommodations and supports to provide for the student. This procedure is also applicable for Special Education students with other types of disabilities.

SUPPORTED EMPLOYMENT

One of the primary goals of the YATT is to assist young adults in the process toward greater independence. Nowhere is the opportunity for this accomplishment greater than in the attainment of a job. Our staff work diligently with youth to help them identify the type of work they would like to pursue and to help connect them to a vocational rehabilitation program as needed. Typically, our clients have limited job experience due to their age, their circumstances and the mitigating effects of their mental illness.

The YATT frequently refers our clients to community vocational rehabilitation programs whenever such services are needed to assist you in acquiring job training skills and connection with potential employers. SCC provides matching funds to state and federal funding which enables the vocational rehab programs to fund staffing, clothing, books supplies and training. Three of our local agencies that provide vocational rehab services include Focus for Work, ALLIANCE for Community Care and the local branch of the Department of Rehabilitation.

Generally speaking, the criteria for eligibility for these programs include a referral from our staff with the indication of the client's disability and need for services. There is an initial orientation and linkage with a Mental Health counseling specialist. At this point, an assessment is conducted to determine the client's individualized needs (job training, placement, etc.) This process usually consists of a three week class where the client is assessed to see if they can be on time, are dressed appropriately, and can practice the job skills training they are taught. Once the assessment is complete, the provider will establish with the client what services they can provide. Providers will work in the community to help connect clients to potential employers and to provide on site job coaching as needed.

Outcomes

There are a variety of ways to measure client outcomes that will help to reflect the degree to which they are benefiting from their participation in the treatment program. With respect to the YATT program, our guiding principles and client needs are the cornerstones on which we build our treatment plans and related client goals and interventions. Typically, clients are seeking

assistance in very basic areas of living, such as obtaining stable housing and/or getting a job. As such, we will than prioritize these needs and begin our work with our clients to help them have their basic needs met in as timely a fashion as available resources will allow.

Based on the above-mentioned guidelines for measuring outcomes, the YATT compiled gathered clinical data pertaining to the approximately one hundred clients referred to in the target population section (Section III). As indicated, the majority of our clients (est. 78%) have been diagnosed with a mood disorder or psychosis. The team provides the level of service, which is necessary to help the client be successful in their life domains. The results of our work are included in the following sections and pertain to a one-year period of time from April 2003 to the same time the following year. This is not meant to be a research design since the YATT is not set up to do research at this time but rather a pre-post type of measurement regarding the distinction of how many clients were assisted in each domain and the success of that assistance.

Housing – The YATT was able to locate and secure appropriate housing for 23 of the clients referenced above. Not all of our clients needed housing over this time period. Of those who required housing, virtually all clients were provided a placement at the level of care that he or she required. At times, some clients had to be placed on waiting list for a short period of time until an opening was available at the designated placement.

A second consideration with respect to housing is to be able to assist clients to transition to the level of care, which they need at any given point in time. The YATT was able to facilitate the transition of 29 clients to lower levels of care that were deemed appropriate by the client and their support system. In many instances, this involved helping clients to transition from a locked hospital facility (IMD) to a Board and Care level of care or higher-level placement. Of those clients who were previously hospitalized, 17 were able to function without a readmission to a psychiatric hospital for the one-year period included in this report.

Employment – There is also a great deal of variance in the area of interest in getting a job. Since employment is not a necessary requirement for receiving YATT services, clients identified when they wanted assistance in this area as well. Approximately 20% of the 100 clients were able to obtain and maintain employment over the year time period referenced above. YATT staff assisted clients in receiving vocational rehabilitation when indicated. Other times, clients were connected to private providers in the community. Case management was provided to assist clients in maintaining employment.

Education – Some of our young adult clients indicated an interest in returning to school. This usually meant a community college or adult education program. When clients indicated an interest in education, they were given the level and type of support necessary to make a connection with designated program. Of the 100 clients in the target group, 20 were linked to academic programs and maintained class enrollment.

Supportive Programs and Independent Living Skills – As previously mentioned, many of our clients require supportive day programs to help them learn independent living skills, prevocational training and other basic skills such as socializing with others. Of the 100 clients referenced above, 17 were connected to Day Treatment programs, which assisted our clients in acquiring these abilities. An example of an important area of focus pertained to money management. Some of our clients are conserved and require Rep Payee services to help them plan how to budget their money. Of the target population of this group, eight clients were able to acquire the necessary money management skills to act as their own Rep Payee within the year time period of this report. In addition, as part of learning increased independence, we

assisted our client to learn how to be responsible for taking their prescribed medications. This compliance is also linked to other outcomes. For example, medication compliance decreases the likelihood of recurrent hospitalizations. Of our clients who were prescribed medications, 29 were compliant for the year period of time of this report.

