

TUNNELS & CLIFFS

***A Guide for Workforce
Development***

***Practitioners and
Policymakers Serving
Youth with Mental Health
Needs***

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Purpose of This Guide

Insuring that a young person is healthy and ready for work, independent living, and civic engagement is easier said than done. There is no coordinated system that guides youth through the process of becoming productive and self-sufficient members of society and the labor market. Pieces of the system exist, such as Career and Technical Education, transition planning under the Individuals with Disabilities Education Act, and programs available through Vocational Rehabilitation and the Workforce Investment Act. Unfortunately, however, these services are often incomplete and uncoordinated – and therefore ineffective. Youth with educational and career challenges, such as those with mental health needs, too often fall off one of the cliffs between youth and adult systems or get shunted down an arbitrary or inappropriate service tunnel based on considerations dictated by the system rather than the youth's wants and needs.

This guide has been developed as part of ODEP's initiative to help workforce development practitioners, administrators, and policymakers enhance their understanding of youth with mental health needs (MHN) and the supports necessary to help them transition into the workforce successfully. This guide provides practical information and resources for youth service practitioners at local One-Stop Career Centers, Vocational Rehabilitation offices, youth programs funded under the Workforce Investment Act, school transition programs, and mental health agencies. In addition, it provides policy makers, from the program to the state level, with information to help them address system and policy obstacles in order to improve service delivery systems for youth with mental health needs.

Throughout this document, the term "*youth with mental health needs*" is used to

refer to the segment of youth (ages 14 to 25) who have significant mental health needs (emotional, behavioral, or neurobiological disorders) that may or may not have been formally identified or served by the mental health system.

The goals of the guide are to improve the quality of services at the local level, enhance strategic planning at state and local levels, and increase positive results for youth.

For practitioners, the guide will

- provide information concerning the incidence of mental health needs in youth,
- describe core components of mental health services in each state,
- present types of strategies and services that might benefit youth with mental health needs, and
- discuss support services needed for youth with mental health needs entering the workforce.
- For administrators and policymakers, the guide will provide
- helpful information on developing practical and effective policies,
- suggestions for creating greater collaboration among programs, and
- strategies for developing an improved interagency transition system for youth, including those with mental health needs.

The guide's contextual framework is the *Guideposts for Success*, a document developed by NCWD/Youth in collaboration with ODEP. The *Guideposts* are research-based and describe components that all youth need to transition successfully to adulthood as well as modifications for youth with disabilities. The *Guideposts for Success for Youth with Mental Health Needs* incorporate all of the elements of the original *Guideposts* as well as additional specific needs relating to youth with mental health needs.

Chapter 1 describes the mental health landscape encountered by youth, including facts, statistics, and the conflicting and confusing terminology used to describe mental health needs and conditions.

Chapter 2 describes the transition cliff that separates youth and adult service systems and the service tunnels that youth with mental health needs must negotiate to access the assistance and support needed to maximize independence.

Chapter 3 introduces the *Guideposts for Success for Youth with Mental Health Needs* and discusses career preparation, resources, and other issues of concern to youth service practitioners serving youth with MHN.

Chapter 4 discusses policy issues related to serving youth with MHN and suggests actions for program administrators and state and local

policymakers.

Exhibit 1 in each chapter is a research summary supporting the chapter's content and is provided for the convenience of readers. Some information may be repeated in both the chapters and these exhibits.

Appendix A contains a list of web-based resources in the following categories: mental health and disability, school-based preparatory experiences, employment and career preparation, youth development and leadership, connecting activities (activities that connect youth with MHN to individual and support services), family involvement and support, and policy and systems change.

Appendix B contains the references cited in each chapter and in each chapter's supporting research exhibit.

Appendix C contains a list of acronyms used in this guide. Chapter 1

Chapter 1: The Mental Health Landscape

Purpose

This chapter provides an overview of

- demographic characteristics of youth with mental health needs,
- terminology used to describe mental health conditions,
- the two most common identification systems for youth — mental health and special education, and
- common mental health or emotional disorders in youth.

Youth with mental health needs often face unemployment, underemployment, and discrimination when they enter the workforce. Employment data indicate that individuals with serious mental illness have the lowest level of employment of any group of people with disabilities. As a result, large numbers of youth with both diagnosed and undiagnosed mental health needs who are transitioning into young adulthood, to the world of work, and to postsecondary education are likely to experience significant difficulties.

Statistics show that youth with MHN are overrepresented in foster care, the juvenile justice system, and among school disciplinary cases and high school dropouts. Table 1.1 provides further statistical data on youth with MHN. The President's New Freedom Commission on Mental Health's Report recognizes that schools have a critical role to play in providing early identification of MHN, research-based interventions, and mental health services, as well as in educating families, service providers, and the local community about supporting youth with MHN. Unfortunately, too many youth do not receive the services they need in order to successfully navigate the road to work and meaningful adult lives.

Youth service practitioners in the workforce development system are responsible for supporting vulnerable youth; several of these targeted groups include many youth with mental health needs. Fortunately, there are a growing number of strategies and resources to support youth with MHN in achieving independence, self-sufficiency, and their employment and postsecondary education goals. Youth with mild to moderate mental health needs who are placed in employment often need minimal or no employment supports.

Table 1.1: Facts and Statistics for Youth with Mental Health Needs

- According to the National Mental Health Information Center, population studies show that at any point in time, 10% to 15% of children and adolescents have some symptoms of depression. The National Institute for Mental Health found that suicide was the third leading cause of death

among 15 to 24 year olds, following unintentional injuries and homicide in 2002.

- Youth with emotional disturbance in secondary schools had the highest percentage (44.8%) of negative consequences for their actions (i.e., were suspended, expelled, fired, or arrested) of any disability group in the National Longitudinal Transition Study-2 (NLTS2).
- Students with emotional disabilities had a higher dropout rate than for any other single disability category in the NLTS2.
- High school youth with emotional disabilities in the NLTS2 were more likely to be involved in bullying or fighting in school (42%) and to initiate bullying (36%) than the general population of youth with disabilities.
- The National Center for Mental Health and Juvenile Justice estimates that on any given day over 100,000 youth reside in juvenile detention and correctional facilities across the country. Existing data suggest that between 65% and 100% of these youth have a diagnosable mental disorder, and that approximately 20% have a serious mental health disorder.
- The Northwest Foster Care Alumni study of over 600 foster care alumni revealed that 54.4% had a mental health disorder, including 25.2% with post-traumatic stress disorder, 20.1% with major depression, and 17.1% with social phobia.
- There is a 90% unemployment rate among adults with serious mental illness, the worst level of employment of any group of people with disabilities according to the President's New Freedom Commission on Mental Health.

(End of Table 1.1)

Terminology

Youth with mental health needs (MHN) are referred to variously as *emotionally disturbed (ED)*, *antisocial*, *psychiatrically disordered (PD)*, *behaviorally disordered (BD)*, *socially maladjusted*, or *emotionally and behaviorally disordered (EBD)*. For purposes of this guide, the category “youth with MHN” refers to the broad population of youth who have been diagnosed with emotional disorders by the public schools and/or the mental health system, as well as those with such conditions that have not been diagnosed. A sizeable proportion of these youth are never formally identified as having mental health disturbances by the educational or mental health systems.

The definitions and terms used to describe youth with MHN vary by system. The terminology used by the two systems — mental health and schools — that deal most directly with youth with mental health needs are described below.

Mental Health System Identification. Two broad and independent dimensions

of MHN, internalizing and externalizing disorders, have been identified among children and youth. Externalizing disorders are represented by behavior that is directed outward toward the external social environment. They are characterized by behavioral excesses such as verbal and physical aggression, tantrums, disturbing others, oppositional behavior, noncompliance, and so on. In contrast, internalizing disorders are usually directed inward. They are represented by such problems as social withdrawal and isolation, low self-concept, phobias, and depression.

Both externalizing and internalizing MHN are described in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)* of the American Psychiatric Association, a publication that presents categories and definitions of disordered behavior and psychopathology for children, youth, and adults. The *DSM-IV-TR* is used primarily by mental health and social service agencies, and by vocational rehabilitation in some states, to determine eligibility for services and treatment, such as pharmacologic or medication interventions, for some diagnoses. Examples of psychiatric disorders (PD) found in the *DSM-IV-TR* include bipolar disorders, schizophrenia, autistic disorder, conduct disorder, oppositional defiant disorder, substance-related disorders, mental retardation, learning disorders, attention deficit/ hyperactivity disorder, obsessive compulsive disorder, and personality disorders.

Special Education Disability Identification — Emotional Disturbance. The public education system uses 13 disability categories defined by the Individuals with Disabilities Education Act (IDEA) to identify the students who need special education. These categories are autism, deafness, deaf-blindness, emotional disturbance (ED), hearing impairment, mental retardation, multiple disabilities, orthopedic impairment, other health impairment (e.g., asthma, leukemia, heart conditions, etc.), specific learning disability (SLD), speech or language impairment, traumatic brain injury (TBI), and visual impairment including blindness.

The most visible label for youth with MHN in the public schools is emotional disturbance, which was previously known as serious emotional disturbance. It is important to note that this classification is based on a student's *inability to learn due to his or her MHN*, not the mere presence of his or her MHN, as emphasized in the federal special education definition contained in Table 1.2.

Table 1.2: Definition of Emotional Disturbance (ED)

The Individuals with Disabilities Education Improvement Act of 2004 defines an emotional disturbance (formerly known as a serious emotional disturbance) as a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree, and which adversely

affects educational performance:

- an inability to learn that cannot be explained by intellectual, sensory, or health factors;
- an inability to build or maintain satisfactory interpersonal relationships with peers and teachers;
- inappropriate types of behavior or feelings under normal circumstances;
- a general, pervasive mood of unhappiness or depression; or
- a tendency to develop physical symptoms or fears associated with personal or school problems.

The term includes children who are schizophrenic and does not include children who are socially maladjusted unless it is determined that they are emotionally disturbed.

(End of Table 1.2)

Mental Health And Special Education: Contrasting Identification Systems

Public schools and mental health agencies use very different criteria to determine which youth are eligible for receiving special services as a consequence of their MHN. A youth who is classified as having a mental health need in school may not be defined as such by a mental health agency, and vice versa. It is also common, especially with internalizing conditions, for youth not to be identified at all.

As noted above, most youth with MHN in schools are classified as having an emotional disturbance. Youth with autistic disorder, mental retardation, specific learning disability, and attention deficit/hyperactivity disorder are not usually considered to have mental health needs unless they also have an emotional disturbance that impairs their ability to learn. In the *DSM-IV-TR*, however, all of these disabilities are considered mental health disorders regardless of whether they affect a youth's ability to learn.

It is critical that the correct disability label for a youth's MHN be used in order for the youth (1) to receive services from the public schools and/or the mental health system, and (2) to be referred from either of those two systems to the adult mental health system and related employment and career services. The correct disability label is the key to receiving transitional services from the schools and mental health agencies. It is entirely possible for a youth to be identified as needing services from the school system because of his or her MHN, but not to be identified by the mental health system as eligible to receive services from that service system. Conversely, the opposite situation also can be true. Some youth with MHN are therefore missed by both of these systems.

At the point of transition from youth to adulthood — and moving from child-based services to the adult service system — it is possible for youth with MHN to fall through the cracks of the unconnected and inadequate network of service delivery systems. In addition, a substantial number of youth with MHN will remain undiagnosed and consequently will receive no services. This is one reason why youth with disabilities are over-represented in juvenile correctional systems and facilities and, most likely, in a number of workforce development programs.

Common Mental Health Or Emotional Disorders In Youth

The classification of mental illness is not a simple or definitive process. Unlike the definition of some obvious disability categories (e.g., spinal cord injuries or deafness), definitions of MHN differ among education, mental health, and social service programs; there is no one uniform description, or profile, of youth with MHN. Youth with MHN also may exhibit more than one MHN or disability that will present additional challenges to their transition to adult life. For example, depression may be combined with attention deficit disorder (ADD) or conduct disorders.

Mental health needs may develop in childhood, adolescence, or adulthood. A large number of mental health disorders first occur and are diagnosed in the teen years. One study showed, for example, that about three-fourths of 26-year-old adults were first diagnosed with a mental health disorder as adolescents. The most common mental health problems faced by youth involve depression, anxiety, and maladaptive behaviors. Other more serious mental health problems, such as schizophrenia, psychosis, and bipolar disorder, are less common. The common mental health needs are defined below.

Depressive Disorders. Young people with clinical depression (defined as a major depressive episode lasting for a period of two weeks or more) often have multiple symptoms, including a depressed mood, irritability, overeating or lack of appetite, difficulty sleeping at night or wanting to sleep during the daytime, low energy, physical slowness or agitation, low self-esteem, difficulty concentrating, and recurrent thoughts of death or suicide. Like many mental health problems, untreated depression can make education or career planning difficult. Fortunately, depression is one of the most treatable of all mental illnesses.

Anxiety Disorders. There are several anxiety disorders that interfere with school performance or attendance and with job training or work. Generalized Anxiety Disorder (GAD) is characterized by six months or more of chronic, exaggerated worry and tension that is unfounded or much more severe than the normal anxiety most people experience. Youth with GAD also have one or more of the following symptoms in association with the worry: restlessness, fatigue, poor concentration, irritability, muscle tension, or sleep disturbance. People with GAD are often pessimistic and worry excessively even though there may be no

specific signs of trouble. These anxieties may translate into physical symptoms such as insomnia, eating problems, and headaches. Young people with GAD may have social anxieties about speaking in public or working in public areas.

Conduct Disorders. Conduct disorders are a complicated group of behavioral and emotional problems in youth manifested by difficulty in following rules and behaving in a socially acceptable way. Youth with conduct disorders may exhibit some of the following behaviors: aggression to people and animals, destruction of property, deceitfulness, lying, stealing, or other serious violations of rules. They are often viewed by other youth, adults, and social agencies as "bad" or delinquent, rather than having a behavioral disorder.

Many youth with conduct disorders often have other conditions affecting mental health, and self-medication (through illicit drugs and alcohol) is common. Early and comprehensive treatment is usually necessary to avoid ongoing problems that impede academic growth or vocational planning. Without treatment, many youth with conduct disorders are unable to adapt to the demands of adulthood and continue to have problems with relationships and with holding a job; many also engage in antisocial or illegal behaviors.

Hidden Disabilities. Some youth systems (e.g., education, mental health, social services, etc.) may base eligibility or service options on a diagnosed disability, and therein lies a potential problem. Up to 75% of youth with disabilities have hidden or non-apparent disabilities, including mental health needs. Hidden disabilities are not readily apparent through observation; in fact, many of these conditions have not been diagnosed or have not been recognized or acknowledged by the individual or his or her parents.

Hidden disabilities include specific learning disabilities (SLD), attention deficit/hyperactivity disorder (AD/HD), attention deficit disorder (ADD), emotional or behavioral problems (such as depression, anxiety disorders, or conduct disorders), and traumatic brain injuries (TBI). Occasionally, young people with mental retardation can be considered to have a hidden disability if, for example, they are socially adept and are able to function without assistance in routine day-to-day activities.

Unfortunately, the frustrations and functional limitations caused by hidden disabilities can lead to harmful, unsafe, or illegal behavior. Unemployment or underemployment, teen pregnancy, drug or alcohol abuse, and involvement with the juvenile or adult justice systems are common outcomes for youth with hidden disabilities. Diagnosing and accommodating the disability are usually necessary prerequisites for good educational and vocational outcomes.

Substance use and learning disabilities may not be the first issues that come to mind as being associated with mental health needs. They are included here, however, because of their high incidence among youth, the frequency of their co-occurrence with other mental health needs, and their symptoms that are typically

visible in the behavioral, emotional, and social domains.

Substance Use. Although not always considered a disability, substance use is relatively common among youth with hidden disabilities and can cause serious problems. Substance use is defined as the use of a chemical substance, legal or illegal, taken to induce intoxication or reduce withdrawal symptoms resulting in dependency, abuse, or addiction. Substances may include alcohol, illicit and prescription drugs, paint, household cleaners, plants, and others.

Youth with mental health needs may use alcohol, marijuana, prescription drugs, and other substances to try to reduce or manage their symptoms. Substance use is a significant behavioral health issue that affects education, transition planning, job training, safety, productivity, and other aspects of a youth's life. For example, youth who use alcohol or drugs while undergoing assessment often end up with poor or invalid results.

The Substance Abuse and Mental Health Services Administration (SAMHSA) reports in the findings from the *2004 National Survey on Drug Use and Health* that approximately 39 million adults of working age (18 to 54) experience mental illness, a substance abuse disorder, or both. Over 10% of all full-time and part-time workers abused or were dependent on drugs or alcohol. Youth may therefore need assistance in managing substance use problems, in becoming aware of the consequences of such behaviors, and in learning how to avoid temptation.

Specific Learning Disabilities. Specific learning disabilities (SLD) affect an individual's ability to interpret what he or she sees and hears or to link information from different parts of the brain. These differences can show up as specific difficulties with spoken and written language, coordination, self-control, or attention. SLDs may include developmental speech and language disorders, academic skills disorders, motor skill disorders, and other specific developmental disorders. It is important to note that not all learning problems are necessarily SLDs; some youth simply take longer in developing certain skills.

Such difficulties may affect a youth's ability to learn to read, write, or do math. In some individuals, many overlapping learning disabilities may be present. Others may have a single, isolated learning problem that has little impact on other areas of their lives. *It is important to note that having an SLD does not indicate deficits in intelligence. Many people with SLDs have very high IQs.*

One of the primary concerns for workforce development staff working with individuals with disabilities is the limited usefulness of diagnostic and clinical information in assisting individuals with mental health needs to secure meaningful employment. Clearly, better tools, information, and resources are needed.

In order to achieve improved transition outcomes for youth with mental health needs, youth service practitioners and policymakers must develop a common understanding of the disability-specific needs of youth with mental health needs and the supports those youth will require for successful employment.

Please see Appendix B for the list of references.

Exhibit 1.1: Supporting Research

More than half of youth with MHN will drop out of school, with few youth ever accessing treatment services. Except for the small portion (3% to 5%) of youth who are placed in long-term mental health care (Rosenblatt & Rosenblatt, 1999), the majority of youth with MHN demonstrate average or above cognitive abilities (Davis & Vander Stoop, 1997). Due to emotional difficulties, however, many in this broad and diverse population will experience sporadic and inappropriate academic and vocational preparation during their school years (Fredericks, 1995).

Psychiatric disabilities are not directly related to any one special education category — including Emotionally Disturbed — and may or may not play a role in decisions regarding eligibility for special education services (Forness, 2003; Forness, Kavale, King, & Kasari, 1994; Forness & Knitzer, 1992).