Program Completion – One of the best indicators of program efficacy can be seen in the area of program completion. One of our goals is to assist clients to successfully complete the program and to move from our support to support in the community. Clients are always welcome to return if their need and circumstances warrant our services. Of the clients in this report, 17 were able to successfully complete our YATT program.

The above-mentioned outcomes provide some indication of program efficacy in helping our clients to live more independent and satisfactory lives. Yet, these figures are not meant to convey outcomes that subscribe to good research methodology. Clearly, for this to occur, such basic practices as random assignment to control and treatment groups and other controls for extraneous variables are needed.

Currently, our program is in the process of developing a best practice approach to providing mental health services to young adults. Through a generous grant from our local Health Trust, we have contracted with Dr. Robert Reiser and his team from Pacific Graduate School of Psychology to develop a treatment manual that will allow us to adapt a standardized approach to treatment our young adult clients in Santa Clara County. So far, the team has conducted an extensive review of the literature for best practice treatment outcomes for young adults who meet the diagnostic criteria described in our target population section. One consistent finding was the successful use of Cognitive Behavior Therapy (CBT) for treatment of mood disorders, psychosis and anxiety disorders in adult populations. We are currently being trained in the use of this method of treatment for our clients. Subsequently, we will also be uniformly trained in family therapy and engagement strategies. Once our training is complete, we will utilize a research design including random assignment to treatment and control groups and update our outcomes section to include the results of this study.

MENDOCINO COUNTY MENTAL HEALTH

INTRODUCTION

In Spring of 2003, Mendocino County Mental Health and Department of Rehabilitation made a decision to apply to the State Department of Rehabilitation for an Establishment Grant to create a new Work Adjustment Program within the Cooperative. After ample consideration, the decision was made to partner with the local high school, the local Workability Program through the Special Education Local Plan Area (SELPA), and attempt to create a transitional age youth work program in a vacant delicatessen on the county campus. Several private food vendors had attempted to provide a food business in the now vacant space, but for various reasons, were unsuccessful. A grant was written while team members searched in the community for a business that was interested in both an expansion into the county campus and was willing to employ TAY clients with a stated disability of mental illness. Such a company was identified, called the “Bottle Shop Delicatessen” that also had a history of employing Regional Center Clients. An agreement was reached that allowed the Bottle Shop Delicatessen to enter into a contract with Mendocino County to utilize the commercial restaurant space and a MOU with Mental Health was generated

spelling out the terms of how youth would work in the business and what each partner would do to insure a positive work experience for participants.

MEMBER STORY

Lorenzo was nearly 17 years old when he was referred to work in the Bottle Shop by his teacher from his special education 10th grade class room at Ukiah High School. Lorenzo was eager for the opportunity to work, and a closer look at his checkered background illustrates why he identified so well with the world of employment.

Lorenzo was born to an agricultural family in Fresno and experienced poor health as a child and was often sick with a fever and diarrhea. His family was monolingual Spanish Speakers and only the father was somewhat literate. He was often absent from the home while he migrated looking for work. As a young boy Lorenzo had a poor appetite and did not appreciate being away from his mother at school or the babysitters. Lorenzo was initially placed into special education at age 7 because he showed language difficulties in English and Spanish and had learning disabilities, especially in processing verbal information. In addition to his academic challenges, behavioral and emotional difficulties were becoming more pronounced and he was referred for counseling.

By the time Lorenzo reached high school, his difficulties seemed to worsen. However, a goal began to develop that he wanted to become a mechanic, and the school directed him toward shop classes. He also got a job in a local appliance shop, which Lorenzo reports as being one of the high points in his life. The job sparked his motivation to learn to read, which was currently at about a first grade level. This seemed to lift him out of feelings of depression he was experiencing that were a result of his failures at academics and the hardships he felt in the world of his peers. However, some months later when he lost his job, Lorenzo began to feel so depressed he doubted that he wanted to go on living. Over the course of the next couple of months he made several visits to the community mental health crisis center and eventually was detained as a danger to himself and hospitalized in San Francisco. His diagnosis was Major Depression with Psychotic features. He was started on a course of Paxil. Because his family did not view the counseling and medication as being consistent with their cultural values, they chose instead to try herbs from a family resource. Lorenzo was referred for a 26.5 assessment by his school

Since his job had been an important part of his daily life, his teacher referred him to the new work adjustment program at the Bottle Shop. Since Lorenzo was a Workability Student, and the return of his symptoms was worrisome, the team believed a new job experience might be the key to a better life. Since Lorenzo qualified as a student with a disability who had an IEP, he could have an opportunity to work in the Bottle Shop as part of his curriculum. He would be allowed to work ten hours per week at a rate of \$5.75 per hour. He began the program and within weeks his family revealed that they were quite pleased with how he was doing in the work adjustment program and that he was getting along much better at home. He agreed with his teacher to begin a reading program that would accelerate his skills. Although Lorenzo was tempted to participate in local gang activities and had threatened during discouraging times to “steal a car,” because he had the “know-how to do it and get away with it,” he made healthy choices.

Lorenzo successfully finished his semester and went on work in the county garage as a mechanic’s helper. While working in the delicatessen, one of his jobs was to deliver orders to go to local county workers. In the course of taking coffee specialty drinks to the county garage, the shop manager befriended Lorenzo and organized a work placement for him the following

semester. Lorenzo now works in a restaurant as a dishwasher and bus boy, still, he sees himself becoming prepared for the future when he will work as a mechanic in a garage. For the past year, no serious symptoms of mental illness have manifested. In this case, work turned out to be the best form of treatment.

TARGET POPULATION

High School students in this program need to be at least 16 years of age, but not older than 24, have an Individual Education Plan (IEP) with a stated disability, be enrolled in the SELPA Transition Partnership Program (TPP) as a Workability participant, or as a Department of Rehabilitation Cooperative Client and have a teacher willing to make the referral to the Mental Health Job Coach for a suitability assessment. Clients do not need to have an open Mental Health Clinical Chart, although most participants are receiving clinic services upon entry into the program.

The target group is individuals who have a psychiatric disability and are 16-24 years of age, Transition Age Youth (TAY). They are clients of Transition Partnership Program (TPP) and/or the Mental Health Cooperative Program (MH Coop). They will have a current IEP with an identified psychiatric or emotional disability and/or a client of MCMH Children's or Adult System of Care. Both TPP and the MH Coop have found it difficult to adequately serve youth who have psychiatric disabilities. TPP has found that the students with psychiatric disabilities or emotional disturbances need more supervision and guidance than the majority of the students they serve. Most would benefit from a more sheltered work environment than is available through existing resources. This group of individuals seem to have a history of dropping out of "the system" when they graduate from school. They seem to reappear later in the Adult Mental Health system needing services.

PROGRAM DESCRIPTION

Mendocino County Mental Health (MCMH) will provide Work Adjustment (WA) training for clients of the Department of Rehabilitation (DOR). MCMH currently operates Work Adjustment services. This new component targets the Transition Age Youth individuals. It proposes to meet the need for more supervision and intensive training by providing a direct Coach at a 1 Coach to 2 trainees ratio. This service is provided in the Ukiah area of Mendocino County which is in the Santa Rosa District of DOR.

The goal of Work Adjustment Training is to overcome employment barriers, which improves an individual's employability. Individuals successfully completing the training will be ready to move on to the next phase of services as outlined in their DOR Individual Plan for Employment. This next phase may be referral to Employment Services (i.e., employment preparation, job development, placement and follow-along and/or job coaching) or other training services (i.e., occupational skills training, college, vocational training program, etc.). In the WA Program, trainees develop work safety skills, customer service and communication skills, punctuality, soft work skills, and work related academic skills in a positive work setting. In addition they may also learn cashier skills, cooking and food preparation skills, as well as cleaning skills.

DOR will refer transitional age clients of the MH Coop and/or TPP by issuing an authorization for services. A multi-disciplinary team (DOR Counselor, MH Case Manager, Work Adjustment Coach, TPP staff and/or the MH Coop staff and client) meet to develop the client's work

adjustment plan, focusing on identified barriers that inhibit the client from obtaining competitive employment. The WA Coach reports progress to the team monthly and, as needed, at meetings. Written records are maintained for all clients. Additionally, the WA Coach makes recommendations for referrals to the appropriate services when an individual's training is nearing the end.

Trainees work 2 to 6 hours per day for a maximum of 20 hours per week. They can be in the program for 3 to 6 months. There are a maximum of two trainees working at one time. It is expected that 20 will be served in a year's time. The Clinical Services Associate (Work Adjustment Coach) provides the Work Adjustment training. This is a grant-funded position. This element of the program proposes to meet this population's need for more supervision and intensive training by providing a direct Coach at a 1 Coach to 2 trainees ratio. The job coach transports or arranges the transportation.

Trainees learn time and money management, transportation, grooming, and work related academic skills. For many of these clients, this is their first work experience. The Work Adjustment Coach helps the trainees to overcome barriers to employment. This is done mostly through work-based training. The WA Coach also uses vocational training curriculums, computer and internet resources, videos, and other resources from the local One Stop Office. Included in this is training in safe food handling using the curriculum offered by the County Environmental Health Department and Work Safe (a curriculum on safe work habits for youth). Assistive technology and reasonable accommodation needs are identified. At the conclusion of Work Adjustment, the DOR counselor refers the client on to the next appropriate service such as, placement services, or additional training or educational experiences.

The WA Job Coach is already in the position and this will continue. Clients are already receiving services and will continue to do so. New referrals are being received on a regular basis. Outreach to the schools, case managers, DOR, the MH Coop and TPP is to be conducted on an on going basis.