The duality of systems and the distinctions in educational and mental health definitions (Achenbach, 1985) mean that youth who receive special education services as a result of their emotional needs may be, and probably are, very different from those youth who receive services from mental health agencies because of their emotional needs. For example, Davis and Vander Stoop found that “schools use the DoED [U.S. Department of Education] definition [of emotional disability] in identifying youth...” and “state mental health agencies use the CMHS [Center for Mental Health Services] definition and a variety of other criteria to define target populations and determine eligibility” (1997, p. 401). Moreover, many youth with MHN will go undiagnosed and untreated by both the educational and mental health systems (Cohen, Brook, Cohen, Velez, & Garcia, 1990; Compas, Orosan, & Grant, 1993; Lewinsohn, Rhode, & Seely, 1995; Lewis, 1990; Lewis & Miller, 1990). This is of particular concern since several types of mental health conditions develop in adolescence. In one study of 26-year-olds with mental disorders, approximately three-fourths were originally diagnosed in their teens (Kim-Cohen, Caspi, Moffitt, Harrington, Milne, & Poulton, 2003).

Studies differ concerning the percentage of youth in correctional settings who have mental health needs. The National Center for Mental Health and Juvenile Justice (n.d.) estimates that between 65% and 100% have a diagnosable mental condition. Other studies indicate that roughly 40% to 60% of youth in correctional settings have a special education disability, usually learning disabilities or ED (Bullis, Yovanoff, & Havel, 2004; Rutherford, Bullis, Wheeler-Anderson, & Griller, 2002). It is unclear, however, how many of those youth were first identified as having a disability in public school or were identified upon entering the correctional system (Rutherford, Bullis, Wheeler-Anderson, & Griller, 2002).

For more than 30 years, Achenbach and his colleagues have examined the structure of psychopathology (i.e., MHN) among children and youth (ages 5 to 17) (Achenbach, 1966, 1985; Achenbach & Edelbrock, 1981; Achenbach &

McConaughy, 1987). They consistently identified two broad and independent dimensions of MHN among this age group: *internalizing and externalizing* disorders. The “broad-band” grouping designated as internalizing mainly involves problems within the self, such as unhappiness and fears. The broad-band grouping designated as externalizing, by contrast, mainly involves conflicts with others, such as aggressive, delinquent, and overactive behavior (Achenbach & McConaughy, 1987, p. 33).

Roughly 10% to 12% of all youth will have some form of mental health problem severe enough to call for short-term special services and treatment during their teenage years (Costello, Mustillo, Erkanli, Keeler, & Angold, 2003; Kauffman, 1997). Of these, less than half (3% to 5% of the total age group) will present MHN of such complexity and seriousness to require long-term educational, mental health, or transition interventions (Kauffman, 1997; Quay & Wherry, 1986).

Less than 1% of all students in the public schools will be identified as having an emotional condition that will qualify them for special education services, a rate that is far below the best estimates of the prevalence of MHN among children and youth cited previously (Forness & Knitzer, 1992; Kauffman, 1997; Kavale, Forness, & Alper, 1986). Estimates also suggest that less than a quarter of youth with MHN will receive any formal services from mental health or social service agencies (Knitzer, Steinberg, & Fleisch, 1990; Stroul & Friedman, 1994). Though some youth identified as having a MHN by the special education system are also served through the mental health system, the percentage of youth served by both systems is not clear (Forness, Kavale, King, & Kasari, 1994; Forness, Kavale, & Lopez, 1993).

As mentioned earlier, youth who exhibit externalizing behaviors predominate among those students labeled as ED in special education (Walker, Colvin, & Ramsey, 1995) and probably also among youth with PD who are served in the mental health system (Quay, 1986). Research conducted by Jessor and Jessor (1977) and Donovan and Jessor (1985) indicate that externalizing behaviors, which are identified in the *Diagnostic and Statistical Manual of Mental Disorders*, tend to be exhibited in a syndrome, or cluster of related behaviors: delinquency/criminality, school failure, pregnancy and high risk sexual behaviors, and alcohol or substance abuse.

Youth with depression may also exhibit attention deficits and/or conduct disorders (Lewinsohn, Rhode, & Seely, 1995). Additionally, the coexistence of learning disabilities, learning difficulties, and emotional disturbance has long been recognized (Lane, 1980; McEvoy & Welker, 2000; Trout, Nordness, Pierce, & Epstein, 2003).

The Substance Abuse and Mental Health Services Administration (SAMHSA) found a strong relationship between substance abuse and mental health problems in youth. Successful treatment for co-occurring conditions requires

individualized treatment plans that treat both mental health and substance abuse conditions across a wide spectrum of services and settings, including cross-referrals, cooperation, consultation, collaboration, and treatment modes (Substance Abuse and Mental Health Services Administration, 2002).

The Center for Mental Health Services, in partnership with the National Institute of Mental Health, was a leader in the development of the first Surgeon General's report ever issued on the topic of mental health and mental illness: *Mental health: A report of the Surgeon General* (U.S. Department of Health and Human Services, 1999). The report found that although a great deal was already known about how to treat mental illness, much remained to be learned about ways to prevent mental illness and to promote mental health. The groundbreaking report also found that in spite of the fact that a range of effective treatments existed for most mental disorders, nearly half of all Americans with severe mental illnesses failed to seek treatment.

These and other findings led the Surgeon General to assert that “growing numbers of children are suffering needlessly because their emotional, behavioral, and developmental needs are not being met by those very institutions which were explicitly created to take care of them” (U.S. Public Health Service, 2000, Foreword). An analysis of the impact of mental illness on mortality in children with disabilities by a national workgroup on child and adolescent mental health concluded that “no other illnesses damage so many children so seriously” (National Advisory Mental Health Council Workgroup on Child and Adolescent Mental Health Intervention and Deployment, 2001).

In 2004, ODEP and SAMHSA sponsored a study to identify critical issues, systemic barriers, and policy recommendations for employment and training agencies regarding the provision of services to individuals with psychiatric disabilities. The study, conducted by the Institute for Community Inclusion (ICI), was intended to provide information and guidance to federal agencies and the workforce development system on effective practices and service implementation for serving people with psychiatric disabilities within local One-Stop Career Centers.

The study (Marrone & Boeltzig, 2004) identified a number of common barriers for the effective employment of young adults and adults with psychiatric disabilities:

fragmentation and lack of seamless service delivery,

- the tendency to see people with psychiatric disabilities as needing only disability-specific services,
- a lack of understanding of employment as a valuable outcome by mental health systems of care,
- insufficient staff knowledge and skills,
- insufficient understanding of the disability community,
- a lack of access to support services,

- a lack of baseline standards,
- a lack of customer marketing plan,
- a lack of a marketing plan for employers connected to overall business services,
- social isolation,
- a lack of access to health insurance,
- the complexity of existing work incentives, and
- limited skill sets in choice and control.

These barriers have important implications for policy and service reforms, and the barrier related to staff knowledge and skills underscores the need to provide information and resource tools to workforce system practitioners. One of the initial barriers to address with workforce development practitioners is the tendency to underestimate the capacities and skills of people with psychiatric disabilities and to overestimate the risk to employers. The ICI study found that often staff in One-Stop Career Centers indicated a need for consistent baseline knowledge and skills to meet the needs of customers with psychiatric disabilities.

Please see Appendix B for the list of references.

Chapter 2: A System of Tunnels and Cliffs

Purpose

This chapter describes

- the “tunnel problem” in systems serving youth,
- an ideal scenario for accessing services,
- treatment interventions for youth with mental health needs, and
- the “transition cliff” between youth and adult systems.

Ross and Miller describe the “the tunnel problem” in systems serving youth as follows:

Each of the many systems that serve youth has a fixed menu of services or solutions to offer. Because most agency staff members think primarily of the set of solutions within their system, they usually send youth down one of these “service tunnels.” The tunnel may be the most appropriate choice among the agency’s set of options, but may still be an ineffective course of action. Once a youth starts down a particular tunnel, it is often hard to reverse course and take a different path (2005, p. 4).

Any discussion of the services that youth receive would be incomplete without highlighting that issues of cultural competence and institutional racism are rife in this field. Youth of color, especially African Americans, are more likely to receive harsher treatment when involved in school discipline proceedings, child welfare cases, or the juvenile justice system... Tunneling, then, is not only a function of a youth’s problem, but is also influenced by conscious and unconscious biases on the part of government agencies (2005, p. 5).

The service tunnels or systems that may serve youth include community-based organizations, foster care, juvenile justice, mental health, Social Security, special education, vocational rehabilitation, youth services funded by the Workforce Investment Act, and others. Table 2.1 illustrates the overlapping and confusing nature of the service tunnels that may serve youth with MHN.

Eligibility requirements for accessing services vary across these systems and range from mandatory services (public schools) to criteria based on factors such as income, severity of a disability, ability to benefit, and family circumstances. Each system has its own terminology, which, as noted previously, may be particularly confusing in the case of youth with mental health needs.

Table 2.1: Service Tunnels

If the youth system was a maze of tunnels, then some of the common entrances and exits (expected outcomes) for youth are as follows:

Youth System Tunnel Entrances

- Community-based Organizations
- Foster Care
- Juvenile Justice
- Mental Health
- Social Security
- Special Education
- Vocational Rehabilitation
- Workforce Investment Act Youth Services

Youth Outcome Goals

- Employment
- Postsecondary Education
- Independent Living

(End of Table 2.1)

For youth service practitioners in a service tunnel, understanding another service system and how to access its services may be overwhelming. Not only is the terminology used to describe mental health needs and services unfamiliar, but the concept of a mental health system itself is dynamic and can vary significantly between communities. Consequently, youth service practitioners in one tunnel, such as a Workforce Investment Act youth program, may need to follow different protocols from a similar program in another area to access mental health services for youth. However, there are some similarities in services between and among states that receive federal funds for mental health services.

States that receive federal funds as part of the Mental Health Block Grant program, awarded by the Center for Mental Health Services, must provide comprehensive community-based systems of care for adults with serious mental illnesses and children with serious emotional disturbances. This approach, often referred to as Systems of Care (SOC), builds (1) partnerships to create a broad, integrated process for meeting the physical, mental, social, emotional, educational, and developmental needs of children in the child welfare systems, and (2) the infrastructure needed to result in positive outcomes for children and families. The SOC philosophy, as described by the National Clearinghouse on Child Abuse and Neglect Information, is based on principles of interagency collaboration; individualized, strengths-based care practices; cultural and linguistic competence; community-based services; and full participation of

families, including youth, at all levels of the system.

Youth up to the ages of 18 or 22, depending on the program, may enter the child/youth mental health system. Table 2.2 describes an ideal scenario for a youth accessing services because of a critical incident requiring intervention from outside the family. This ideal has yet to be achieved, since mental health services for adults and youth differ considerably across states and localities due to variations in available resources and community needs.

At each step of the process, a number of different service providers and others providing natural supports, as well as youth and family, are involved in key decision points that affect the next steps and ultimately access to effective treatment to address the critical incident.

Table 2.2: An Ideal Scenario for a Youth's Initial Point of Entry into Mental Health Services

A youth has an incident that is typically identified by an adult within one of the major youth serving or law enforcement agencies (or by a parent) as a significant concern warranting external support.

- Step 1. **Diagnostic Formulation**
Depending on the nature of the event, one or more diagnostic activities are conducted.
- Step 2. **Determination of Eligibility**
Youth and family are evaluated to determine the adequacy of financial resources needed to support the treatment plan. Case management should be implemented here or at the interagency coordination stage and should continue through followup and monitoring.
- Step 3. **Interagency Coordination**
Agencies, youth, and families convene to discuss support for eligible youth with agency partners determining their respective level of support for treatment.
- Step 4. **Treatment Plan**
A treatment plan is developed based on the diagnostic impressions and on input from the youth and family.
- Step 5. **Treatment Implementation**
Treatment services such as home and/or community support (preferred); individual, group, and/or family therapy; special education; medication; or residential treatment are implemented.

Step 6. **Follow-up/Monitoring**

This process keeps track of treatment progress and ensures a measure of quality control.

Step 7. **Aftercare Services and Supports**

This process provides supports and service to youth after treatment is completed, if necessary, to ensure that the youth sustains progress

(End of Table 2.2)

Treatment Interventions

It should be noted initially that youth with mild to moderate mental health needs may need minimal or no supports. There are, however, several effective treatment options open to those youth with MHN who do access treatment. This section provides a brief overview of the mental health services that youth may access as part of their treatment plans. The descriptions are not intended to imply a perspective on treatment effectiveness or to cover the multiple aspects of the treatment modalities, but instead to orient youth service professionals to the organization of treatment services for youth.

Home-Based Services. The major goal of home-based services is to maintain the youth at home and prevent an out-of-home placement (i.e., in foster care or in residential or inpatient treatment). Home-based services are usually provided through the child welfare, juvenile justice, or mental health systems. Home-based services are also referred to as in-home services, family preservation services, family-centered services, family-based services, or intensive family services. The services are tailored to the individual needs of families.

Community-Based Interventions. Since the 1980s, community-based interventions have become more widespread within the youth mental health treatment continuum. These interventions seek to provide a range (mild to intensive) of clinical and social supports to create a network of services for youth and families within their community. Community-based interventions may include services such as case management, home-based services, respite services, wraparound approaches, therapeutic foster care, therapeutic group homes, and crisis services.

School-Based Mental Health Services. School-based treatment and support interventions are designed to identify emotional disturbances and to assist parents, teachers, and counselors in developing comprehensive strategies for addressing these disturbances. School-based services may include wraparound services such as counseling or other school-based programs for emotionally disturbed children, adolescents, and their families within the school, home, and community environment. For example, “community schools” have partnerships

between the school and other community resources, with an integrated focus on academics, services, and supports (such as in-school mental health services) that ultimately lead to improved student learning, stronger families, and healthier communities. (More information on community schools is available from the Coalition for Community Schools at <<http://www.communityschools.org>>.)

Outpatient Treatment and Intensive Outpatient Treatment. This is one of the most common types of mental health treatment and simply refers to the mode of service delivery in which the youth and family visit an office for treatment while living in a home environment. This intervention covers a large variety of therapeutic approaches, with most falling into the broad theoretical categories of cognitive, interpersonal, and behavioral psychotherapy.

Medication Treatment. Medication treatment refers to the use of drugs to treat a range of emotional, behavioral, and mental disorders in children. Mental health experts recommend the following: (1) A comprehensive evaluation by a qualified mental health professional with expertise in diagnosing and treating children and youth should be conducted prior to initiating treatment; and (2) This treatment should be part of an integrated and comprehensive treatment plan (which might include behavior management techniques or behavioral rehabilitation services) developed cooperatively with the youth and family.

Partial Hospitalization and Day Treatment. Partial hospitalization is a specialized and intensive form of treatment that is less restrictive than inpatient care but is more intensive than the usual types of outpatient care (i.e., individual, family, or group treatment). The most common type of partial hospitalization is an integrated program combining education, counseling, and family interventions. The setting may be a hospital, school, or clinic and may be tied to the type of treatment recommended for the youth. Partial hospitalization has also been used as a transitional service after either psychiatric hospitalization or residential treatment at the point when the youth no longer needs 24-hour care but is not ready to be integrated into the school system or community. It may also be used to prevent inpatient placement.

Residential Treatment Centers. Residential treatment centers (RTC) are the second most restrictive form of care (next to inpatient hospitalization) for youth with severe mental disorders. A residential treatment center is a licensed 24-hour facility (although not licensed as a hospital), which offers mental health treatment. The period of treatment at RTCs can range from brief placements of a few weeks to longer-term treatment of several months. The type of treatment provided at an RTC can vary greatly. The more common treatments include individual psychotherapy, psychoeducation (e.g., educating the youth and family about his or her MHN and about treatment options), behavioral management, group therapies, medication management, and peer-cultural therapies. Settings for RTCs can range from formal or structured environments that resemble psychiatric hospitals to those that are more like group homes or halfway houses.

Inpatient Treatment. Inpatient treatment (or hospitalization) is the most restrictive and expensive type of care in the continuum of mental health services for children and adolescents. Inpatient treatment typically refers to clinical care provided on a 24-hour basis in a hospital setting.

Case Management. Case management is an important and widespread component of mental health services, especially for children with serious emotional disturbances. The main purpose of case management is to coordinate the provision of services for individual children and their families who require services from multiple service providers. Case managers take on roles ranging from brokering services to linking with and advocating for services that families need. There is a considerable amount of variation in case management models. In the wraparound model, case managers involve families in a participatory process of developing an individualized plan focusing on individual and family strengths in multiple life domains.

Treatment plans and services need to be factored into a youth's career planning process as appropriate. For example, workforce development counselors, transition specialists from the public schools, vocational rehabilitation counselors, youth service provider staff, and other youth service practitioners who are working with youth and families to develop a career plan should be involved in several of the stages depicted in Table 2.2. These stages may include determination of eligibility, financial resources needed for services, interagency coordination, treatment implementation, follow-up and monitoring, and aftercare services and supports.

The Transition Cliff

In addition to service tunnels, youth encounter a "transition cliff" when they age out of youth systems and attempt to access adult services. Many youth systems end at age 18 and others when the youth reaches age 22, which means a youth could simultaneously be a youth in one system and an adult in another. The adult systems of education, mental health, Social Security, vocational rehabilitation, and workforce development often have different terminology, eligibility requirements, and service options than those of the corresponding youth systems. This disconnect can result in consequences such as termination of services and lost progress in career planning.

Linked to the transition cliffs in government-funded youth and adult service systems are transition cliffs in the private sector that further complicate matters. For example, youth ages 19 to 29 comprise a disproportionately large share of people without health insurance. Many young people lose health coverage under their parents' insurance policies (as well as under Medicaid and the federal Children's Health Insurance Program, CHIP) when they reach the age of 19 or graduate from high school or college.

The education, mental health, and Workforce Investment Act (WIA) systems are good examples of the transition cliff. Some youth with mental health needs are identified and diagnosed when they are in school. As a result of a youth's diagnosis, an Individualized Educational Program (IEP) is developed that includes specific academic goals, strategies, accommodations, and behavioral interventions. Wraparound approaches such as psychiatric counseling, youth mental health services, job coaches, or residential placements may also be part of the IEP and may be paid for by the school system. Meetings of school staff, parents, youth, mental health specialists, and other service providers are convened to monitor and update the youth's IEP as needed, and a school psychologist or staff member will facilitate arrangements for approved support services. When youth exit the school system, usually between the ages of 16 and 22, their IEPs legally do not follow them (although a quality transition plan can do much to bridge the cliff).

Mental health services for children and youth usually terminate at age 18 or 22, depending on the program. Adult mental health service options vary widely among jurisdictions and may be severely limited in rural areas. Because of high demand, eligibility is often limited to those with the greatest need, and long waiting lists for services through the mental health agency in the local health department are not unusual. Youth who do not qualify for subsidized services or who are on the waiting list will find that they must pay for expensive services such as emergency hospital care, residential and day programs, substance abuse programs, and psychiatric counseling. Even if the youth qualifies for subsidized services through the mental health agency, funds are limited, especially under state guidelines that set expenses at specified amounts based on the diagnosis and treatment options. Transportation to and from services is usually the responsibility of the youth. Medicaid and TANF may cover transportation costs for eligible youth for some mental health services from qualified providers.