GUIDING PRINCIPLES

We believe it is useful to develop employment opportunities for the high school age student who is experiencing symptoms of mental illness for a variety of reasons. Some of our guiding principles that have served this project well are noted below:

- Begin assisted employment by age 16 as this activity is normalizing to the TAY and boosts self confidence. Some TAY may have academic barriers, but may find success in the arena of employment and this promotes new motivation in standard classroom learning.
- In order to serve the TAY high school student who has an IEP, it is critical to gather the entire group of individuals working with the TAY including the teacher, the parent, the Special Education school case carrier, the MH job coach, the Department of Rehab Counselor, and the TTP or Workability Program Specialist. Without all providers on the same team, confusion results and there is little hope for success.
- Similar to the recovery model with adults, plans should be client driven and involve the family whenever possible. By being strength focused, the TAY can experience new successes. While the money earned on the job is a reward, the contacts made while in the program can lead to bridges for the future.

- The nature of the disability that the TAY bring to the workplace requires a job coach who possesses a variety of skills in rehabilitative treatment. The youth needs the full attention of the job coach who must be willing to begin with basics and patiently build on skills acquired, so the TAY can become prepared a non-assisted job.

OUTCOMES

We had planned to serve a minimum of 20 individuals the first year. We expected that at the end of the first year, a minimum of 6 individuals would have successfully completed their training. We have served 13 unduplicated DOR clients with 6 individuals successfully completing their training and moving on to the next step in their IPE. Successful completion of the Work Adjustment Program is when the barriers outlined in the Work Adjustment Plan have been addressed and/or removed. This is documented in progress notes and monthly progress reports. The outcomes are measured by the number of WA plans completed successfully (all goals met) and the number of referrals to either job placement services and/or vocational training.

The outcome for the restaurant is a real success story! Because of the Cooperative effort to find a business willing to employ TAY workers, and the willingness of General Services of the County to create a business friendly lease, the restaurant is open from 7:30 a.m. until 3:30 p.m. and is well frequented by county employees, local students from both the high school and middle school and other community residents. This has become a gathering place for informal meetings, lunch time bridge games and a waiting place for timed agenda items for citizens attending the Board of Supervisors meetings.

EMERGING PRACTICE

The Mendocino County Cooperative has long wanted to establish a service delivery system that would help target the TAY group more effectively. It is anticipated that this Establishment Grant Program will improve services to the TAY population. The primary promising practice discovered in this project has been the success of supported employment for high school students. When identified barriers are addressed, the individual will be more employable and better equipped to succeed on the job and in life. Success on the job in a sheltered environment with a sensitive but professional job coach leads to gains in self confidence and motivation that allow the student to return to the classroom setting with increased focus.

CONCLUSION

The truth is that much of the programmatic policy efforts on behalf of TAY have come from family members, advocacy groups, researchers, and other human services agencies. We hope that the information within this chapter will express the California mental health system's desire to contribute to the growing body of knowledge about TAY. This was a direct result of the California Mental Health Directors Association's desire to address California's ability to better understand and address the varying needs of young people with emotional and behavioral difficulties who are in transition. We hope that the information presented will assist mental health systems, program designers, individual providers, advocates, family members, other human service agencies, and most importantly TAY, in helping to create a better mental health system;

whether TAY are transitioning from the children's system to the adult system, the children's system to the community, or the community to the adult system.

RECOMMENDATIONS

The following recommendations regarding TAY are offered to guide mental health systems in promoting improved design and implementation of programs and practices for TAY, as well as better outcomes for young people with emotional and behavioral disturbances and their families. These recommendations were derived from a multitude of sources including the members of the committee, the literature on TAY, and the good work in *practice* occurring across California.

1. Mental health systems must conduct new or review existing system and system component assessments to adequately measure their readiness to adopt, implement, and evaluate evidence-based, promising, or emerging TAY programs and practices.
2. Science-to-practice and practice-to-science initiatives, including evidence-based practices, implementation projects, and performance improvement projects for TAY need to be enhanced and adequately funded to improve their level of science and value to the target population.
3. Evidence-based practices which have been proven to be effective with TAY populations, as well as promising practices which demonstrate positive outcomes for TAY, if implemented, must track their implementation with fidelity, effectiveness, and value to the target population.
4. Evidence-based practices or promising practices for TAY which have been proven to be effective with non-ethnic minority populations must track any modifications and/or adaptations made, to collect and generate new information to enhance the effectiveness of these practices to diverse populations.
5. The use of TAY educational curricula should be mandated in clinical training programs, county technical assistance efforts, and continuing education strategies.
6. Better tools for assessing language abilities in clinical assessment and linguistic and cultural issues in the diagnostic process for TAY are needed.
7. The selection of a treatment practice for TAY needs to be based on mutual decision-making between informed young people, their family members or caregivers, and their providers.
8. Efforts to eliminate barriers to accessing mental health care for TAY including stigma, discrimination, bias, and costs need to be continued and expanded.
9. Efforts to eliminate disparities in access to and quality of mental health care for TAY need to be continued and expanded.

TAY RECOMMENDATIONS

TAY PRINCIPLES

1. Be passionate about working with young adults or stay home.
2. One of the primary goals of TAY services should be the diversion of young adults with emotional and behavioral disorders from the mental health and criminal justice systems.

3. Young adults with EBD are at a psychosocial stage when they are exploring and forming new, adult roles (identity formation) that will probably influence behavior more than any other factor. Providers would get the biggest bang for their service buck if they first and foremost offered an array of age appropriate, normalized experiences (“exposures”) unrelated to mental health.
4. Seek not just to educate and inform, but to inspire.
5. If young adults with emotional and behavioral difficulties are to transcend the confining boundaries of disability and the mental health system; providers must transcend the boundaries of disability and the mental health system. Partnerships must be established with institutions of education, job training and youth development.
6. Most young adults avoid the mental health system for good reasons; it is rarely welcoming, tolerant or cool. Effective TAY services must adopt more youth friendly approaches and environments.
7. If the “average” American young adult does not fully “emancipate” from their families until age 28; it is not reasonable to expect young adults with EBD, many with little or no family support, to emancipate successfully at age 18.
8. Early “upstream” interventions (by age 14) are imperative and will result in better outcomes and substantial cost avoidance later.
9. Know that today you will be ignored, dismissed and cursed at for things that you will be thanked for profusely years later. (Unless you’re wrong, in which case you will just be ignored, dismissed and cursed at.)
10. Remember all the dangerous, ill-advised, destructive things you and your friends may have done as a transition age youth and consider that many of the disturbing behaviors that you are witnessing are not due to mental illness or deep-seated pathology.

TAY PRACTICES

1. Recognize and support developmentally appropriate relationships with young adults that may include: coach, teacher, mentor, sponsor, “awakener,” learner and even proxy parent.
2. Seek balance in all programmatic efforts and be prepared to adjust them often as needs change.
 - Between doing for, doing with and letting young adults do for themselves.
 - Between protecting and buffering young adults from natural consequences vs. allowing them full contact with natural consequences.
 - Between accepting a great deal of vile, obnoxious banter vs. teaching and coaching more acceptable styles of communication.
3. Don’t be afraid to incentivize, reward and outright bribe for constructive behaviors, remember you’re often competing with crack, Nintendo and incredible lethargy.
4. Involve members in activities that encourage them to practice delayed gratification, cause and effect, planning etc.
5. Accept and understand the young adults’ current behavior without assuming its permanence. Repeat to yourself; “it’s just a phase, it’s just a phase.”
6. Develop exposure strategies that provide life experiences that often precede the choosing, getting and keeping of jobs, permanent housing and relationships.
7. Consider “entitlement issues” (the expectation that others will provide for you) as an age appropriate attitude.
8. Get in touch with your “inner parent,” don’t be afraid to “encourage getting up” by shaking bed, pulling covers and making snippy comments.

9. If people being punctual and keeping their appointments is really important to you, you may want to consider another line of work.

TAY PROGRAM

1. Identify developmentally appropriate housing – consider family-like settings with caring adults, peer mediated college-dorm, semi-independent apartments etc.
2. Put as much staff support into your housing as possible and then add 2.
3. Career development should be at the center of any self-respecting TAY system of care with mental health and dual disorder services aimed at removing barriers to achievement in these areas.
4. Qualifying young adults with EBD for SSI may compromise their long term goals for short term survival and stability. Explore other funding sources and housing subsidies as well.
5. Strategies to reduce early parenthood are a crucial goal.

TAY POLICY

1. Provide continuity of relationships across systems (transition facilitators). Stop abrupt, re-traumatizing terminations based on arbitrary age limits.
2. Change psychiatric diagnostic criteria for service eligibility; consider functional impairments or risk and protective factors. “All Youth – One System.”
3. Change Department of Rehabilitation standards for 90 days of employment as a definition of success. They are developmentally inappropriate and discourage experimentation.
4. Identify developmentally appropriate outcomes/milestones – consider drivers licenses, parenthood, graduation, etc.

RECOMMENDATIONS FOR TRANSITION AGE YOUTH PROGRAMS

The following suggestions are for providers who intend to provide mental health and/or case management services for Transition Age Youth (TAY). These recommendations are based on work experience as a Program Manager for Santa Clara County’s Young Adult Transition Team (YATT) and suggestions from clinical staff. These suggestions involve two dimensions of program development. These are the developmental phases of program design and the domains covered by the TAY Program. These suggestions also primarily pertain to youth who are being served by County Mental Health Systems but can be utilized by other providers as well with consideration as to the mental health needs of the TAY group being served.