A number of services may be provided to youth under WIA. Services under WIA Title I for youth ages 14 to 21 are delivered via service providers whose programs have been approved by the local Workforce Investment Board (WIB) to prepare youth for the needs of the local labor market. Eligibility requirements are based on income and on the existence of barriers to employment such as disabilities. Youth activities may include tutoring and study skills training, GED programs, summer employment opportunities, paid and unpaid work experiences, occupational skills training, leadership development opportunities, supportive services, adult mentoring, follow-up services, and guidance and counseling services. Youth activities and programs are provided at the youth provider's location, which may be in public schools, on job sites, at community colleges, or at adult education or GED locations. Youth who are 18 or older may qualify for both youth and adult services. The goal is for youth to leave the youth programs with one or more of the following achievements: (1) significant gains in

literacy and numeracy, (2) attainment of a degree or certificate, or (3) placement in employment, advanced training, or education.

WIA Title I also includes Job Corps, a federally administered program providing academic and occupational training in a residential setting to youth ages 16 to 24. In addition to age limits, eligibility requirements are also based on income and barriers, and the upper age limits may be waived for eligible youth with disabilities.

Adult literacy programs funded under WIA Title II provide basic education instruction in a variety of program settings to individuals over the age of 16 who are not currently enrolled in school and who lack a high school diploma or the basic skills to function effectively in the workplace.

WIA Title IV incorporates the Rehabilitation Act of 1973, which funds state rehabilitation agencies, supported employment services, and independent living centers. State rehabilitation agencies provide employment preparation services to individuals who have a physical or mental impairment that results in a substantial impediment to employment, who are able to benefit from services, and who require vocational rehabilitation in order to secure employment. There are no statutory age requirements for service, which may be set by states or state regions. Supported employment provides on-going workplace supports to individuals with the most significant disabilities. These services may include recruitment, workplace training, transportation, counseling, and independent living. Age is not specified for supported employment. Independent Living Centers help people with disabilities maximize opportunities to live independently in the community. Centers can provide employment-related support, but actual training or education is not typically provided. Centers set their own age requirements.

In contrast to WIA youth programs, the goal of WIA Title I adult services is employment via the services of a One-Stop Career Center. Core services are available to all adults 21 and older and include self-directed job searches using computerized and on-site resources, career interest surveys and job-matching software, computer tutorials on topics such as preparing a resume and cover letter, and basic job search orientations. Adults who have difficulty finding a job may qualify for “intensive services” based on income and employment barriers. Intensive services may include comprehensive and specialized assessments of skill levels and service needs, in-depth interviewing, evaluation to identify employment barriers and goals, seminars and training in job search techniques, and one-on-one counseling by One-Stop Career Center staff. Adults who are unsuccessful in finding a job after receiving intensive services may be eligible for short-term job training based on priorities established by the local Workforce Investment Board.

The transition from a system where services are provided via an Individualized

Education Program in school or through a youth service provider program to an adult system with different eligibility requirements and self-directed activities can be traumatic. *This is especially true for youth with mental health needs in workforce development programs, who are less likely than others to disclose their disability because they wish to avoid being stigmatized or labeled.* Youth with hidden disabilities may enroll and enter educational, training, and employment programs without communicating their disability and needs for accommodations and special assistance.

As discussed in Chapter 1, the nature of hidden disabilities makes identifying and accessing needed interventions and supports more difficult. Additionally, parents and youth service professionals often have an inadequate understanding of the nature of hidden disabilities or of useful accommodations. Awareness of service tunnels and the transition cliff on the part of policymakers, administrators, and youth service practitioners is the first step in creating service delivery systems that will serve youth and adults more effectively.

Table 2.3: The Transition Cliff For Youth With Disabilities

(Ages at which youth services terminate)

Vocational Rehabilitation: 17 to 26

Job Corps: *

Youth Build: 24

Special Education: 16 to 22

WIA: 18 to 22

Development Disabilities: 22

Mental Health: 18 or 22

Foster Care: 18 or 22

Medicaid: 18 or 22

TANF: 18 or 19

Social Security: 18

This table lists the ages at which youth services terminate in several federally funded programs. For example, if a program serves youth age 14 to 21, the termination date would be age 22. End dates may vary between and among states and localities based on the service options provided and on youth needs.

* The age limit for services in Job Corps (usually 25 or 26) may be waived for youth with disabilities.

(End of Table 2.3)

Please see Appendix B for the list of references.

Exhibit 2.1: Supporting Research

The Center for Mental Health Services has identified a number of effective, evidence-based practices for young adults and adults including the following: (1) Illness Management and Recovery, which helps people manage their mental illness by setting personal goals and developing day-to-day action strategies; (2) Customized Assertive Community Treatment, which actively involves the community in supporting people with mental illness so that they stay out of the hospital and function effectively in the local community; (3) Supported Employment that helps people find and keep competitive employment and integrates on-the-job support strategies with mental health services; (4) Family Psychoeducation, which is a partnership among consumers, families, supporters, and practitioners, in which individuals and their families learn about and discuss mental health needs and treatment options; and 5) Integrated Dual Diagnosis Treatment for people who have both mental illness and a substance abuse problem, in which treatment for both conditions is provided at the same time and in the same setting rather than in separate programs (Center for Mental Health Services, n.d.).

The SOC philosophy is based on principles of interagency collaboration; individualized, strengths-based care practices; cultural and linguistic competence; community-based services; and full participation of families, including youth, at all levels of the system (National Clearinghouse on Child Abuse and Neglect Information, 2005).

Connecting schools and transition programs with social service agencies in order to negotiate and coordinate services is termed a wraparound model (Stroul, 1993), and it emphasizes four overarching principles: (a) Services should be individualized, based on the specific needs of the youth with MHN and his or her family; (b) Services should be family-centered and involve families in all aspects of planning and treatment; (c) Services should be community-based and provided in the least restrictive environment; and (d) Services should be culturally and linguistically competent, and sensitive to cultural and ethnic values (Burns, Hoagwood, & Maultab, 1998).

The wraparound philosophy and resulting approaches differ further from the traditional service delivery system in that they (a) focus on the strengths of the individual and his or her family, (b) are driven by the needs of the individual as opposed to the needs of agencies, (c) deal with all aspects of the individual's life, and (d) provide services and support for the individual in natural settings and use social networks such as family and friends. The wraparound approach is fully consistent with transition planning in that it requires interagency teams to be outcome oriented and to use resources in

flexible and creative ways to meet the transition needs and goals of youth with MHN (Eber, 1996).

Of the 4.3 million teens who received mental health treatment in 2001, about 2 million were served by school-based health services; an equal number received specialty health services, and about 332,000 were served in residential or in-patient settings. These numbers represent only about a third of those who needed mental health services, and service use dropped as youth move into the adult world (Gralinkski-Bakker, Hauser, Billings, Allen, Lyons Jr., & Melton, 2005, p. 1).

Outpatient psychotherapy is the most common form of treatment for children and adolescents and is used annually by an estimated 5% to 10% of children and their families in the United States (Burns, Hoagwood, & Maultab, 1998). Although used by a relatively small percentage (8%) of treated youth, nearly one-fourth of the national outlay on child mental health is spent on care in residential treatment settings (Burns, Hoagwood, & Maultab, 1998).

Despite the varied and intense service needs of youth with MHN, few in this population will receive services from community-based agencies, connections that may be critical to transition success. Moreover, social and mental health services too often are offered slowly, ineffectively, and inefficiently (Burns, 1999; Burns, Hoagwood, & Maultab, 1998; Burns, Hoagwood, & Mrazek, 1999; Kutash & Rivera, 1996; Smith & Cuthino, 1997).

Collins, Schoen, Tenney, Doty, & Ho (2004) found that youth ages 19 to 29 comprise a disproportionately large share of people without health insurance. Many young people lose health coverage under their parents' insurance policies (as well as under Medicaid and the federal Children's Health Insurance Program, CHIP) when they reach the age of 19 or graduate from high school or college.

Please see Appendix B for the list of references.

Chapter 3: Implications for Practice

Purpose

This chapter focuses on issues at the direct service level and provides information on

- the Guideposts for Success for Youth with Mental Health Needs,
- youth entering a workforce development program,
- the determination of whether a youth has a mental health need,
- the signs of potential mental health needs in adolescents,
- mental health screenings,
- culturally and linguistically competent practices,
- transition strategies and accommodations for youth with MHN,
- supported education and supported employment, and
- promising and effective practices for serving youth with MHN.

As noted in the previous chapter, uncoordinated service tunnels and the transition cliff between youth and adult services pose significant challenges to transitioning youth; however, these are not insurmountable obstacles, as John's story on the next page illustrates.

Eliminating the tunnels and cliffs that characterize transition services for youth, including those with MHN, will take a major systems change effort. Meanwhile, youth service practitioners must assist youth in preparing for the adult world without getting lost in a tunnel or falling off a cliff. This will require a concerted effort in getting to know what other systems may provide, making contacts within those systems, and coordinating services. Knowing what youth need in order to succeed in the transition process is critical, especially for youth with mental health needs.

The Guideposts For Success

Built on 30 years of research and experience, NCWD/Youth in collaboration with the ODEP created the *Guideposts for Success*, a comprehensive framework that identifies what all youth, including youth with disabilities, need to succeed during the critical transition years.

An extensive literature review of research, demonstration projects, and effective practices covering a wide range of programs and services — including lessons from youth development, quality education, workforce development, and the child welfare system — has identified core commonalities across disciplines, programs, and institutional settings. The review points out that all youth,

particularly at-risk youth such as youth with mental health needs and other youth with disabilities, achieve better outcomes when they have access to

- high quality standards-based education, whether they are in or out of school;
- information about career options and exposure to the world of work, including structured internships;
- opportunities to develop social, civic, and leadership skills;
- strong connections to caring adults;
- access to safe places to interact with their peers; and
- support services and specific accommodations to allow them to become independent adults.

The *Guideposts* provide the foundation for this guide and are built on the following basic values:

- high expectations for all youth, including youth with disabilities;
- equality of opportunity for everyone, including nondiscrimination, individualization, inclusion, and integration;
- full participation through self-determination, informed choice, and participation in decision-making;
- independent living, including skill development and long-term supports and services, where necessary;
- competitive employment and economic self-sufficiency, with or without supports; and
- individualized transition planning that is person-driven and culturally and linguistically appropriate.

(Sidebar) John's Story

John was in his mid-20s with a diagnosis of paranoid schizophrenia and drug and alcohol abuse. He had not been able to maintain employment, had lost the support of his family, and was living at the YMCA after a period of homelessness. He had numerous hospitalizations and arrests, including several periods of incarceration, brought about by drug and alcohol use and failure to comply with his treatment. John was a Supplemental Security Income (SSI) recipient and was considered to have a severe disability. He was a high school graduate but had few marketable skills.

John was referred by his Community Treatment Team (CTT) case manager to a two-week pilot project on employment and opportunity operated by Vocational Rehabilitation (VR). (A Community Treatment Team is made up of experts in the areas in which a person with MHN might need help, such as housing, transportation, substance abuse treatment, employment, or family counseling.) Although he initially appeared bored and uninterested, John became more

engaged, completed the program, and expressed an interest in employment assistance. A comprehensive rehabilitation plan was developed, including 24 weeks of training in data and word processing and in job seeking skills, counseling and guidance from the VR counselor, treatment and medication through the community treatment program, Alcoholics and Narcotics Anonymous counseling, transportation assistance, and job placement.

John was placed at a local copying company in a part-time position making \$8.00 an hour. With support from his VR counselor and members of the pilot project group, he began working full-time at \$8.75 an hour. At the end of 90 days, he had moved up to a quasi-managerial position earning \$12.00 an hour plus health benefits. As problems arose, John discussed them with his VR counselor and CTT case manager. One of the problems he encountered was that his SSI representative encouraged him to quit the program and then the job so he would not lose his benefits rather than providing the encouragement and support he needed.

Three years later, John has had one in-patient hospitalization but is now a manager with the same company. He also has an apartment, a car, a significant other, and a positive outlook for his future.

As this story illustrates, life throws many challenges in the paths of youth with mental health needs, but when individuals and their families can't go it alone, effective cross-agency programming and supports can lead to positive outcomes.

(Excerpted from Dew, D. W., & Alan, G. M. (Eds.). (2005). Case Study II. Institute on Rehabilitation Issues Monograph No. 30. Washington, DC: The George Washington University, Center for Rehabilitation Counseling Research and Education.)

(End of Sidebar)

Table 3.1, *The Guideposts for Success for Youth with Mental Health Needs* incorporates all the elements of the original *Guideposts* for all youth and youth with disabilities as well as the additional specific needs of youth with MHN regardless of whether they have been identified and/or are receiving mental health services.

Table 3.1: Guideposts For Success For Youth With Mental Health Needs

1. School-Based Preparatory Experiences

Specific Needs

In order to perform at optimal levels in all education settings, all youth need to

participate in educational programs grounded in standards, clear performance expectations and graduation exit options based upon meaningful, accurate, and relevant indicators of student learning and skills. These should include

- academic programs that are based on clear state standards;
- career and technical education programs that are based on professional and industry standards;
- curricular and program options based on universal design of school, work and community-based learning experiences;
- learning environments that are small and safe, including extra supports such as tutoring, as necessary;
- supports from and by highly qualified staff;
- access to an assessment system that includes multiple measures; and
- graduation standards that include options.

In addition, youth with disabilities need to

- use their individual transition plans to drive their personal instruction, and strategies to continue the transition process post-schooling;
- access specific and individual learning accommodations while they are in school;
- develop knowledge of reasonable accommodations that they can request and control in educational settings, including assessment accommodations; and
- be supported by highly qualified transitional support staff that may or may not be school staff.

Because of the episodic nature of mental health disabilities, youth with mental health needs require educational environments that are flexible and stable and that provide opportunities to learn responsibilities and become engaged and empowered. These youth may need additional educational supports and services such as

- comprehensive transition plans (including school-based behavior plans) linked across systems, without stigmatizing language, that identify goals, objectives, strategies, supports, and outcomes that address individual mental health needs in the context of education;
- appropriate, culturally sensitive, behavioral and medical health interventions and supports;
- academically challenging educational programs and general education supports that engage and re-engage youth in learning;
- opportunities to develop self-awareness of behavioral triggers and reasonable accommodations for use in educational and workplace settings; and
- coordinated support to address social-emotional transition needs from a highly qualified, cross-agency support team (e.g., wraparound team), which includes health, mental health, child welfare, parole/probation professionals, relevant case managers, and natural supports from family,

friends, mentors, and others.

2. Career Preparation & Work-Based Learning Experiences

Specific Needs

Career preparation and work-based learning experiences are essential in order for youth to form and develop aspirations and to make informed choices about careers. These experiences can be provided during the school day or through after-school programs and will require collaboration with other organizations. All youth need information on career options, including

- career assessments to help identify students' school and post-school preferences and interests;
- structured exposure to postsecondary education and other life-long learning opportunities;
- exposure to career opportunities that ultimately lead to a living wage, including information about educational requirements, entry requirements, income and benefits potential, and asset accumulation; and
- training designed to improve job-seeking skills and work-place basic skills (sometimes called soft skills).

In order to identify and attain career goals, youth need to be exposed to a range of experiences, including

- opportunities to engage in a range of work-based exploration activities such as site visits and job shadowing;
- multiple on-the-job training experiences, including community service (paid or unpaid), that is specifically linked to the content of a program of study and school credit;
- opportunities to learn and practice their work skills ("soft skills"); and
- opportunities to learn first-hand about specific occupational skills related to a career pathway.

In addition, youth with disabilities need to

- understand the relationships between benefits planning and career choices;
- learn to communicate their disability-related work support and accommodation needs; and
- learn to find, formally request, and secure appropriate supports and reasonable accommodations in education, training, and employment settings.

Because some youth with mental health needs may feel their employment choices are limited or may not understand the value of work in recovery, they need connections to a full range of youth employment programs and services such as

- graduated (preparatory, emerging awareness, proficient) opportunities to gain and practice their work skills ("soft skills") in workplace settings;

- positive behavioral supports in work settings;
- connections to successfully employed peers and role models with mental health needs;
- knowledge of effective methods of stress management to cope with the pressures of the workplace;
- knowledge of and access to a full range of workplace supports and accommodations such as supported employment, customized employment, job carving, and job coaches; and
- connections as early as possible to programs and services (e.g., One-Stop Career Centers, Vocational Rehabilitation, Community Rehabilitation Programs) for career exploration provided in a non-stigmatizing environment.

3. Youth Development & Leadership

Specific Needs

Youth development is a process that prepares young people to meet the challenges of adolescence and adulthood through a coordinated, progressive series of activities and experiences which help them gain skills and competencies. Youth leadership is part of that process. In order to control and direct their own lives based on informed decisions, all youth need the following:

- mentoring activities designed to establish strong relationships with adults through formal and informal settings;
- peer-to-peer mentoring opportunities;
- exposure to role models in a variety of contexts;
- training in skills such as self-advocacy and conflict resolution;
- exposure to personal leadership and youth development activities, including community service; and
- opportunities that allow youth to exercise leadership and build self-esteem.

Youth with disabilities also need

- mentors and role models including persons with and without disabilities; and
- an understanding of disability history, culture, and disability public policy issues as well as their rights and responsibilities.

Some youth with mental health needs may be susceptible to peer pressure, experiment with antisocial behaviors or illegal substances, and/or attempt suicide as a manifestation of their disability and/or expression of independence. To facilitate positive youth development and leadership, these youth need

- meaningful opportunities to develop, monitor, and self-direct their own treatment, recovery plans, and services;
- opportunities to learn healthy behaviors regarding substance use and avoidance, suicide prevention, and safe sexual practices;
- exposure to factors of positive youth development such as nutrition,

- exercise, recreation and spirituality;
- an understanding of how disability disclosure can be used pro-actively;
- an understanding of the dimensions of mental health treatment including medication maintenance, outpatient and community-based services and supports;
- an understanding of how mental health stigma can compromise individual health maintenance and appropriate engagement in treatment and recovery;
- continuity of access to and an understanding of the requirements and procedures involved in obtaining mental health services and supports as an independent young adult;
- strategies for addressing the negative stigma and discrimination associated with mental health needs including cultural, racial, social, and gender factors;
- opportunities to develop meaningful relationships with peers, mentors, and role models with similar mental health needs;
- exposure to peer networks and adult consumers of mental health services with positive treatment and recovery outcomes;
- social skills training and exposure to programs that will help them learn to manage their disability/ies; and
- opportunities to give back and improve the lives of others, such as community service and civic engagement.

4. Connecting Activities

Specific Needs

Young people need to be connected to programs, services, activities, and supports that help them gain access to chosen post-school options. All youth may need one or more of the following

- mental and physical health services;
- transportation;
- tutoring;
- financial planning and management;
- post-program supports through structured arrangements in postsecondary institutions and adult service agencies; and
- connection to other services and opportunities (e.g., recreation, sports, faith-based organizations).