DEVELOPMENTAL PHASES

- I. *The Vision.* Each TAY Program begins with a vision of therapeutic services that would help meet the needs of young adults in the particular community being served. In order to best meet these needs, the involved mental health and social service

leaders need to meet with all stakeholders and interested staff and community leaders for input to develop a shared vision of what the needs and goals would be for a TAY program. In addition, these same leaders should interview and meet with young adults to get their input on what type of services would be helpful and how service delivery could best be tailored to them. The availability of community resources, sources of funding and support are necessary consideration for program design. Exclusionary criteria such as age and diagnostic criteria need to be defined. Finally, the vision should be one that is culturally and clinically competent, includes family involvement whenever possible and addresses the developmental opportunities and challenges associated with young adulthood.

- II. *The Plan.* Once the vision has been established, involved parties need to determine how to go about putting a plan into place that will include all the elements already identified. Involved staff requires training in the therapeutic approaches that are identified as promising or best practices for young adults. Lines of communication and coordination of services need to be established between the different service providers. Points of entry into the program also need to be clarified. In general, a clear plan is necessary on how to access services, what the services will be and when the services will be discontinued.
- III. *Implementation.* After staff has been adequately trained, mental health services can be provided to identified clients. Referral processes and coordination of care can begin to take place between all relevant parties. Clear lines and channels of communication are important since providers can include staff from any of the domain areas identified below. For this reason, intensive case management is a core requirement of a good TAY program. Case management staff should have small caseload size (range of 15 to 25 clients, depending on job description and support staff). A multi-disciplinary approach is also recommended. Members of a team should include Master level clinicians (LMFT/LCSW), a psychiatrist, and rehabilitation counselors. Supervised interns and volunteers are also suggested to increase service range and provide training for potential future staff. An Occupational Therapist is also helpful to assist clients in the area of prevocational training as well as increasing their independent living skills. Finally, it is also helpful to explore whether clients who are advanced or graduated from the program would be willing to serve as mentors and positive role models for new clients.
- IV. *Program Modification.* Ongoing program evaluation and modification is needed to respond to changing client needs and to enhance program efficacy and efficiency. Staff should actively seek client feedback along the way to find out how the program is working for them. It is also suggested that staff define clear outcome measures at program inception and used the feedback from these measures as an indicator of program efficacy and necessity for modifications and changes in services. Supervisors and staff should also establish ongoing meetings with members of the community (stakeholders, providers, DFCS, JPD, educators, etc) to get feedback on the accessibility of services and the degree to which services are helpful. Program modification is an ongoing process and a good TAY program is a dynamic one that changes as the cultures and needs of the clients change.

DEFINING TAY AT THE LOCAL LEVEL

Throughout the TAY Resource Guide, there are numerous references to youth who would be considered eligible and in need of TAY services. For example, it has been recommended in this guide that the age range be between 14 to 25 years. It is also recommended that TAY services be offered to youth who have been placed in the foster care system and TAY who are having difficulties associated with mental illness. In general, youth who have been in the Juvenile Justice system and Social Service system should be offered TAY services to help them navigate the transition to adulthood. At the same time, decisions regarding eligibility criteria need to be determined to some extent by county systems and the community members and stakeholders who comprise these systems.

ACCESSIBILITY OF CARE

There should be relatively easy access for TAY who qualifies for these services. If the county system is large enough and set up to allow multiple entry points at different sites, than a centralized access and referral center is helpful. Information regarding eligibility criteria, screening processes and available services should be clearly indicated in written form and provided to all stakeholders as potential referring parties. Specially trained staff should be available at each site to answer questions pertaining to the above stated information. Ideally, there would be no such thing as a waiting list for youth qualified for this program. Information and services should be available to all TAY who are monolingual speaking when that language reflects a significant number of members of the community.

LENGTH OF CARE

Another general consideration for a TAY program is the length of time the youth will be assisted by the staff of that particular program. In the mental health system, TAY services can serve as a bridge between children and adult services. In this system, it is preferable to begin the transfer of mental health services from the children's system to the TAY program at the point when this form of specialized service will be most useful in helping prepare the TAY for the challenges of young adulthood. In this sense, the main goal is the *prevention* of major problems in functioning in each of the life domains. In the event that TAY will require some ongoing support (e.g., medications, etc) through the adult mental health system, it is helpful to consider whether guidelines other than age will be a determinant in the decision making on the timing of this transition. This will help to reduce possible *dependency* on TAY services and allow for TAY staff to assist other youth who are transitioning into their program. In situations where TAY youth are transitioning to the community rather than adult mental health, the establishment of some criteria of client readiness would be beneficial.