In addition, youth with disabilities may need

- acquisition of appropriate assistive technologies;
- community orientation and mobility training (e.g., accessible transportation, bus routes, housing, health clinics);
- exposure to post-program supports such as independent living centers and other consumer-driven community-based support service agencies;
- personal assistance services, including attendants, readers, interpreters,

- or other such services; and
- benefits-planning counseling including information regarding the myriad of benefits available and their interrelationships so that they may maximize those benefits in transitioning from public assistance to self-sufficiency.

Some youth with mental health needs may require a safety net accepting of the boundary pushing that is part of identity development and may include additional and more intense connections to information, programs, services, and activities that are critical to a successful transition. These youth may need

- an understanding of how to locate and maintain appropriate mental health care services, including counseling and medications;
- an understanding of how to create and maintain informal personal support networks;
- access to safe, affordable, permanent housing, including options such as transitional and supported housing;
- access to flexible financial aid options for postsecondary education not tied to full-time enrollment;
- policies and service practices that provide a safety net for fluctuations in a youth's mental health status;
- case managers (e.g., health care, juvenile justice, child welfare) who connect and collaborate across systems; and
- service providers who are well-trained, empathetic, and take a holistic approach to service delivery.

5. Family Involvement & Supports

Specific Needs

Participation and involvement of parents, family members, and/or other caring adults promote the social, emotional, physical, academic, and occupational growth of youth, leading to better post-school outcomes. All youth need parents, families, and other caring adults who have

- high expectations that build upon the young person's strengths, interests, and needs and fosters their ability to achieve independence and self-sufficiency;
- been involved in their lives and assisting them toward adulthood;
- access to information about employment, further education and community resources;
- taken an active role in transition planning with schools and community partners; and
- access to medical, professional, and peer support networks.

In addition, youth with disabilities need parents, families, and other caring adults who have

- an understanding of their youth's disability and how it affects his or her education, employment, and/or daily living options;
- knowledge of rights and responsibilities under various disability-related legislation;

- knowledge of and access to programs, services, supports, and accommodations available for young people with disabilities; and
- an understanding of how individualized planning tools can assist youth in achieving transition goals and objectives.

Youth with mental health needs also need parents, families, and/or other caring adults who

- understand the cyclical and episodic nature of mental illness;
- offer emotional support;
- know how to recognize and address key warning signs of suicide, the co-occurring relationship between substance abuse and mental health needs, and other risky behaviors;
- monitor youth behavior and anticipate crises without becoming intrusive;
- understand how the individualized plans across systems can support the achievement of educational and employment goals;
- access supports and professionals to help navigate the interwoven systems such as mental health, juvenile justice, and child welfare;
- access supports and resources for youth with mental health needs, including emergency contacts and options for insurance coverage;
- extend guardianship past the age of majority when appropriate; and
- have access to respite care.

(End of Table 3.1)

The *Guideposts for Success* are particularly helpful for youth service practitioners serving youth with mental health needs. As noted in Chapter 1, youth with mental health needs may not be properly diagnosed, if they are diagnosed at all, especially during the teenage years when it is sometimes difficult to distinguish between (1) a mental health issue; (2) typical anxiety experienced by youth, particularly if those feelings are not behaviorally expressed; and (3) substance abuse, which may be a secondary issue that many youth with mental health needs may experience. Youth with MHN may not have a stable base of support, or any support, which hampers their successful transition from adolescence to adulthood, especially given the stigma associated with mental illness.

The likelihood for economic stability and success is increased for youth with MHN if an intentional, integrated, and well-coordinated set of supports is in place, a sort of unconditional safety net. The *Guideposts* point the way to providing those supports. It should also be noted that the *Guideposts for Success for Youth with Mental Health Needs* are in perfect alignment with the National Consensus Statement on Mental Health Recovery described in Table 3.2.

Table 3.2: National Consensus Statement on Mental Health Recovery

The Substance Abuse and Mental Health Services Administration and the Interagency Committee on Disability Research, in partnership with six other federal agencies, have defined mental health recovery as follows:

“Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.”

The ten fundamental components of recovery identified by the interagency group are

- Self-Direction
- Individualized and Person-Centered
- Empowerment
- Holistic
- Non-Linear
- Strengths-Based
- Peer Support
- Respect
- Responsibility
- Hope

“Mental health recovery not only benefits individuals with mental health disabilities by focusing on their abilities to live, work, learn, and fully participate in our society, but also enriches the texture of American community life. America reaps the benefits of the contributions individuals with mental disabilities can make, ultimately becoming a stronger and healthier Nation.”

Source: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services website; available online at <http://www.mentalhealth.samhsa.gov/publications/allpubs/sma05-4129/>.

(End of Table 3.2)

There are several aspects of the *Guideposts* that merit particular attention from youth service practitioners who support youth with MHN.

Academic Instruction. Effective instructional approaches for youth with mental health needs, who may be easily distracted or upset in class, must include a clarification of instructional goals and the teaching of academic content in clear and discrete units of instruction. Structured teaching procedures, such as advance planning, problem solving, repeated practice and review, and universal access and Universal Design for Learning, are also effective for youth with MHN. Teaching approaches and transition planning should also incorporate opportunities for youth to develop an awareness of accommodations that are

appropriate in an educational setting so that they may develop skills to advocate for such accommodations in future educational settings.

Career Assessment. Many youth, including those with MHN, do not have the knowledge or experiences to make an informed choice about career goals, training programs, or employment. Accordingly, interest inventories and career assessments should be used as one part of a transition planning process that includes a number of activities such as interviews, work experiences, record reviews, and behavioral observations.

Additionally, the 1992 Amendments to the Rehabilitation Act called for the following: (1) persons with disabilities to be involved to the maximum extent possible as informants on their unique skills and needs in the rehabilitation process; and (2) the “match” between the person and the job requirements, possible adaptations, and available supports to be assessed in the settings (including work settings) into which individuals may be placed.

Career Exploration. Youth with MHN should have varied job experiences in order to make decisions about their career goals. An “appropriate” competitive job
is consistent with the youth’s stated career interests (which often change as he or she gains work experience);
can be performed legally by the young person (i.e., is within the parameters of job placement for minors dictated by federal and state rules);
fits within the youth’s school and life schedule;
is accessible given the individual’s personal mode of transportation (e.g., bicycle, city bus, car, car pool); and
provides ongoing support, if necessary, for antisocial behaviors or lack of job-related social skills.

Graduated opportunities (i.e., those that move from emerging awareness, through preparatory training, to proficiency) to learn and practice soft skills and technical skills for work place settings should be provided. The general rules in providing job support to youth with MHN in a competitive job are to *provide that support in such a way as to maximize the likelihood that the student will succeed on the job, and to provide that support in a manner that is least intrusive to the job site and is as “normal” as possible.* Positive behavioral supports that replace negative behaviors with appropriate ones can provide an approach for doing so.

Youth Development. Involvement in youth development and leadership activities is especially valuable for youth with disabilities, including those with MHN, who are often left out of mainstream programs and activities such as service organizations, sports, and clubs. NCWD/Youth defines *youth development* as a process that prepares young people to meet the challenges of adolescence and adulthood through a coordinated, progressive series of

activities and experiences that help them to become socially, morally, emotionally, physically, and cognitively competent. Positive youth development addresses the broader developmental needs of youth, in contrast to deficit-based models that focus solely on youth problems. The connection to a permanent family member, other significant adult, and/or peer support is a critical element in the equation for success.

Youth Leadership. NCWD/Youth has adopted a two-part working definition of youth leadership: (1) “The ability to guide or direct others on a course of action, influence the opinion and behavior of other people, and show the way by going in advance” (Wehmeyer, Agran, & Hughes, 1998); and (2) “The ability to analyze one’s own strengths and weaknesses, set personal and vocational goals, and have the self-esteem to carry them out. It includes the ability to identify community resources and use them, not only to live independently, but also to establish support networks to participate in community life and to effect positive social change” (Adolescent Employment Readiness Center, Children’s Hospital, n.d.).

Effective youth leadership programs offer a number of activities such as mentoring, community service, real life problem solving (e.g., researching a community problem and implementing an action plan to address it), and the development of personal career plans. They also involve youth in all aspects of organizational administration (including the board of directors) and hands-on decision-making in planning, budgeting, implementing, and evaluating programs. A number of publications from NCWD/Youth address youth leadership issues and can be accessed on its website.

The National Youth Development Board for Mental Health Transformation’s draft framework for active youth involvement at the individual, community, and policy-making levels can be found in Exhibit 3.2. Its goal is to provide leadership and education opportunities for youth to have a decision-making role in their own lives as well as in the policies and procedures governing care in the community, state, and nation. The framework describes a process for the progressive growth of leadership skills — one that is fun as well as meaningful.

Self-Determination. Historically, persons with disabilities have not been taught decision-making or self-advocacy skills and have not been encouraged to exercise those abilities. Self-determination skills are especially important in order for an individual to access adult services, civil rights, legal protections, and workplace and educational accommodations. Youth with disabilities who develop self-determination and self-advocacy skills have been found to have improved employment and educational outcomes and are better able to articulate and access their civil rights and accommodation needs. The active involvement of youth in the planning and service delivery of their supports is essential for their development, as is their ability to fail safely.

The task of helping youth with MHN to develop their own transition and life

plans, while at the same time providing the *appropriate* level of support and assistance to them in their efforts, is a critical responsibility of the youth service practitioner. As part of the self-determination process, many youth need help overcoming the stigma attached to mental illnesses and disclosing their disability. (See *The 411 on disability disclosure: A workbook for youth with disabilities*, available on NCWD/Youth's website.) Mentors have been successful in helping youth with and without disabilities meet a number of personal and career goals, such as making informed career choices, developing self-esteem, and accepting responsibility for their actions.

Social Skills Instruction. Social skills are a necessity on and off the job and include communication, team work, and conflict resolution. Despite the critical nature of social skills instruction, it is often not available to youth with disabilities. To be effective in preparing youth with MHN for the work place, social skills instruction must focus on those skills that are both relevant to youth with MHN and applicable to the work setting, and it must present them in the most powerful manner possible, including application-based techniques such as role-playing. Providing youth with MHN with competitive work placements makes it virtually certain that these young people will interact with unfamiliar persons in unfamiliar settings and under unfamiliar rules and expectations. Thus, it is essential to identify the key social skills needed by youth with MHN to succeed in the work setting. This can be done before the placement by reviewing position descriptions and employee manuals, talking to supervisors, and observing interactions in the targeted work place.

Service Coordination. Given the multifaceted nature of youth with MHN, as well as the overall poor transition outcomes of this population, one would expect that these young people would receive services from a number of community-based social service agencies, including mental health. Unfortunately, despite the varied and intense service needs of youth with MHN, few will receive services from community-based agencies — connections that may be critical to transition success — thereby making it difficult for youth with MHN and their family members to establish a coordinated system of services to meet their transition goals. Service coordination and collaboration are major foci of the next chapter.

Connecting to the Right People. Families and youth with MHN must be connected to the right people as well as to useful resources. The right people may include emergency contacts, adult and peer mentors, youth advocates, conflict mediators, and knowledgeable and supportive teachers, administrators, youth service practitioners, and other professionals in a number of organizations and agencies. The right people know how to access resources and services for youth with MHN and their families and can cut through administrative requirements quickly while respecting confidentiality and privacy rights. The Guidelines for Youth Service Practitioners (see Table 3.3 below) highlight key characteristics of effective mental health youth service delivery and therefore complements the material presented in the *Guideposts*.

Table 3.3: Guidelines for Youth Service Practitioners

Clark (1998) identified five guidelines for the transition specialist's [or youth service practitioner's] role and responsibilities when working with youth with mental health needs:

1. Staff must be youth-centered, addressing the strengths, needs, and preferences of the youth with MHN and his or her family members.
2. Services must be individualized, focusing on each person's unique personal, educational, and employment profiles.
3. Staff must provide an "unconditional safety net" of support to the students they serve. This guideline may sound simplistic but is perhaps the most difficult to follow.
4. Transition services must be provided in a manner that ensures continuity of effort and support from the student's perspective. Service delivery decisions should include the youth and his or her family. On a broader scale, transition services should be planned coherently so that there is a continual and appropriate level of support offered to each youth.
5. Services should be outcome-oriented, emphasizing activities that will promote student achievement in education, employment, and independent living and that will prepare each youth to enter the community as successful and contributing adults.

(End of Table 3.3)

When A Youth Enters A Workforce Development Program

The traditional definition of workforce development refers to career and technical education (CTE) and programs funded by the Workforce Investment Act and the Rehabilitation Act, as described in Chapter 2. However, there are other resources that can and should be accessed to support youth, including those with mental health needs. Workforce development, as used in this guide, encompasses not only CTE and WIA-funded programs, but also secondary and postsecondary education, general and special education, Vocational Rehabilitation, One-Stop Career Centers, youth employment programs, community rehabilitation programs, and community-based organizations that

serve youth. Medicaid and mental health funds may be able to support many of the categories of services identified in the *Guideposts* for eligible youth, although community resources may not be plentiful. More comprehensive and effective youth services can be provided by linking the expertise from a wider array of disciplines, funding streams, and agencies. The linking process should be initiated when a youth enters a workforce development program or earlier if the youth receives special education services. (See Chapter 4 for systemic approaches to maximize expertise, funding, and services.)

The transition from youth to adulthood is a lengthy process. Career development and transition often involve a few false starts as youth explore multiple developmental options; these should not be considered failures but rather a natural part of the process toward being able to make informed choices about individual career options. For those youth with disabilities who explore careers through structured programs, the process of transition may involve transferring from one program or service provider to another. Each time a youth begins working in a new program, support services, funding options, and service coordination should be revisited.

It is important to use a person-centered planning approach that includes the active involvement of the youth in developing transition plans, selecting program options, and making informed career decisions. The person-centered planning process is driven by the youth's individual needs and desires. In transition, person-centered planning focuses on the interests, aptitudes, knowledge, and skills of the youth, not on his or her perceived deficiencies. It also involves the people who are active in the life of a youth, including family members, caregivers, educators, and community service professionals.

The purposes of person-centered planning are to identify desires and outcomes that have meaning to the youth and to develop individualized support plans to achieve them. The process closely examines the interests and abilities of each youth in order to establish a basis for identifying employment, training, and career development possibilities. A person-centered career plan identifies marketable job skills and career choices, establishes individual outcome objectives, and maps specific action plans to achieve them. Effective assessment, both formal and informal, can play an important part in this process. (For more information on career assessment, see *Career planning begins with assessment: A guide for professionals serving youth with educational and career development challenges*, available online at <http://www.ncwd-youth.info/resources_&Publications/assessment.html>.)

As the person-centered planning process progresses, youth should take increasing responsibility for researching and making informed career decisions. For this process of self-determination and empowerment to be effective, youth will need a safe environment, support, and training, as well as opportunities to exercise and grow their knowledge and skills. The National Youth Development

Board for Mental Health Transformation's framework for active youth involvement (Exhibit 3.2) describes a progression of leadership skills that moves from youth-guided, to youth-directed, to youth-driven at the individual youth level, the community level, and the policy-making level as the young person transitions into adulthood.

Prior to beginning formal or informal testing or performance reviews, youth service practitioners can gather information by observing and interviewing a youth and by reviewing his or her records. Privacy and confidentiality must be maintained, and securing information from other agencies must be done ethically and legally, using signed consent forms when these are needed. See Exhibit 3.3 for a sample release of records form.

Care should be taken to ensure that forms and procedures comply with applicable federal and state laws and regulations. Federal laws, such as the Family Educational Rights and Privacy Act (Exhibit 4.2) and the privacy rule of the Health Insurance Portability and Accountability Act (Exhibit 4.3), set guidelines regarding the release of educational and health information. State law sets the age of majority (the age at which a person acquires the full legal rights of an adult), which varies from state to state and which determines whether a youth will need a guardian to co-sign legal documents and record releases.

The initial interview should establish rapport with the youth and his or her family, and should help everyone develop a realistic understanding of what an agency has to offer. Personal information about health or disability issues may be part of the interview process and should be handled with tact and sensitivity.

Whether or not to disclose a disability to prospective employers, teachers, or others is an important decision that can have both short and long term ramifications. To help youth understand the complex issues involved, NCWD/Youth has published *The 411 on disability disclosure: A workbook for youth with disabilities*, available at http://www.ncwdyouth.info/resources_&Publications/411.html. This workbook was developed with youth to help young people and the adults who work with them make informed decisions about disclosure. It also shows how these decisions can affect their education, employment, and social lives.

While an interview should not be overly rigid, all youth should be asked essentially the same questions. To comply with nondiscrimination requirements, it is acceptable to ask questions about possible disabilities only if the same initial questions are asked of everyone. Depending on the answer to a given question, there may be a need for follow-up questions to probe for further details. Some questions may uncover a need for testing or referral for additional services.

Exhibit 3.4 is a form that can be adapted for use when interviewing youth who are known or thought to have disabilities. With the youth's permission, many of these questions can also be asked of parents or family members to verify the information provided by the youth. With proper releases, teachers or other adults

who have worked with the youth can also be part of the interview process. Youth service providers, One-Stop Career Centers, and other entities funded by the Workforce Investment Act need to be aware of the nondiscrimination requirements of WIA Section 188. A Section 188 Disability Checklist is available from the Office of Disability Employment Policy in the U.S. Department of Labor to assist in compliance when conducting initial interviews and administering subsequent assessments (available online at <http://www.dol.gov/oasam/programs/crc/section188.htm>). The following elements of the checklist apply specifically to the intake process:

5.1.9 The recipient [of WIA Title I funding] must not impose or apply eligibility criteria that screen out or tend to screen out an individual with a disability or class of individuals with disabilities unless such criteria can be shown to be necessary for the provision of the aid, benefit, service, training, program or activity being offered.

5.1.12 An individual with a disability is not required to accept an accommodation, aid, benefit, service, training, or opportunity that such individual chooses not to accept.

The checklist also requires staff to know and comply with what constitutes legal and illegal inquiries in a pre-employment interview and to ensure that records and medical information are kept confidential:

5.8.3 For employment-related training, does the recipient review selection criteria to ensure that they do not screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying the training unless the criteria can be shown to be necessary for the training being offered?

5.8.4 Does the recipient prohibit pre-employment inquiries and pre-selection inquiries regarding disability? Note: Pre-employment and pre-selection inquiries are permissible if they are required or necessitated by another federal law or regulation.

Family members or caregivers have very important roles in supporting and preparing youth for adulthood. As youth make this transition, there is a natural tendency to seek independence and to rely less and less on parents and other family members. Youth service practitioners must be aware that there is often a tension between a youth's wants and needs and those of the rest of the family as each are defining their new roles: families' role to respect the youth as an emerging adult; youth's role to be respected as an adult; and the role of both to develop agreement on when help is needed and how to receive it. Both the family and the youth may need support in the transition process. Additionally, parents and youth may have different expectations of schools and workforce development programs as well as different access to information about transition

and career planning. All participants in a youth's transition team should have a clear understanding of the ongoing and evolving roles they play in this process.

Youth with no family, from non-traditional family settings, or from families that are not engaged, may not have adults in their lives who can give guidance and support. For example, some youth may live with grandparents, a court-appointed guardian, foster parents, or in homeless shelters. In these cases, extra care must be taken to ensure that the youth has access to caring adults to help make decisions (and sometimes share responsibilities) that are customarily handled by parents or other family members and to increase the information capacity and support of those adults who are involved in the life of the youth.

Determining Whether A Youth Has A Mental Health Need

A youth's records, behavior, assessment results, or interview responses may suggest previously unidentified or undiagnosed problems that may affect career planning and career development. These problems may include low literacy levels, inconsistent academic performance, and limited vocabulary. Learning disabilities, behavior disorders, mental and physical health problems, or other hidden (nonapparent) disabilities may be present. A screening process may be needed to determine whether further diagnostic assessment, conducted by a trained specialist, should be provided.

Determining whether a youth's behavior indicates a mental health need or is a result of the normal, albeit turbulent, process of adolescent development can be challenging. This is particularly important because many youth with mental health needs receiving special education services are identified in elementary school. In spite of their large numbers, youth who develop a mental health need in adolescence are often not identified at all, although some research indicates that several mental health syndromes tend to appear first during that timeframe. Racial bias, language, and cultural factors also affect the accuracy of identifying mental health needs and determining service needs. Therefore, youth service practitioners need to be familiar with the warning signs that may signal a mental health need (Table 3.4 provides a sample list of potential indicators of mental health needs), the culturally and linguistically appropriate screening tools available for determining if further evaluation is necessary, and culturally competent practices. The expertise of practitioners from other agencies is often needed to determine whether a genuine mental health need is present. Collaboration across agencies is essential.

Screening instruments may point to previously undiscovered physical problems (such as vision or hearing loss), academic problems (such as learning disabilities), mental health needs, or substance use problems. Screens should be used only to identify potential problems that require referral for more in-depth

evaluation by a psychologist, physician, or other professional (see Table 3.5). Screens should never be used to classify a youth with a disability or to deny services or program access. Therefore, schools, workforce programs, and service providers should have specific policies about when and how to screen and about the process of referral for further assessment.

Screeners need to be properly trained to be sensitive to developmental, cultural, linguistic, and individual differences among youth in order to accurately estimate the significance of the indicators identified through the screen. Screening instruments should be carefully selected based on their specificity, sensitivity, and positive predictive value as well as their appropriateness for the youth population being served. Active parental consent, in the form of written permission to administer the screen, should be mandatory.

Since some youth may need additional assessment and subsequent treatment as a result of the screening process, the availability of mental health professionals to whom youth may be referred for in-depth diagnosis, as well as the availability of treatment options and follow-up for students who are diagnosed, should also be considered in developing an effective screening program.

Screening programs should be regularly assessed to determine (1) the extent to which youth and families follow through with referrals, (2) the results of mental health assessments and diagnoses, and (3) the relationship between the screens used (and resulting referrals) and the success of youth in education or vocational training. Screening programs should be updated or procedures should be redesigned as needed.

The Columbia University TeenScreen Program has developed three research-based screening instruments that include a general purpose screen for mental health disorders and specific screens for depression and the risk factors of suicide (see Table 3.6). These instruments do not diagnose mental health needs but identify risk factors that may be associated with depression and other mental health needs. Organizations or agencies who become TeenScreen sites must reflect quality principles in their policies and practices, such as those described above, as well as complete a site development process that includes gathering support, developing a plan, and training personnel to administer, score, and interpret screening results.

If, after proper screening and evaluation, a youth is identified as having a mental health need, services may be needed through the mental health system. Career preparation can be an important part of the mental health recovery process, although it may be temporarily interrupted for intensive or initial mental health services for some youth. The importance of proper screening and evaluation cannot be overemphasized – they may be the difference between success and a tragic outcome such as suicide, incarceration, or homelessness for an affected

youth.

Table 3.4: Signs of Potential Mental Illness in Adolescents

There are several indicators that may signal potential mental health needs in youth. One or two alone are not enough to indicate this potential, but combinations of these behaviors coupled with problems getting along with family member or peers or doing well at school may indicate a need for further evaluation.

The National Alliance for the Mentally Ill (NAMI) has identified behaviors that may indicate a mental illness in teenagers:

- truancy, school failure, frequent expulsion from school;
- encounters with the juvenile justice system;
- reckless, accident-prone behavior;
- risky behaviors such as sexual activity or drug and alcohol abuse;
- persistent crying;
- lethargy or fatigue;
- irritability or grouchiness;
- over-reactions to disappointments or failures;
- isolation from friends and family;
- sleep difficulties;
- hyperactivity or agitation;
- separation anxiety;
- panic attacks;
- social phobias;
- sudden weight loss or lack of hygiene;
- repetitive, ritualistic behaviors (hand-washing, counting, writing/rewriting);
- obsessive fears, doubts, or thoughts;
- changes in speech (rapidity, brevity, incoherence);
- changes in behavior (disorganization, pacing, rocking, grimacing);
- delusions, paranoia, or hallucinations;
- lack of motivation;
- flat emotional responses; and
- low self-esteem that may be masked by a “tough” demeanor.

Source: Burland, J. (2003). Parents and teachers as allies: Recognizing early-onset mental illness in children and adolescents (2nd Ed.). Arlington, VA: National Alliance for the Mentally Ill.

See also Chapter 1 of this guide.

(End of Table 3.4)

Table 3.5: Mental Health Screens vs. Evaluations

Mental Health Screen

A brief process or instrument that provides preliminary information on risk factors, behaviors, or other issues that may indicate the presence of a mental health need.

May take as little as 8 to 10 minutes to administer and 5 to 10 minutes to score.

May be administered by properly trained youth service practitioners.

Used to decide if referral for a mental health evaluation is needed.

Mental Health Evaluation

An in-depth evaluation for diagnosing a mental health need and its severity, often requiring a combination of record reviews, assessment instruments, interviews, and observations.

May take days or weeks to collect information and interpret the results.

Must be administered by specialists such as psychologists, psychiatrists, or others with graduate-level training in the mental health discipline.

Used to determine if a disability is present and the level of its severity.

(End of Table 3.5)

Table 3.6: Columbia University TeenScreen Program Tools

Diagnostic Predictive Scales (DPS-2)

- General purpose screen to identify youth with a mental health disorder
- 52-item, computerized interview (via headphones) available in English and Spanish
- For youth ages 9 to 18
- Usually takes 10 minutes to complete
- About 30% of youth are screened “positive” and should be referred to a

- clinician
- Columbia University can also provide information on a more comprehensive diagnostic interview called the Voice DISC

Columbia Depression Scale (CDS)

- Screens for child and adolescent depression
- One page, 22 item, paper and pencil questionnaire
- Usually takes less than 8 minutes to complete
- For youth ages 11 to 17 who read at a 6th grade level or higher
- About 35% of youth are screened “positive” and should be referred to a clinician

Columbia Health Screen (CHS)

- Screens for the risk factors of suicide
- 14 item, paper and pencil questionnaire
- Usually takes 10 minutes to complete
- For youth 11 to 18 who read at a 6th grade level or higher
- About 30% of youth are screened “positive” and should be referred to a clinician

Source: Columbia University TeenScreen Program. (n.d.). Screening instruments. New York, NY: Author. Available online at <http://www.teenscreen.org/cms/content/view/49/78/>.

TeenScreen Quality Principles

- Screening must always be voluntary
- Approval to conduct a screening project must be obtained from appropriate organizational leadership
- All screening staff and volunteers must be qualified and trained
- Confidentiality must be protected
- Youth identified through the screening as needing further evaluations must be offered a referral to an appropriate mental health service provider
- Parents of identified youth must be provided information on the screening results and referral recommendations and provided assistance with securing an appointment with a qualified professional for further evaluation.

Source: Columbia University TeenScreen Program. (n.d.). Principles of quality screening programs. New York, NY: Author. Available online at <http://www.teenscreen.org/cms/content/view/110/143/>.

(End of Table 3.6)

Culturally And Linguistically Competent Practices

America today is characterized by an increasingly diverse array of cultures and languages. This diversity is reflected in different cultural views of mental health issues and career preparation. Some cultures view MHN in much the same manner as physical health needs, while others associate MHN with shame and/or fear. As a result, some families may not consider career preparation as an option for youth with MHN, just as some cultures view women working outside the home in a negative way.

To show respect for cultural beliefs and traditions while providing appropriate career preparation services, youth service practitioners should seek training and resources on culturally and linguistically competent practices. The National Mental Health Information Center suggests that culturally competent practitioners

- be aware and respectful of the importance of the values, beliefs, traditions, customs, and parenting styles of the people they serve;
- learn as much as they can about an individual's or family's culture, while recognizing the influence of their own background on their responses to cultural differences;
- include neighborhood and community outreach efforts and involve community cultural leaders if possible;
- work within each person's family structure, which may include grandparents, other relatives, and friends;
- recognize, accept, and, when appropriate, incorporate the role of natural helpers from the youth's community;
- understand the different expectations people may have about the way services are offered (for example, sharing a meal may be an essential feature of home-based mental health services; a period of social conversation may be necessary before each contact; or access to a family may be gained only through a specific family member such as a grandfather);
- know that many people will need help with problems such as obtaining housing, clothing, and transportation or resolving a problem with a child's school, and work with other community agencies to make sure these services are provided; and
- adhere to traditions relating to gender and age that may play a part in certain cultures (for example, in many racial and ethnic groups, elders are highly respected). With an awareness of how different groups show respect, providers can properly interpret the various ways people communicate.

Youth service practitioners should also create a local reference list of culturally and linguistically relevant contacts and resources to assist the youth they serve. Contacts may be developed through a number of local organizations such as schools, colleges, and universities; faith-based groups; community centers; cultural heritage groups; and businesses that are owned by or that serve members of different cultural groups.

Local resources for addressing clothing, housing, and transportation needs include (1) state and local government offices, such as social services, mental health, housing authority, community services, and transportation; (2) community-based organizations, such as emergency and transitional shelters, Goodwill, the Salvation Army, Catholic Charities, and food and clothes banks; and (3) business and fraternal organizations, such as the Chamber of Commerce, Rotary Club, Lion's Club, and various trade and professional associations, which are often willing to help a young person of any culture.

Transition Strategies For Youth With Mental Health Needs

Youth service practitioners, mental health professionals, other service providers involved in the youth's mental health plan, the family or caregiver, and the youth will need to work closely together to ensure that essential services – as well as needed modifications or accommodations to the career preparation process – are available. An interagency/cross-organizational case management team, as referenced in Table 2.2, is one way to ensure that this process is initiated and implemented.

The interagency team can be particularly helpful in discussing the impact of competitive employment on Supplemental Security Income (SSI) and other disability-related services. Many families are concerned about the loss of these benefits, so benefits counseling may be needed as part of the youth's transition plan in order to ensure that the youth and family members understand any changes in health care, housing, SSI, or other services as a result of employment (T-TAP, 2005).

For many youth with mental health needs, minimal or no modifications will be needed in an organization's usual career preparation process. For other youth with MHN, modifications or accommodations will need to be individually determined. Some youth may need relatively simple modifications, such as the job site accommodations described in Table 3.7.

Modifications and accommodations are of particular concern when placing youth with mental health needs on worksites with employers. Exhibits 3.5A, B, and C contain a profile of an employer who would be receptive and supportive of a youth with MHN on his or her worksite, the Vocational Phase System for supporting a youth with potentially disruptive MHN on a jobsite, and an informal behavior management system that can be implemented by job site supervisors or employers. The materials provided in Exhibits 3.5 are adapted from Bullis and Fredericks (2002) with permission from the publisher.

Table 3.7: Accommodating Youth with Mental Health Needs

Youth with mental health needs may have difficulty in a work environment with activities such as communicating with co-workers or supervisors, concentrating on work assignments, remembering instructions or task sequences, making decisions, dealing with interruptions or changes in routine, problem-solving, and critical thinking skills. The Job Accommodation Network (JAN) can suggest accommodations that comply with the Americans with Disabilities Act and that have been proven effective. Examples of effective workplace accommodations include the following:

An employee had difficulty completing paper work on time because he continually checked and rechecked it. JAN suggested making a checklist for each report and checking off items as they were completed. When he felt the urge to recheck the report, he could do it quickly by using his checklist. JAN also suggested allowing him time off the telephone each day to complete paperwork and file information.

The duties of an employee who had difficulties with concentration and short-term memory included typing, word processing, filing, and answering the telephone. Her accommodations included assistance in organizing her work and a dual headset for her telephone that allowed her to listen to music when not talking on the telephone. This accommodation minimized distractions, increased concentration, and relaxed the employee. Weekly meetings were held with her supervisor to discuss workplace issues and were recorded so the employee could replay the information to improve her memory.

An employee needed to attend periodic work related seminars, but he had difficulty taking effective notes and paying attention in the meetings. JAN suggested that a coworker use a notebook that made a carbon copy of each page written. At the end of the session, the coworker gave the carbon copy of the notes to the employee. Once the employee was able to give full attention to the meetings, he was able to retain more information.

An employee was unable to meet crucial deadlines because she had difficulty maintaining her concentration and staying focused when trying to complete assignments. She discussed her performance problems with her supervisor, and accommodations were implemented that allowed her to organize her time by scheduling “off” times during the week during which she could work without interruptions. She was also provided a flexible schedule that gave her more time for counseling and exercise. The supervisor provided information about the company Employee Assistance Program and trained her coworkers on stress management.

An employee was experiencing difficulty staying on task and meeting deadlines. JAN suggested restructuring the job to eliminate nonessential job functions such as making copies of files and greeting walk-in customers. The JAN representative also suggested relocating her work station out of the front reception area to reduce distractions. The employee was scheduled one hour off the telephone every afternoon to complete tasks without interruption. She also met with her supervisor every Monday to set goals and discuss weekly projects.

An employee was experiencing reduced concentration and memory loss. His job required operating copy machines, maintaining the paper supply, filling orders, and checking the orders for accuracy. He was having difficulty staying on task and remembering what tasks he had completed. JAN suggested laminating a copy of his daily job tasks, checking items off with an erasable marker, and using a watch with an alarm to remind him to check his other job duties.

(Source: Job Accommodation Network. (2005). Employees with psychiatric impairments. Accommodation and Compliance Series. Available online at <<http://www.jan.wvu.edu/media/Psychiatric.html>>.

(End of Table 3.7)

Supported Education And Supported Employment

The two primary workforce development goals for youth, as described in the WIA common performance measures and in the Individuals with Disabilities Education Act, are (1) enrollment in postsecondary education or training, and (2) unsubsidized employment. Youth with mental health needs may need accommodations or supports in order to be successful in both of these environments. As a result, supported education and supported employment models have been developed to maximize successful outcomes for youth with MHN. Both strategies are tailored to the informed choices, assets, and individual needs of the youth involved.

Supported education may be helpful for some youth with mental health needs who are entering postsecondary education or training. Supported education encompasses a number of support services and options such as pre-admission counseling and financial planning, peer support groups, and training and information-sharing among staff and service providers. Institutional strategies identified by the Institute for Community Inclusion include (1) implementing a universal instructional design that incorporates accommodations and individual differences; (2) creating student sub-communities to encourage social connections; (3) improving clarity, coordination, and communication among stakeholders; and (4) promoting access to resources. Youth service practitioners working with transitioning youth are stakeholders and should be active participants in the coordination and communication process.

Employment supports for youth with mild to moderate mental health needs may be minimal or even unnecessary. “Natural” supports, such as a supportive supervisor or a quiet work-station, may be all that is needed. Supported employment for youth with more severe MHN includes the active involvement of an employment support team of youth service practitioners, case managers, mental health professionals, and workplace personnel to ensure that accommodations and supports are on-going and integrated with mental health treatment.

The Vocational Phase System describes a supported employment program for high school students in which a transition specialist prepares a youth with mental health needs for employment, supports the student on the job every day, and then gradually withdraws from the worksite as the student gains knowledge, skills, and confidence and is able to work independently. An outline for this system is provided in Exhibit 3.5B at the end of the chapter.

(Sidebar) Sam’s Story

At the age of 14, I started having serious hallucinations and blackouts. I’m half African American and half Native American, and I didn’t try to get help because, in both communities, they called that “going to the white man.” But I became an outcast, because my symptoms got so bad that none of my friends wanted to have anything to do with me.

Instead, I lived with these symptoms for four years. My mental illness got so bad that I couldn’t cope with school and they asked me to leave. I went to Miami to live with my father, but he threw me out; and from the age of 15 until I was 18 I lived on the streets of Miami, with constant hallucinations and delusions.

At 19, I joined the military. But I was still sick and, after basic training, they gave me an honorable discharge and directed me to get mental health treatment, so I did. After taking medication and seeing therapists, I went back to work two years later, as a cook. Four years after that, I got an associate’s degree from the Restaurant School of Philadelphia and became a chef.

I worked as a chef for about 15 years. But there was a lot of stigma around mental illness in the restaurant business. Every restaurant I worked at, I saw other people disclose about themselves, and they wound up being badly harassed and losing their jobs. So I hid my illness.

In 1995 I started working part time for the Chester City Consumer Center. After attending the Center for six months, I asked the director if there were openings and she said she had wanted to hire me for the last six months. I’m still at the Center, now as its director, and it will be 10 years in November. Working with the Mental Health Association of Southeastern Pennsylvania, which is out there advocating for consumers, has helped me. Until I started working here, I felt like

no one really cared.

Substance Abuse and Mental Health Services Administration. *Mental health – It's part of all our lives*. Rockville, MD: Center for Mental Health Services, U.S. Department of Health and Human Services. Retrieved February 8, 2006, from <http://www.allmentalhealth.samhsa.gov/story_samharris.html>.

(End of Sidebar)

Promising And Effective Practices

There are several youth workforce development programs that are effectively guiding youth with mental health needs to successful career outcomes. Table 3.8 highlights 18 Pro-Bank programs that either serve youth with mental health needs exclusively or include significant percentages of youth with MHN among their participants.

Pro-Bank is an online database of promising programs and practices in the workforce development system that effectively address the needs of youth with disabilities. It was developed by NCWD/Youth and ODEP to promote quality program services to youth with disabilities throughout the workforce development system. Programs selected for inclusion in Pro-Bank are (1) pilot demonstration projects, funded by ODEP, which are undergoing or have completed an independent evaluation by an independent research organization; and (2) programs with proven records of success, whose effectiveness has been validated by an outside source and which include or specifically serve youth with disabilities.