LEVEL OF SERVICE

The level of need for support and guidance by TAY will vary from person to person and tend to fluctuate across time and experience. For example, TAY who have been traumatized, are homeless, lack a primary support system, and/or have experienced the recent acute onset of mental illness, will need a higher level of support cope with these stressful events. Conversely, TAY who has a high level of internal and environmental support will tend to have relatively lower levels of need. TAY programs should be constructed to offer that level of support that is consistent with each clients needs while he or she is in the program. This is particularly relevant with regard to housing. Clients needs in this area can vary from the most to least intensive in the

following order: hospitalization, crisis residential, supportive housing, transitional housing, and independent housing. The level of client need may also substantiate additional services. At the lowest level case management and medication may be sufficient. At higher levels, psychotherapy in the form of individual, family and/or group treatment may be required.

LIFE DOMAINS

As previously stated at various points in this Resource Guide, there are four basic life domains which each TAY program would hopefully include as essential service areas for youth they serve. These domains include housing, education, vocation, and community living. Each of these basic aspects of living represents such vital needs for TAY that is difficult to imagine a program meeting the needs of this population without providing some degree of service in each of these four areas. Services such as housing can either be provided by county or contracted agencies. Collaboration with local education providers, such as adult education and colleges is necessary. Similarly, it is necessary to establish this same coordination with vocational programs throughout the community. Finally, community supports in the form of social networks, clubs and organizations, support groups and specific peer interest groups are needed. Overall, it is important that each TAY staff have access to as much information as possible regarding community resources in each of the areas listed above.

INTENSIVE CASE MANAGEMENT

At any point in time, TAY may require basic linkage and support in one or more of the domains indicated above. When this domain involves basic needs such as housing, it is important to have immediate assistance. TAY who needs food or shelter should receive this service on the same day as the expressed need. In addition, in order to be effective, TAY may need to spend a significant amount of time with TAY staff for case management and/or other therapeutic services. It is recommended that TAY staff have smaller caseloads than is normally associated with adult mental health systems in order to respond to TAY needs at a potentially intensive level.

PSYCHOTHERAPY

The vast majority of TAY clients have suffered from a traumatic experience and/or mental illness. Psychotherapy is essential to help TAY recover and cope from these stressful events and to minimize the impact of these same negative experiences on the functioning and well being of our youth. TAY programs need to consider both the psychotherapeutic modalities and theoretical approaches used by TAY clinicians. In terms of modalities, individual, group and family counseling are recommended as types of counseling that can be offered depending on the need of each TAY. Each of these types of treatment can be useful in building peer and family relations as well as increasing TAY resiliency and communication skills.

Insofar as therapeutic orientation is concerned, it is recommended that TAY staff be capable of providing supportive psychotherapy at the very least. All TAY will benefit from having the therapeutic support of a humanistic counselor who provides active listening, accurate empathy, and genuineness as part of their approach. However, it is important to also provide evidenced-based psychotherapeutic approaches to assist TAY.

There is a growing body of research that substantiates the efficacy of Cognitive Behavioral Therapy (CBT) as the treatment of choice to help ameliorate the symptoms associated with serious mental illness, such as major depression, bipolar disorder and psychosis (site multiple references). Therefore, it would appear that at least some TAY staff should be sufficiently trained in this type of psychotherapy so that TAY will be given the best opportunity to cope with their emotional difficulties and improve their problem solving skills. Furthermore, CBT is extremely beneficial in helping TAY address other difficulties they may be experiencing, such as chemical dependency or recovery from traumatic events. (Site multiple references). Finally, psychotropic medications are often necessary to help TAY cope with the symptoms associated with mental illness. Every TAY program needs to have a qualified psychiatrist who understands the mental health needs associated with TAY.

Day Rehabilitation Programs can also be of benefit to TAY. Such programs offer a structured format in a social setting for TAY to increase independent living skills; learn to increase socialization with peers and others, and to better understand how to cope with their mental illness in general. Typically, such services are beneficial to TAY who has higher level of service needs. Ideally, such programs should also include family members and other means of support and should include a psycho-education component to help TAY and family members better understand the particular mental illness the youth and family are learning to cope with at the time. Psychiatric services in the form of evaluation, prescription and monitoring as well as approaches to assist TAY in medication compliance are necessary.

INITIAL AND ONGOING TRAINING

In order to be helpful TAY staff need to know how to help. This requires initial and ongoing training, especially in each of the following areas:

- *Clinical training:* To help increase TAY staff knowledge of current best practice approaches and how to use the techniques associated with these approaches.
- *Cultural competency training:* To increase TAY staff knowledge of the culture of the clients who are receiving their services.
- *Young Adult Developmental Phase training:* TAY staff in particular need to know the challenge and opportunities associated with this phase as well as the associated needs that TAY have for making the successful transition to adulthood.
- *Miscellaneous Staff and Program Characteristics:* There are some staff and program characteristics that are difficult to measure and quantify but are appreciated by TAY and their families when they are present and harmful when absent. Such human qualities as compassion, dedication, and ongoing commitment should be integral to every TAY program. Moreover, TAY staff should possess personal characteristics of resiliency, flexibility, a sense of humor, and a positive approach to their work in order to engage TAY and help them on the path to adulthood. TAY staff also need to have exceptional skills in the areas of planning, organization, and decision making in order to help TAY cope with daily and developmental demands and to collaborate with TAY in developing their vision of the future and building the road to get there. Finally, TAY staff should have a natural interest in assisting TAY cope with the challenges of this developmental phase, perhaps arising, in part, from the remembrance of a mentor or other adult who similarly helped them get through this time of life in successful fashion.