The programs listed in Table 3.8 include youth with MHN among their participants and are run primarily by workforce development and educational organizations. They reflect a number of funding sources and sites, including public schools, non-profit agencies, Vocational Rehabilitation agencies, Job Corps Centers, and partnerships with the private sector.

Table 3.8: Pro-Bank Promising Transition Programs Serving Youth with Mental Health Needs

<http://www.ncwd-youth.info/promising_Practices/index.html>

Access Living's YIELD the Power Program, Chicago, IL

Access Living's YIELD (Youth for Integration through Education, Leadership and Discovery) the Power Project increased the participation of youth with disabilities

in mainstream workforce development activities through a variety of youth-led systems change initiatives. YIELD the Power Project offered participants referrals when mental health or physical health services were needed and structured post-program support was arranged through postsecondary institutions and adult-serving agencies.

Innovative Practices

- Career Preparation & Work-Based Learning
- Youth Development & Leadership

Bay Cove Academy, Boston, MA

Bay Cove Academy (BCA) is a psychoeducational program that serves an urban adolescent population (ages 13 to 21) from the greater Boston area with severe emotional, behavioral, and learning disabilities. The Career Development program (CDP) provides students with classroom and real-world employment skills training and community job placement, supported by employment training specialists. CDP also helps students research and explore post-school career options. Under CDP, job placement and career development are highly individualized, and appropriate job matching is emphasized for successful placement.

Innovative Practices

- Program Structure and Design • School-based Preparatory Experiences
- Career Preparation & Work-based Learning
- Youth Development & Leadership
- Individual & Support Services (Connecting Activities)

Blackstone Valley Regional Vocational Technical High School, MA

Blackstone Valley Regional Vocational Technical High School serves 13 towns in central Massachusetts. It provides students with a safe learning environment with an emphasis on integrating specialized vocational and technical training and academic learning. A specialized curriculum called “Across the Curriculum” focuses on reading, math, study strategies, and respect. Instruction is individualized and recognizes diverse learning styles while incorporating state-of-the-art technology. A comprehensive counseling program and a wide array of extracurricular activities are available to all students. The school actively participates with government agencies, chambers of commerce, educational collaboratives, and the media. It also sponsors local, regional, and state level conferences on the economy, technology, and education.

Innovative Practices

- Program Structure and Design
- School-based Preparatory Experiences
- Career Preparation & Work-based Learning
- Youth Development & Leadership
- Individual & Support Services (Connecting Activities)

Circle Seven Workforce Investment Board, Greenfield, IN

Circle Seven Workforce Investment Board's mission is to become the focal point for all workforce related activity, bringing together the collective resources of all existing services within the seven central Indiana counties that surround Indianapolis. It supports capacity building of those within the workforce development system that serve youth with disabilities in order to expand the number and enhance the quality of services provided. Among the training topics provided to stakeholders was "Effective Transition & Community-Based Employment Supports for Youth with Emotional & Behavioral Challenges."

Innovative Practices

- Program Structure & Design
- Career Preparation & Work-Based Learning
- Youth Development & Leadership
- Individual & Support Services (Connecting Activities)
- Family Involvement & Supports

Imua Project, Honolulu, HI

In the Hawaiian language, "Imua" means the act of moving forward in a proactive and positive way despite existing barriers. Imua is therefore an appropriate descriptive name for the project whose objective was to support youth pushing forward or transitioning from school to employment or higher education with an additional focus on self-advocacy and leadership training. Youth received postsecondary education, employment transition services, and supportive services, and participated in in-school and out-of-school workshops focusing on self-advocacy and leadership training. Imua also trained hundreds of staff from Workforce Investment Act (WIA) youth service providers, vocational rehabilitation, and education and partner agencies.

Innovative Practices

- Career Preparation & Work-based Learning
- Youth Development & Leadership
- Individual & Support Services (Connecting Activities)

ISUS Institutes of Construction Technology, Manufacturing, and Health Care, Dayton, OH

Improved Solutions for Urban Systems (ISUS) operates three state-chartered high schools for youth ages 16-22, many of whom are returning high school dropouts, over age for grade level, and lacking basic skills. The schools combine rigorous academics and occupational skills with youth development and community development leading to high school diplomas, college credit, and nationally recognized skill certifications. Twenty-four percent of the students have disabilities, including emotional disturbance.

Innovative Practices

- Program Structure & Design
- School-Based Preparatory Experiences
- Career Preparation & Work-Based Learning
- Youth Development & Leadership
- Individual & Support Services (Connecting Activities)
- Family Involvement & Supports

Jewish Vocational Services High School, High School/High Tech Program, San Francisco, CA

Jewish Vocational Services (JVS) operates several programs that help youth with disabilities explore, experience, and transition to the world of work, including the following:

- Work Resource Program or WRP, a nationally honored, year-long vocational training program for youth with disabilities offered in special education classrooms throughout the San Francisco Unified School District;
- Youth Employment Programs and Workforce Investment Act (WIA) services for in-school and out-of-school youth with disabilities;
- Mayor’s Youth Education and Employment Program (MYEEP), providing year-round internships in public and nonprofit agencies;
- REACH, an eight-week computer skills training program that covers Microsoft Word, Excel, PowerPoint, and Internet applications; and
- WorkLab, a High School/High Tech (HS/HT) Program that includes career exploration, job shadowing, employer site visits, and paid internships as well as job development, placement, and support activities for youth with disabilities.

Innovative Practices

- Program Structure and Design
- Career Preparation & Work-based Learning
- Youth Development & Leadership
- Individual & Support Services (Connecting Activities)

Job Link, Cleveland, OH

Job Link is a youth development and employment program of Linking Employment, Abilities, and Potential (LEAP), a Cleveland Center for Independent Living. LEAP’s mission is to “empower people with disabilities in making significant life choices and changes to enhance their employment and independent living opportunities.” Job Link is a year round transition program providing work-related and independent living skills training. It combines classroom instruction and community-based training to address individual student needs and goals.

Innovations

- Program Structure & Design

- Career Preparation & Work-Based Learning Experiences
- Youth Development & Leadership
- Individual & Support Services (Connecting Activities)
- Family Involvement & Supports

Marriott's Bridges...from School to Work

Bridges programs operate in seven sites around the country: Washington, DC; Montgomery County, MD; Chicago, IL; Los Angeles, CA; San Francisco, CA; Philadelphia, PA; and Atlanta, GA. Bridges...from School to Work provides youth with disabilities job training and work experiences that enhance employment potential while helping local employers gain access to an often overlooked source of entry-level workers. It features paid internships to youth with disabilities (ages 17 to 22 years old) who are placed in local companies where employers pay the youth directly in a competitive work situation. A second program, Bridges Plus, supports program participants who need a longer period of time to achieve a positive outcome by focusing on vocational development for 18 to 24 months.

Innovative Practices

- Program Structure and Design
- Career Preparation & Work-based Learning
- Individual & Support Services (Connecting Activities)

Montgomery Youth Work's Partnership for All Youth (MYW), Wheaton, MD

MYW is a partner in the Montgomery County One-Stop Career Center, and its services are available to all Montgomery County youth with and without disabilities. MYW's mission is to provide all youth with meaningful training and job opportunities aimed at facilitating a successful transition from school to work and to contribute to workforce development in Montgomery County. Services for youth include job placement assistance, generic job readiness training, customized job readiness training, career institutes, intensive career counseling, and referrals to community organizations such as mental health agencies.

Innovative Practices

- Career Preparation & Work-Based Learning
- Youth Development & Leadership
- Individual & Support Services (Connecting Activities)

MY TURN, Brockton, MA

MY TURN is a leading provider of vocational and education services for youth in small, urban communities. MY TURN helps underserved young people make a successful transition to adulthood, measured, in part, by job placement and retention, and postsecondary education enrollment and credential acquisition. MY TURN serves both in-school and out-of-school youth in the 16 – 21 age range and provides services such as academic and work place skills, interpersonal tools needed for success in postsecondary education and the workplace, a sequence of activities that prepare youth for the adult world, and

referrals to social services such as mental health counseling.

Innovative Practices

- Program Structure & Design
- Career Preparation & Work-Based Learning Experiences
- Youth Development & Leadership
- Individual & Support Services (Connecting Activities)

Open Meadow Alternative School, Portland, OR

Open Meadow is one of Oregon's oldest alternative schools providing education and support services to youth who have not achieved success in traditional academic settings. Open Meadow educates youth in small relationship-based programs that emphasize personal responsibility, academics, and service to the community. Open Meadow works primarily with youth with mental and learning disabilities.

Innovative Practices

- Program Structure and Design
- Career Preparation & Work-Based Learning
- Youth Development & Leadership
- Individual & Support Services (Connecting Activities)

Pacer Center's Project SWIFT, Minneapolis, MN

One of the objectives of Project SWIFT (Strategies for Workforce Inclusion and Family Training) was to increase awareness of parents of transition-age youth with disabilities about the resources of WIA-funded youth programs, as well as assist families in their efforts to access these programs. Technical assistance and training was provided to youth, families, and youth service practitioners on a variety of topics including youth mental health needs. The staff also responded to individual advocacy and referral requests from youth, adults with disabilities, parents and other caregivers.

Innovative Practices

- Family Involvement & Supports

Project COFFEE, Oxford, MA

Project COFFEE (Co-Operative Federation for Educational Experience) was created in 1979 to meet the academic, occupational, social, emotional, and employability needs of high school students considered significantly at risk of dropping out of school or becoming involved with the juvenile justice system. It is an alternative occupational education program that integrates academic and vocational instruction to increase the likelihood that participants will complete high school with a diploma (not a GED) and obtain employment. Over 75% of participants have or have had IEPs. Most students are between the ages of 16 and 19. The program also has a small middle school component called Project JOBS (Joining Occupational and Basic Skills) that tries to "catch" students with

behavioral or emotional problems to re-engage them in school.

Innovative Practices

- Program Structure and Design
- School-based Preparatory Experiences
- Career Preparation & Work-based Learning

Project CRAFT

Project CRAFT (Community, Restitution, and Apprenticeship-Focused Training) is designed to improve educational levels, teach vocational skills and reduce recidivism among adjudicated youth, while addressing the home building industry's need for entry level workers. The program incorporates the apprenticeship concept of hands-on training and academic instruction. Under the supervision of instructors, students learn residential construction skills while completing community service construction projects. Nearly 60% of participants have a disability, including mental health needs, and special education planning is a key component of the program. Project CRAFT has nine sites in four states, including Florida, Tennessee, New Jersey, and Mississippi.

Innovative Practices

- Program Structure & Design
- School-Based Preparatory Experiences
- Career Preparation & Work-Based Learning
- Youth Development & Leadership
- Individual & Support Services (Connecting Activities)

Tucson Job Corps Center, Tucson, AZ

The Fred G. Acosta Job Corps Center serves youth between the ages of 16 and 24 from Tucson and Southern Arizona, with about two-thirds of the youth residing at the Center. The Center teaches marketable skills in a safe and supportive setting and finds meaningful employment for students when they leave the program. Several programs are available, including basic education leading to a GED or high school diploma, vocational training in eight skill areas, basic computer skills, basic employment skills, health and wellness education, and training in cultural diversity. High school diplomas are also available on campus. Numerous partnerships with community organizations and agencies provide opportunities for cultural, recreational, and community service activities. The Center emphasizes early identification of disabilities and the development of a comprehensive accommodation plan that meets each youth's needs.

Innovative Practices

- Program Structure and Design
- School-based Preparatory Experiences
- Youth Development & Leadership
- Individual & Support Services (Connecting Activities)

WAVE and PAVE Services for Youth, Mount Pleasant, MI

In 1998, Mid-Michigan Industries began programs designed specifically to transition youth from school to work. WAVE (Work and Vocational Exploration) is a seven-week summer program primarily for 14- and 15-year olds. PAVE (Personal and Vocational Exploration) takes place during the school year and is designed to instruct youth who are new to the program and to provide ongoing support to youth who have participated in WAVE. Both WAVE and PAVE work with middle school and high school youth who meet program criteria through referrals made chiefly by school counselors and teachers. WAVE and PAVE participants can attend for two years and complete a wide range of activities to help them identify career choices. Specialized supports include job coaching for work experience, modified lesson plans for non-readers, specialized career interest assessments, and individualized mentoring. Youth also work together to support each other and learn to respect each other's differences.

Innovative Practices

- Career Preparation & Work-based Learning
- Youth Development & Leadership
- Individual & Support Services (Connecting Activities)

Youth with Disabilities Demonstration Project, Seattle, WA

The Youth with Disabilities Demonstration Project was intended to complement and support existing youth programming under the Workforce Investment Act (WIA) for in-school and out-of-school youth. WIA youth case managers identified youth potentially in need of mental health care and referred them to care coordinators. Linkages were established with mental health agencies so that youth in need of services could be referred.

Innovative Practices

- Program Structure & Design
- Career Preparation & Work-Based Learning
- Individual & Support Services (Connecting Activities)

YouthBuild McLean County, Bloomington, IL

YouthBuild McLean County is affiliated with YouthBuild USA and AmeriCorps and serves Bloomington and Normal, Illinois, and the surrounding rural areas. Unemployed and undereducated young people ages 16 to 24 work toward their GED or high school diploma while learning construction skills by building affordable housing for homeless and low-income people. Strong emphasis is placed on leadership development, community service, and the creation of a positive mini-community of adults and youth committed to success. Since 1994, participants have built or renovated over 17 affordable residences in McLean County.

Innovative Practices

- Program Structure and Design

- School-based Preparatory Experiences
- Career Preparation & Work-based Learning
- Youth Development & Leadership
- Individual & Support Services (Connecting Activities)

Additional information on these and other youth programs is available through Pro-Bank, NCWD/Youth's online database of promising workforce development programs and practices that effectively address the needs of youth with disabilities. Pro-Bank can be accessed online at <http://www.ncwd-youth.info/promising_Practices/index.html>.

(End of Table 3.8)

The programs listed in Table 3.9 provide mental health services to transition-age youth. Some of these programs provide transition services to youth while others provide services and supports (Connecting Activities) as part of a coordinated interagency plan. These programs are operated by mental health organizations and most are supported by federal and state mental health funds.

Table 3.9: Promising Mental Health Programs Serving Transition-Age Youth

<<http://www.nasmhpd.org/publications.cfm>>

Transitional Community Treatment Team, Columbus, OH

This program uses the evidence-based Assertive Community Treatment (ACT) model to provide transition support to youth with mental health needs ages 16-22 who are at high risk for institutional placement, suicide, or homelessness. A supervised and unsupervised housing program is also available.

Our Town Integrated Service Agency, Indianapolis, IN

This program combines an ACT approach with psychosocial rehabilitation for youth ages 18-25 with serious mental health needs using a consumer-led planning team approach. Individual strengths and abilities are emphasized, and links to psychiatric and substance abuse treatment and housing supports are provided.

Transition-Age Project, Delaware/Chester County, PA

This program serves youth ages 14-22 with mental health needs using a Person Centered Planning (PCP) approach with intensive support for case managers.

Youth In Transition Case Management Teams, VT

These teams provide intensive case management to youth who are crossing the boundary between child and adult services with access to mental health services, roommate services, vocational and educational services. Funding is provided through Medicaid.

Peer Supports, Georgia

The adult mental health system and the Georgia Parent Support Network combined forces to provide peer support to youth ages 17-25 who are eligible for adult mental health services. Contracted peers are supervised by a mental health professional.

Comprehensive State System, MD

Using legislation passed in 1996 to improve transition services for children and youth in the education and health systems, Maryland has eliminated most of the demarcation between adult and child mental health services. A diverse range of programs and expertise was created that local mental health authorities could access to expand their own transition programs. The system focuses on capacity-building and overcoming the obstacles to service coordination during the transition period.

For more information on these and other programs, contact the State Mental Health Program Director, listed in Appendix E of the source document: Davis, M. & Hunt, B. (2005). *State efforts to expand transition supports for young adults receiving adult public mental health services: Report on a survey of members of the National Association of State Mental Health Program Directors*. Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, U.S. Department of Health and Human Services. Available at < <http://www.nasmhpd.org/publications.cfm>>.

Please see Appendix B for the list of references.

Exhibit 3.1: Supporting Research

As noted earlier in this chapter, the *Guideposts for Success* are evidence-based. The Institute for Educational Leadership's Center for Workforce Development, in collaboration with ODEP and the National Center on Secondary Education and Transition, took the lead in collecting and compiling the research for NCWD/Youth's Guideposts for all youth and the corresponding National Alliance for Secondary Education and Transition's national standards and quality indicators. The resulting 40-page document, *Supporting Evidence and Research*, will be updated as needed and includes research on school-based preparatory experiences, career preparation and work-based learning, youth development and leadership, family involvement and supports, and connecting activities. It is available online in Adobe PDF and Microsoft Word format at [http://www.ncwdyouth.info/resources_& Publications/guideposts/index.html](http://www.ncwdyouth.info/resources_&_Publications/guideposts/index.html).

The following section contains research specifically related to direct *services* for youth with mental health needs. Chapter 4 contains information and research related to effective transition *systems* for youth with mental health needs.

Despite the fact that many youth with MHN possess average or above average intellectual skills, youth labeled as ED frequently experience more academic difficulty than other youth with MHN. Effective, evidence-based instructional procedures called "learning strategies" have been developed to address these difficulties for use with low-achieving youth, including those with MHN, through the University of Kansas (Alley, Deshler, Clark, Schumaker, & Warner, 1983; Deshler, & Schumaker, 1986). There is a parallel line of research and development on the "direct instruction" model (Becker, Engelmann, & Thomas, 1975; Gersten, Woodward, & Darch, 1986). Essentially, both instructional approaches seek to clarify instructional goals and to teach academic content in clear and discrete units of instruction, through structured teaching procedures including advance planning, problem-solving, and repeated practice and review. These procedures are focused primarily on academic instruction offered in the classroom, but could be adapted to teaching transition skills.

Coordinating academic instruction with community and work-based learning has been called "contextualized learning." Benz, Yovanoff, & Doren (1997) suggested that structured activities such as apprenticeships, paid work experience, and continuing education following dropping out of school should all be considered and explored as viable educational options.

Because most youth with MHN may have minimal work experience and ill-defined career goals and aspirations, work samples, skill assessments, and career interest inventories may not reflect their true interests and abilities (Sitlington, Brolin, Clark, & Vacanti, 1985). Accordingly, such measures should be used as one part of a transition planning process that includes a number of

experiences such as interviews, work experiences, record reviews, and behavioral observations (Timmons, Podmostko, Bremer, Lavin, & Wills, 2004).

Successful work experiences during the high school years are strongly associated with both high school completion (Thornton & Zigmond, 1988; Weber, 1987) and work success after leaving high school (Benz, Yovanoff, & Doren, 1997; Hasazi, Gordon, & Roe, 1985). Moreover, studies of now-successful adults with MHN conducted during their adolescence supported the importance of work and identified job experiences beginning in adolescence and continuing after high school as a key element of becoming successful later in life (Werner & Smith, 1992).

There is a growing body of research that recognizes that youth need to be exposed to an array of leadership development opportunities. Self-advocacy and self-determination skills instruction have been found to be important components of leadership development for youth with disabilities (Agran, 1997; Sands & Wehmeyer, 1996; Van Reusen, Bos, Schumaker, & Deshler, 1994; Wehmeyer, Agran, & Hughes, 1998). Wehmeyer and Schwartz (1997) found that students with disabilities who have self-determination skills are more likely to be successful in making the transition to adulthood, including employment and community independence, and have increased positive educational outcomes, than students with disabilities who lack these skills. These skills are especially important for young people with disabilities to develop in order to be able to advocate on their own behalf for adult services and basic civil and legal rights and protections (Sands & Wehmeyer, 1996; Wehmeyer, Agran, & Hughes, 1998), and workplace and educational accommodations.

In addition to leadership development activities, mentoring is an important component of successful transition support. Research findings corroborate the positive impact of mentoring in helping youth with mental health needs to achieve goals that are part of the transition process such as “succeeding in school, understanding the adult world, developing career awareness, accepting support while accepting responsibility, communicating effectively, overcoming barriers and developing social skills” (Moccia, Schumacher, Hazel, Vernon, & Dessler, 1989; Rhodes, Grossman, & Resch, 2002).

The critical role decision-making plays in the general wellbeing and adjustment of all people has been discussed and studied for some time (D’Zurilla, 1986), as has the importance of choosing a meaningful and personally rewarding career (Dawis & Loftquist, 1976, 1984). Self-determination skills are especially important for young people with MHN so that they may advocate on their own behalf for adult services and basic civil and legal rights and protections (Sands & Wehmeyer, 1996; Wehmeyer, Agran, & Hughes, 1998). An experimental, treatment-control group study (Powers, Turner, Westwood, Matuszewski, Wilson, & Phillips, 2001) conducted with adolescents with varying disabilities, including ED, found that those individuals who received instruction in self-determination skills

demonstrated significant increases in their involvement in transition planning activities, empowerment, transition activities, and level of participation in transition planning meetings.

Among adults with severe and persistent mental illnesses, the issue of disclosure is highly controversial and many adults with these conditions are unwilling to tell potential or current employers about their illness, thus precluding ADA protections (Goldberg, Killeen, & O'Day, 2005). There are no research data on exactly what proportion of youth with MHN in transition programs are willing to disclose their MHN to employers.

Competence in social interactions is crucial to peer acceptance and general life adjustment (Parker & Asher, 1987), as well as to transition success for persons with disabilities (Chadsey-Rusch, 1986, 1990) including those with MHN (Bullis, Nishioka-Evans, Fredericks, & Johnson, 1993; Bullis & Davis, 1996). Research has demonstrated that social skills instruction is one of the weakest interventions offered to students with disabilities (Forness, Kavale, Blum, & Lloyd, 1997) and specifically to children and youth with MHN (Magee-Quinn, Kavale, Mathur, Rutherford, & Forness, 1999).

The National Center on Youth Transition (NCYT) provides technical assistance to sites funded by SAMHSA's Youth Transition Initiative which develop and implement transition programs for youth with emotional and behavioral difficulties as they enter adulthood. NCYT (n.d.) has identified research-based best practices in four domains of developmental outcomes that lead to successful adulthood for youth with MHN:

- **Being Autonomous:** Self-determined youth are responsible, determined citizens that create and strive to reach goals. They are also able to navigate the social resources made available to them.
- **Being Connected:** Youth that are connected actively engage in a 2-way dialogue with their friends, significant others, co-workers, teachers, families, and communities. They partner with others to achieve the changes they seek to make.
- **Being Educated:** Educated youth seek further instruction on areas of interest to enhance their competencies. Knowledge and experience are gained through this youth-pursued process.
- **Being Productive:** Physical, intellectual, and social accomplishments are gained through goal setting and achievements.

To view the four domains in more detail and the supporting research, go to <http://ntacyt.fmhi.usf.edu/promiseppractice/index.cfm>.

Please see Appendix B for the list of references.

Exhibit 3.2: National Youth Development Board for Mental Health Transformation Framework for Active Youth Involvement At the Individual, Community and Policy Making Levels (2006 Draft)

Youth Driven

- Policy and services are initiated, planned and executed by youth in partnership with others
- Expert level of understanding
- Youth advocate for other young people

Youth Directed

- Continue with Youth Guided process
- In a safe place (not in a continual crisis)
- Taking a more active decision making role in treatment and within the System of Care (policy, etc.)
- Increased knowledge of services and resources
- Deeper understanding of the system

Youth Guided

- Knowledge of services
- Beginning to research and ask questions about resources
- Beginning to understand the process of system and services
- Voice in identifying needs and supports
- Learning how to self advocate
- Articulate experience and what helps and what harms

The foundation of Youth Driven, Youth Directed, and Youth Guided are Education, Awareness, Resources, Support, and Philosophies

Young people have the right to be empowered, educated, and have a decision making role in their own lives as well as in the policies and procedures governing care in the community, state, and nation. This includes giving young people a sustainable voice with a focus on creating a safe environment enabling young people to gain self-sustainability in accordance with their culture and beliefs. In this approach there is a continuum of power and choice that young people should have based on their understanding and maturity in this strength-based change process. This process should also be fun and worthwhile. Youth involvement is a process that moves from youth guided, to youth directed, to youth driven at three levels: the individual youth level, the community level, and the policy making level. The following lists describe in more detail what should be happening at each stage in the process as the young person transitions into adulthood. “Youth” are young people who have experience as consumers and are (or would be) the youth served in a System of Care (SOC) community.

Youth Guided

Youth Guided Individual

- Youth is engaged in the idea that change is possible in his or her life and the systems that serve him or her.
- Youth need to feel safe, cared for, valued, useful, and spiritually grounded.
- The program needs to enable youth to learn and build skills that allow them to function and give back in their daily lives.
- There is a development and practice of leadership and advocacy skills, and a place where equal partnership is valued.
- Youth are empowered in their planning process from the beginning and have a voice in what will work for them.
- Youth receive training on systems players, their rights, purpose of the system, and youth involvement and development opportunities.

Youth Guided Community

Community partners and stakeholders have:

- An open minded viewpoint and there are decreased stereotypes about youth.
- Prioritized youth involvement and input during planning and/or meetings.
- A desire to involve youth.
- Begun stages of partnerships with youth.
- Begun to use language supporting youth engagement.
- Taken the youth view and opinion into account.
- A minimum of one youth partner with experience and/or expertise in the systems represented.
- Begun to encourage and listen to the views and opinions of the involved youth, rather than minimize their importance.
- Created open and safe spaces for youth.
- Compensated youth for their work.

Youth Guided Policy

- Youth are invited to meetings.
- Training and support is provided for youth on what the meeting is about.
- Youth and board are beginning to understand the role of youth at the policy-making level.
- Youth can speak on their experiences (even if it is not in perfect form) and talk about what's really going on with youth people.
- Adults value what youth have to say in an advisory capacity.
- Youth have limited power in decision making.
- Youth have an appointed mentor who is a regular attendee of the meetings and makes sure that the youth feels comfortable to express him/herself and clearly understands the process.

- Youth are compensated for their work.

Youth Directed

Youth Directed Individual

The young person is:

- Still in the learning process.
- Forming relationships with people who are supporting him or her and is learning ways to communicate with team members.
- Developing a deeper knowledge and understanding of the systems and processes.
- Able to make decisions with team support in the treatment process and has a understanding of consequences.
- In a place where he or she can share his or her story to create change.
- Not in a consistent period of crisis and his/her basic needs are met.

Youth Directed Community

- Youth have positions and voting power on community boards and committees.
- Youth are recruiting other youth to be involved throughout the community.
- There is increased representation of youth advocates and board and committee members throughout the community.
- Everyone is responsible for encouraging youth voice and active participation.
- Community members respect the autonomy of youth voice.
- The community is less judgmental about the youth in their community.
- Youth are compensated for their work.

Youth Directed Policy

- Youth understand the power they have to create change at a policy-making level.
- Youth are in a place where they understand the process behind developing policy and have experience being involved.
- Youth have an enhanced skill set to direct change.
- Youth have understanding of the current policy issues affecting young people and are able to articulate their opinion on the policy.
- Policy makers are in a place where they respect youth opinions and make change based on their suggestions.
- All parties are fully engaged in youth activities and make youth engagement a priority.
- Youth receive increased training and support in their involvement.
- There is increased dialogue during meetings about youth opinions, and action is taken.
- There is increased representation of youth and a decrease in tokenism.
- Equal partnership is evident. • Youth are compensated for their work.

Youth Driven

Youth Driven Individual

- The youth describes his or her vision for the future.
- The youth sets goals for treatment with input from team.
- The youth is aware of his or her options and is able to utilize and apply his or her knowledge of resources.
- The youth fully understands his or her roles and responsibilities on the team.
- The youth and all members of the treatment team are equal partners and listen and act upon youth decisions.
- The youth facilitates open lines of communication, and there is mutual respect between youth and adults.
- The youth is able to stand on his or her own and take responsibility for his or her choices with the support of the team.
- The youth knows how to communicate his or her needs.
- Youth are mentors and peer advocates for other youth.
- Youth give presentations based on personal experiences and knowledge.
- The youth is making the transition into adulthood.

Youth Driven Community

- Community partners are dedicated to authentic youth involvement.
- Community partners listen to youth and make changes accordingly.
- Youth people have a safe place to go and be heard throughout the community.
- There are multiple paid positions for youth in every decision making group throughout the system of care and in the community.
- Youth are compensated for their work.
- Youth form and facilitate youth groups in communities.
- Youth provide training in the community based on personal experiences and knowledge.

Youth Driven Policy

- Youth are calling meetings and setting agendas in the policy- making arena.
- Youth assign roles to collaboration members to follow through on policy.
- Youth hold trainings on policy making for youth and adults.
- Youth inform the public about current policies and have a position platform.
- Youth lead research to drive policy change.
- Youth have the knowledge and ability to educate the community on important youth issues.
- Youth are able to be self advocates and peer advocates in the policy

making process.

- Youth are compensated for their work.
- Community members and policy makers support youth to take the lead and make changes.

Exhibit 3.3: Sample Release Of Records

INTERAGENCY RELEASE OF INFORMATION

By signing and dating this release of information, I allow the persons or agencies listed below to share specific information, as checked, about my history. I understand that this is a cooperative effort by agencies involved to share information that will lead to better utilization of community resources and better cooperation amongst our agencies to best meet my needs.

Agencies or agency representatives that will be sharing information:

Name	Address	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

The information to be released is:

- _____ History
- _____ Lab Work
- _____ Diagnosis
- _____ Psychological Assessment
- _____ Summary of Treatment
- _____ Psychiatric Evaluation
- _____ Medications
- _____ Legal issues/concerns
- _____ School Evaluation
- _____ Performance
- _____ Other specify) _____

and is to be released solely for the purpose of _____

This consent to release is valid for one year, or until otherwise specified, and thereafter is invalid. Specify date, event, or condition on which permission will expire: _____

I understand that at any time between the time of signing and the expiration date listed above I have the right to revoke this consent.

Student Name _____

Date of Birth _____

Address _____

City _____

State _____

Zip Code _____

Student Signature _____ Date _____

Guardian or Responsible Party (if student is under legal age)

_____ Date _____

Guardian/Responsible Party's Relationship to Student _____

Witness _____ Date _____

Witness/Position _____

Sample contributed by Flint Hills Special Education Cooperative

(End of Exhibit 3.3)

Exhibit 3.4: Compiling Personal Transition Data

What follows are common starting points when compiling personal information for young people in career planning programs. Note that the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPAA) establish strict federal standards concerning the use of health, education, and human services information. (See Chapter 4 for more information.) Programs or providers who are funded by the Workforce Investment Act should also review the Section 188 Disability Checklist and local service plans for guidelines on acceptable inquiries, confidentiality, accommodations, and universal access.

Transition Information Summary

Personal Information

Name _____

Date of Birth _____

Street Address _____

Telephone _____

City, State, Zip _____

E-mail _____

Support Network

Family Contacts/Roles _____

Other Adults/Roles _____

Friends/Roles _____

Living Arrangements

Current Situation _____

Education

Current Situation _____

Health

Current Situation _____

Transition Goals

Training/Education _____

Employment, Short-term _____

Employment, Long-term _____

Transportation _____

Independent Living _____

Recreation _____

Other _____

Personal Details

Living Arrangements

Stability _____

Independent Supports _____

Training Needs _____

Income/Monetary Status

Current Cost of Living _____

Current Expenses _____

Current Sources of Personal Income _____

Family/Other Sources of Income _____

Government Benefits _____

Transportation

Currently Uses:

- Public transportation
- Drives own car
- Drives family/other car
- Supported transportation

Needs:

- Drivers license
- Buy car
- Orientation/Mobility training

Health/Behavior

Medical Conditions _____

Physical Conditions _____

Communication Issues _____

Medical Treatment _____

Medications/Side effects _____

History/Prognosis _____

Adaptive Equipment _____

Assistive Technology _____

Mental Health History _____

Substance Use History _____

Counseling _____

Behavior at School _____

Behavior at Work _____

Contact with Courts/Law Enforcement _____

Incarceration/Probation _____

Other _____

Education Details

Background

_____ In School Where/Grade _____

_____ Out of School Highest Level Completed _____

Assessments Completed

Reading Skills _____

Math Skills _____

Writing Skills _____

Other Skills _____

Memory Skills Issues _____

Speech Issues _____

Listening Skills Issues _____

Other _____

Schools/Colleges Attended

Most Recent _____

Plans for Additional Education/Training

_____ No

_____ Yes If yes, describe:

Personal Traits

Hobbies _____

Leisure Activities _____

Interpersonal Skills _____

Things that Motivate _____

Work History

Recent Employment

1. _____

2. _____

3. _____

4. _____ 35

Wages/Reasons for Leaving

1. _____

2. _____

3. _____

4. _____ 35

Employment Details

_____ Resume completed

_____ Letters of recommendation

_____ Skills certification

Transferable Skills _____

Work Speed/Quality/Productivity _____

Learning Experiences _____

Volunteer/Other Positions _____

Disability Issues

Accommodations _____

Adaptive Equipment _____

Job Supports _____

Job Coach _____

Health Insurance Status _____

On-Going Medical Needs _____

Legal Issues _____

Other _____

Job Preferences

___ Using my hands

___ Working with computers

___ Daytime hours

___ Using my mind

___ Working outdoors

___ Early morning work

___ Driving a truck or car

___ Working for a large company

___ Evening hours

___ Working with tools

___ Working for a small company

___ Part-time hours

- Working with machines
- Consistent hours
- Using my education/training
- Working with advanced technology
- Flexible hours
- Jobs that require reading
- Jobs that require math
- Working in loud, noisy places
- Working toward a career goal
- Being challenged
- Being warm/hot
- Having the opportunity to be promoted
- Doing physical labor
- Being cold
- Doing repetitious tasks
- Getting my hands dirty
- Earning a lot of money
- Having a variety of duties
- Working alone
- Receiving company benefits
- Having frequent changes in routine
- Working with others
- Making new friends

- Feeling needed
- Being my own boss
- Being close to home
- Having others view my work as important
- Having close supervision
- Traveling
- Having minimal supervision
- Being home on weekends
- Waiting
- Being given detailed instructions
- Working on weekends
- Sitting for long periods of time
- Being given orders with no explanation
- Taking the bus to work
- Standing for long periods of time
- Traveling long distances to work
- Doing heavy lifting
- Working in a relaxed atmosphere
- Disclosing my disability
- Walking
- Being pressured to work fast

Job Search Assistance Needed

- Working independently

- Resume
- Reference letters
- Working with agencies
- Disclosure/Disability issues
- Finding job openings
- Working with schools
- Informational interviews
- Job interviews
- Clothing
- Applications
- Other support

Exhibit 3.5: Materials from Vocational and Transition Services for Adolescents with Emotional and Behavioral Disorders: Strategies and Best Practices

The following materials have been adapted, with permission from the publisher, from:

Bullis, M., & Fredericks, H. D. (Eds.). (2002). *Vocational and transition services for adolescents with emotional and behavioral disorders: Strategies and best practices*. Champaign, IL: Research Press, and Arden Hills, MN: Behavioral Institute for Children and Adolescents. Available online at <http://www.researchpress.com/>.

Exhibit 3.5A – Employer Profile

Exhibit 3.5B – Vocational Phase System

Exhibit 3.5C – Informal Behavior Management System

Note: These materials were developed for students in school-based transition programs but are also applicable to youth in out-of-school or other settings.

Exhibit 3.5A: Employer Profile

Acceptable Employer

- Interested in training job skills
- Willing to accept some behavior problems and work to remedy them
- Accepting of workers with physical/mental disabilities
- Willing to have a job trainer on-site
- Willing to adapt some parts of the worksite to accommodate workers with disabilities
- Monitors all workers, including student trainees
- Flexible in hours/day, and scheduling
- Maintains a good rapport with all employees
- Maintains adequate safety on the worksite
- General overall positive response to program needs

For information on an unacceptable employer profile, see Figure 4.3, page 67, in Nishioka, V. (2002). Chapter 4: Job development and placement. In M. Bullis & H. D. Fredericks (Eds.), *Vocational and transition services for adolescents with emotional and behavioral disorders: Strategies and best practices*. (55-67). Champaign, IL: Research Press, and Arden Hills, MN: Behavioral Institute for Children and Adolescents. Available online at <http://www.researchpress.com/>.

Exhibit 3.5B: Vocational Phase System

Phase I: Learning

1. The student is supervised and trained by the Transition Specialist (TS).
2. The student learns various job duties required at the worksite.
3. The student learns and follows all rules and regulations of the worksite.
4. The student begins to identify and work on skills and behaviors exhibited at the worksite.
5. The TS collects and records all data from skill and behavior programs.
6. The TS, in conjunction with the student, begins to explore transportation options, such as city buses, bicycling, walking.
7. The student begins bus training, if appropriate.
8. The student maintains a minimum of 3 working hours per week.
9. The TS delivers all consequences and makes all contacts with the student.

Phase II: Responsibility

1. The TS makes intermittent quality checks while remaining on the worksite.
2. The student begins to maintain various job duties independently.
3. The student begins to follow all rules and regulations of the worksite independently
4. The student begins to set own goals with the TS and watches own behaviors.
5. The TS collects and records all data from skill and behavior programs.
6. The student begins traveling to and from work, using public transportation if available, with guidance and supervision by the TS.
7. The student uses vocational time wisely and maintains satisfactory work rate and quality.
8. The student maintains at least 5 working hours per week.
9. The student begins to receive and respond to occasional feedback from employer.
10. The TS delivers all consequences and maintains the majority of contacts with the [student] worker.