DIAGNOSTIC/MEDICATION HISTORY

A. Diagnosis Axis I _____
Axis II _____
Axis III _____
Axis IV _____
Axis V Current GAF _____ Past GAF _____

B. Current Psych. Meds _____ Treating Psychiatrist: _____

1. _____

2. _____

Is the Client Meds. Compliant? Yes _____ No _____ If no, describe _____

Medical Problems? No _____ Yes _____ If yes ,describe _____

PSYCHIATRIC HISTORY

A. Age of Onset of Psychiatric Symptoms _____ First Contact with Mental Health System if known _____

B. Number of Previous Psychiatric Hospitalizations _____ Age at First Hospitalization, if known _____

Circumstances of Most Recent Hospitalization and **date**: _____

C. Current Mental Health Treatment; type, length and with whom: _____

CURRENT AT RISK BEHAVIOR

Suicide Ideation/Self harm _____ Threats/Aggression towards others _____

Sexualized Behavior _____ Drug/Alcohol Abuse _____ Other _____

Please describe any areas check above _____

EDUCATION

Last Year of School Completed _____ Most Recent Educational Program _____

History in Special Education: Yes _____ No _____ Unknown _____ 26.5 Services: Yes ___ No ___

Prospective HS Graduation Date or completion of 26.5 Services _____

Legal Status

Voluntary_____ Conserved _____ Parole/Prob_____ Wardship_____ Dependency _____

Legal Issues or Current Legal Problems: Yes___No___

Please describe any areas checked above: _____

Financial Information

A. Source of Income: General Assistance _____ SSI_____SSA_____ SDI_____VA_____ job_____

Family _____ Other_____

B. Is SSI pending? No_____ Yes___ If Yes, Approximate Date:_____

C. Medi-Cal #_____ Medicare # _____

D. Other Insurance? Yes___ No___ if Yes, Specify and explain_____

APPENDIX #15.2

YATT OT Program

Best Practice

Prepared by Cathy Smiddy, OTR/L, collaborative with the following OTIs: Melissa Garland, Sophia Jones, Rob Domrese, Jeni Yamashita

The definition of Occupational Therapy (OT) according to the American Occupational Therapy Association is a skilled treatment that helps individuals achieve independence and increased satisfaction in all facets of their lives. OT strives to assist clients with achieving a balance of work, rest, leisure and self-care. The Young Adult Transition Team (YATT) OT program collaborates with clients and facilitates optimal functional performance through the following services:

- Cognitive assessments and performance skills assessments
 - The OTR/OTI serves clients in a variety of settings ranging from emergency psychiatric facilities to home care.
 - The OTR/OTI administers standardized evaluations including Allen's Cognitive Levels (ACL) assessment that provides objective, measurable functional outcomes.

- The OTR/OTI assesses client's functional performance outcomes using skilled observation during Activities of Daily Living (ADLs and IADLs) such as grooming and hygiene, meal preparation, caregiving, money management, pre-vocational and other life management skills.
- Customize treatment programs to improve one's ability to perform daily activities
 - Through 1:1 interviews based on the Canadian Occupational Performance Measure (COPM) the OTR/OTI in conjunction with the client identifies goals and areas for improvement and then structures the treatment specifically for that client.
 - During group therapy, tasks, the amount of structure, and the type of instructions are graded according to the individuals learning style and cognitive level.
- Health and Safety
 - The OTR/OTI assists clients in obtaining valid identification such as California ID cards.
 - The OTR/OTI will create an emergency card that contains the client's address, contact information for Las Plumas and the case manager's name, medications, and allergies if known.
 - The OTR/OTI provides a Medication Journal to each client, and provides training on the use of journal.
 - The OTR/OTI provides education on the importance of medication compliance and monitors behavioral and functional changes on a regular basis.
 - The OTR/OTI promotes wellness and awareness in the areas of sexual education.
- Community mobility and integration
 - The OTR/OTI assist client in obtaining bus pass and disability discounts.
 - The OTR/OTI provides opportunities and assistance in using the transit system.
 - The OTR/OTI informs about community resources and encourages participation in various community programs with emphasize on education, health, work and leisure.
 - The OTR/OTI provides training in communication and social skills.
- K-9 Therapy
 - Used to assess and improve multi-tasking skills
 - Provide opportunity to be responsible for another being
 - To aid in communicating with a withdrawn client