Phase III: Transition

1. The TS is not at the worksite but makes intermittent quality checks.
2. The student is independent in all job duties and tasks.
3. The student follows all rules and regulations of the worksite independently.
4. The student works toward vocational goals and maintains own behaviors.
5. The student's work skills and behavior data are monitored.
6. The student travels independently to and from work.
7. The student maintains work quality equal to that of regular employees.
8. The student maintains at least 10 working hours per week.
9. The student responds to the employer in all job-related matters.
10. The employer delivers the majority of consequences.

Phase IV: Independence

1. The TS makes intermittent quality checks by phone.
2. The student is independent in all job duties and tasks.
3. The student independently follows all rules and regulations of the worksite.
4. The student continues to work toward vocational goals and monitors own behaviors.
5. The student has no formal behavior programs.
6. The student travels independently to and from work.
7. The student maintains work quality equal to that of regular employees.
8. The student maintains at least 15-20 working hours per week.
9. The student responds to the employer in virtually all job-related matters.
10. The employer delivers nearly all consequences.
11. The student is eligible for placement in paid employment with TS support.

Phase V: Employability

1. The TS assists with administrative issues.
2. The employer trains and manages.
3. The student reaches vocational goals.
4. The student travels independently to and from work.
5. The student maintains at least 20 working hours per week for 6 months.
6. The student is able to gain paid employment independently.

For a complete explanation of the Vocation Phase System, see pages 83-87 in Nishioka, V. (2002). Chapter 5: Job training and support. In M. Bullis & H. D. Fredericks (Eds.), *Vocational and transition services for adolescents with emotional and behavioral disorders: Strategies and best practices*. (69-89). Champaign, IL: Research Press, and Arden Hills, MN: Behavioral Institute for Children and Adolescents. Available online at <<http://www.researchpress.com>>.

Exhibit 3.5C: Informal Behavior Management System

Category of Behavior: Failure to follow directions

Examples: Slow to comply. Refusing to follow a directive. Poor or incomplete job. Breaking a known rule.

Treatment When behavior occurs: Assist to comply or arrange natural consequence

Treatment When behavior does not occur: Reinforce compliance

Category of Behavior: Self-indulgent behavior

Examples: Tantrums. Whining. Complaints. Crying.

Treatment When behavior occurs: Withdraw attention

Treatment When behavior does not occur: Reinforce appropriate behavior

Category of Behavior: Aggressive behavior

Examples: Punching. Stealing. Lying. Breaking or throwing objects.

Treatment When behavior occurs: Time away from group

Treatment When behavior does not occur: Reinforce prosocial behavior

Category of Behavior: Self-stimulation or self-abuse

Examples: Rocking. Grinding teeth. Biting self. Head banging.

Treatment When behavior occurs: Interrupt behavior

Treatment When behavior does not occur: Reinforce appropriate behavior

For more examples of these behaviors, see Figure 6.2, page 95, in Nishioka, V. (2002). Chapter 6: Behavioral interventions. In M. Bullis & H. D. Fredericks (Eds.), *Vocational and transition services for adolescents with emotional and behavioral disorders: Strategies and best practices*. (69-89). Champaign, IL: Research Press, and Arden Hills, MN: Behavioral Institute for Children and Adolescents. Available online at <<http://www.researchpress.com>>.

Chapter 4: Implications for Policy

There is currently ample evidence that current policies and practices are generally inappropriate and foreshortened at the critical juncture when youth with serious mental health (MH) conditions are on the threshold of becoming functioning adults in our society. (Davis & Koyanagi, 2005)

Purpose

This chapter focuses on systems and policy issues at the national, state, and program levels. Information for program administrators and policymakers is provided on

- policy challenges and solutions for youth with MHN,
- components of effective transition systems for youth with MHN,
- the beginning road map to establish a systemic foundation,
- critical design elements,
- universal access,
- competitive employment,
- the importance of youth leadership in developing services and policy,
- family involvement and support,
- caring adults,
- critical process design features,
- interagency coordination and collaboration,,
- resource management,
- cultural and linguistic competence to address institutional bias, and
- professional preparation and development of youth service practitioners.

The Policy Challenge

In the past few years, significant attention has been given to improving the nation's mental health services for both youth and adults with mental health needs. In April 2002, President George W. Bush signed Executive Order 13263 establishing the New Freedom Commission on Mental Health and charged the group with conducting a comprehensive study of the problems and gaps in the mental health service system and to making concrete recommendations for immediate improvements that the federal government, state governments, local agencies, as well as public and private health care providers, could implement. In July, 2003, the Commission issued its final report to the President, which called for nothing short of *fundamental transformation* of the mental health care delivery system in the United States.

In response to the Commission's report, the Federal Partners Senior Workgroup for Mental Health Transformation was created, made up of senior-level staff representing six federal departments, including 11 agencies/offices and the

Social Security Administration. As an extension of the ongoing work of the Senior Workgroup, the Federal/National Partnership (FNP) for the Transformation of Children's Mental Health Care in America was formed. In July 2005, the Department of Health and Human Services released the "Federal Mental Health Agenda" which articulates objectives for a long term strategy to transform the nation's child, adult, and older adult public and private mental health service delivery toward community-based care.

Included in the Agenda are several beginning steps that call upon multiple federal departments to become a part of the solution. As part of a strategy to meet this challenge, the Agenda charges the Department of Education's Office of Special Education and Rehabilitative Services to work with other federal agencies on researching, demonstrating, and disseminating promising practices on transitioning youth with MHN into employment. Underscoring the particular employment challenges facing youth with mental health needs in the juvenile justice system, DOL, DOJ and SAMHSA are to work together to identify such youth and help them find employment, specifically through DOL's One-Stop Career Centers.

Additional challenges faced by this population include transitioning to independent living, and negotiating the shift from child to adult service systems. Through SAMHSA's Partnerships for Youth Transition Grants Program, states develop and implement comprehensive program models to support youth throughout the transition process. To support this effort, the Agenda calls for the expansion of the Program to additional states and communities by enlisting the financial support of other federal agencies.

According to the Commission, the challenge of improving service delivery can be tackled, in part, by more effective use of research findings. For example, through Policy Academies, SAMHSA will share findings from its Juvenile Justice and Mental Health project with states and localities, and discuss strategies for implementing effective youth program models.

Increasing state infrastructure to support mental health services for transition-age youth is yet another significant policy challenge. Grants such as SAMHSA's Child and Adolescent State Infrastructure Grants enable states to improve their service delivery systems through increased access to services, workforce development, and implementation of evidence-based interventions, among other strategies. The Commission's recommendations reflect a belief that federal agencies must play a significant role in promoting shared responsibility for change across all levels of government and the private sector. However, the Commission acknowledges that states will ultimately be the "center of gravity" for transformation of the mental health system.

Shortly after the New Freedom Commission's report was issued, the final report of the White House Task Force for Disadvantaged Youth was released. It began

with the following statement: “The complexity of the problems faced by disadvantaged youth is matched only by the complexity of the traditional federal response to those problems. Both are confusing, complicated, and costly.” The report outlined a vision for all youth that would have them grow up

- healthy and safe;
- ready for work, college, and military service;
- ready for marriage, family, and parenting; and
- • ready for civic engagement and service.

The resulting work of the Task Force concluded that federal programs should focus on four goals:

- better management,
- better accountability,
- better connections, and
- priority to the neediest youth.

The need for long term, systemic change was evident. Several federal funding streams already required coordination and collaboration, accountability systems, and a service focus on the most in need. In response to the Task Force’s report, federal departments and agencies took action. The U.S. Department of Labor’s Employment and Training Administration, for example, issued a Training and Employment Guidance Letter in May, 2006, that expanded its strategic vision for serving youth under the Workforce Investment Act to include youth with disabilities among our nation’s neediest youth.

Legislative mandates also are fueling the need to address youth with mental health needs, particularly as they transition out of school. Transition services have been identified as critical parts of the educational process for all students in the No Child Left Behind Act of 2001, and for students with disabilities in the 2004 Amendments to the Individuals with Disabilities Education Act. These legislative mandates call for the creation of a universally available, high-quality school-to-work transition system that prepares all students, including those with MHN, for work and further education and increases their opportunities to enter first jobs in high skill, high wage careers. Specifically, the transition outcomes of all students, including those with MHN, will be improved by encouraging students to stay in school and attain high standards of academic and occupational achievement, and by building effective partnerships among secondary schools, postsecondary educational institutions, community members, and parents. Transition services for youth with MHN should be based on these fundamental service delivery pillars.

Components Of Effective Transition Systems For Youth With Mental Health Needs

Research on effective transition programs for youth with mental health needs is limited, but a review of school-based transition programs for youth with

disabilities, employment programs, mental health and social service programs, and supported work programs for adults with severe mental health needs finds several components that appear to be instrumental in their success:

- a systemic foundation,
- family involvement and support,
- transition staff (discussed in Chapter 3) and other caring adults, and
- competitive employment.

The Beginning Road Map To Establish A Systemic Foundation

A well-marked road map has not yet been established for what should be included in a systemic foundation to upgrade the support systems for youth with MHN; however, components are beginning to emerge. As a part of the development of the Federal Mental Health Agenda, a national panel of experts was convened by SAMHSA's Center for Mental Health Services. This group provided a range of policy suggestions to address the barriers (e.g., broaden eligibility for services, enhance interagency focus on the youth population, broaden existing grant programs, and require outcome-driven approaches and accountability), which build on the following characteristics, identified by Dryfoos in the 1990s, of a comprehensive system for supporting the needs of youth with MHN:

- system level change involving federal, state, and local agencies in education, mental health, vocational rehabilitation, Workforce Investment Act programs, Ticket to Work, Medicaid, Social Security, juvenile justice, foster care, transportation, and other areas;
- continuity of effort that provides for long-term programs, reduces interruptions in services, spans the transition cliff, and includes outreach and recovery options for youth who fall through the cracks;
- multiple service options for addressing work skills, emotional problems, educational issues, interpersonal skills, and independent living that reflect the fact that there is no one solution that works for all youth with MHN;
- multiple opportunities for success that emphasize small triumphs and multiple chances;
- community specific services geared to specific needs and resources;
- programs that are grounded in a stable, flexible educational context that include wrap-around services such as social services, vocational experiences, and focused academic instruction; and
- administrative and service flexibility that includes community settings such as competitive job placements, community service, etc.

The systemic policy changes recommended by the panel, which focused on enhancing services and outcomes for youth with MHN include

- eliminating disincentives for youth employment such as SSDI, organizational cultures, and the "creaming" of easy-to-serve youth in order to improve outcome data;

- encouraging the funding of Peer Support Specialists to help youth navigate service tunnels; and
- increasing the age for mental health and related services for children and youth to as high as 30 years of age.

Much remains to be done. For example, a 2005 survey of members of the National Association of State Mental Health Program Directors revealed that states either did not have any programs focused on young adults or had programs in only a part of the state. Only two states (Maryland and Connecticut) were working on developing systematic services for youth with mental health needs statewide. Survey recommendations noted the need for leadership at the federal, state, and local levels, stating that “providing continuous and appropriate services for this age group cannot be achieved by any single agency,” and that continuity of services and developmentally appropriate supports are needed. Other thoughtful recommendations from the survey included (1) setting the transition period for youth with mental health needs at ages 16 to 30; (2) adjusting definitions of mental health needs so that they do not screen youth out of needed services; (3) developing partnerships to expand service delivery; and (4) collecting data and supporting research that will expand the limited research studies on youth with MHN. The good news from the survey is that there is “developing expertise and leadership available to states” (Davis & Hunt, 2005) that can help span the transition cliff and eliminate ineffective service tunnels.

The Center Of Gravity — The States

The states are being recognized as the place where the road maps will be developed to improve the needed services for youth with MHN. There are several critical program design elements as well as a set of process issues that need to be addressed by the states. In the list of key suggestions from the panel of experts discussed above, preparing for the world of work is a reoccurring theme that must be addressed. This will require deeper engagement of education and workforce development programs than has been the case in past.

As noted in Chapter 2, ensuring that a youth is healthy and ready for work, independent living, and civic engagement is easier said than done. There is no coordinated system that guides a youth through the process of becoming a productive and self-sufficient member of society and the labor market. Pieces of the system exist, such as Career and Technical Education, transition planning under the Individuals with Disabilities Education Act, and programs available through Vocational Rehabilitation and the Workforce Investment Act, but because these services are often incomplete and uncoordinated, they are frequently ineffective. Youth with educational and career challenges, such as those with MHN, too often fall off one of the many cliffs in the system or get shunted down an arbitrary or inappropriate service tunnel based on the point of entry into the system rather than the youth’s needs. Thus particular attention must be given to improving the processes and procedures used by all of the stakeholder agencies that have a role in contributing to the evolution of a new

system.

Given the varied needs of youth with MHN, it will be necessary to include a number of different federal, state, and local agencies in the systems change effort to improve transition services and outcomes. Logically, the leadership on this task should begin at the state level, although the role of each specific agency will need to be established. Changes will be required in the service structure and procedures of workforce development organizations such as state Departments of Labor and Vocational Rehabilitation agencies, as well as the state and local mental health systems for children and youth. Prototypes will need to be tested through local partnerships and collaboratives to assess a myriad of service strategies to identify those that most successfully improve outcomes; such testing will benefit all partners.

Critical Design Elements

What follows are a set of design elements that should be considered as these prototypes are developed.

Universal Access

An effective service delivery system should be based on a clear understanding of universal design, access, and service; however, there are no agreed upon definitions of these terms, which are often used interchangeably.

Therefore, for the purposes of attempting to create clarity throughout the system, NCWD/Youth proposes the following definition of universal access: *the design of environments, products, and communication as well as the delivery of programs, services, and activities to be usable by all youth and adults, to the greatest extent possible, without adaptation or specialized design.* In essence, this definition offers a common term that contains two parts, the physical and the abstract, the visible and the invisible. It is about both design and service delivery and captures the core concepts across the system.

Examples of universal access include ergonomic designs for tools and products in order to enable the maximum number of consumers to use them (e.g., “rocker” light switches; large, easy-to-grasp knobs on equipment; automatic doors; ramps instead of stairs) and Universal Design for Learning, in which teachers include all learners in their classes by presenting information in a number of different ways, provide different ways for students to demonstrate learning, and engage students by incorporating their interests into the class in order to motivate and challenge them. Table 4.1 outlines some basic principles of universal design.

Clearly, many complex concepts around “universal” and “access” converge in the workforce development system. This convergence results in enormous implications for policymakers and practitioners alike, beginning with a single definition of universal access that is commonly understood across the myriad of

stakeholders in the system.

Achieving universal access under the above broader definition, however, will require substantially different approaches to the design of instruction, services, materials, products, communications, locations, and environments. Useful tools and instruments need to be developed to assist youth and adult workforce program practitioners to conduct self-assessments and to operationalize, implement, and measure their success in applying universal access. Staff competencies will need to be established and new forms of professional development for staff of service providers will be necessary.

Table 4.1: Principles of Universal Design

1. The design does not stigmatize or disadvantage users.
2. A wide range of individual preferences and abilities are accommodated by the design.
3. How to use the design is easy to understand regardless of the experience, knowledge, language skills, or current concentration level of the user.
4. Information is effectively communicated to the user, regardless of the user's sensory abilities, or surrounding conditions.
5. Adverse consequences of accidental or unintended actions are minimized by the design.
6. The design is used efficiently and comfortably with a minimum amount of fatigue.
7. Regardless of the user's body size, posture, or mobility, appropriate size and space is provided for approach, reach, manipulation, and use.

©1997, North Carolina State University, Center for Universal Design

(End of Table 4.1)

Competitive Employment

Ensuring that new, young workers have access to high skill, high wage careers is critical. The labor market implications of the statistics for youth with mental health needs (see Table 1.1) are obvious and disturbing. The National Longitudinal Transition Study II, however, has some good news about youth with mental health needs. The study indicates that within a one-year period, youth with MHN were employed at a slightly higher rate than youth in the general population. High school students, however, are usually employed in low wage, entry-level

positions with high turnover rates. Youth with mental health needs, who often have dropped out of or were suspended or expelled from school, were fired from a job, or have been arrested or incarcerated, are unlikely to have the knowledge or skills needed to qualify for or hold down a high skill, high wage career.

The most effective way for youth to learn work skills is in competitive employment and other work-based learning experiences. An effective transition system will ensure the involvement of employers at all appropriate levels, including advisory boards, cooperative arrangements with transition programs, job-shadowing, mentoring, and employing youth with MHN. The system will also need to provide assistance to employers on such issues as disclosure, accommodations, and job modifications.

Fortunately, the teenage years can be an effective time to intervene with youth with mental health needs because their impending entry into adulthood may generate a strong desire to learn positive work and “real world” academic skills. Effective transition strategies do exist and there is substantial reason to believe that many of these youth can succeed as adults in our society — if they receive appropriate services and support.

Many youth with MHN will need additional support and longer-term services to be successful in the transition process. There is no “magic cure” or simple solution, but there are emerging concepts and service models that indicate that coordinated educational, vocational, mental health, and social services can prepare young people with MHN to enter and succeed in the workplace, and — ultimately — to assume productive adult roles.

An example of a specific policy change, suggested by a national panel of experts convened by SAMHSA to consider transition issues for youth with MHN, is to increase the age for mental health services for youth from 16 to 30 years. By doing so, many of the discontinuities between adult and youth services would be ameliorated and the youth would have additional time in which to mature. This policy change is currently being considered by Pennsylvania and other states.

The Importance of Youth Leadership

Effective workforce development programs have youth development and leadership components at their core. Research shows that youth who participate in youth development and leadership experiences are more likely to do well in school, participate in their communities, and positively transition through adolescence to adulthood. Both the youth and the community benefit.

The mental health and the workforce development systems have both recognized the importance of youth leadership. Mental health Systems of Care emphasize the active involvement of youth in making decisions and developing service plans. The Workforce Investment Act of 1998 fused youth development

principles with traditional workforce development. The 10 required WIA program elements for youth include “youth leadership opportunities which may include community service and peer-centered activities encouraging responsibility and other positive social behaviors during non-school hours.”

Due to the growing recognition of the importance of youth development and leadership, the voice of youth is being heard in the development of programs, services, and policy for youth. Youth-directed organizations such as What Kids Can Do (“Voices and Work from the Next Generation” at <http://www.whatkidscando.org/index.asp>) and the National Youth Leadership Network (“the national voice for young leaders with disabilities” at <http://nyln.org>) conduct research, develop youth agendas, and communicate recommendations to policymakers and program administrators at a number of levels.

The framework for active youth involvement, found in Exhibit 3.2 (see page 3-28), describes youth leadership at the individual, community, and policy-making levels. Its continuum of power and choice leads to the progressive growth of youth leadership skills. The framework can guide youth to a decision-making role in developing and implementing the policies and procedures that have a direct impact on their lives.

Program administrators and policymakers should ensure that the youth voice is incorporated into program organization, services, and activities, as well as into decision-making on policies affecting youth, their families, and their communities. Examples of youth leaders in action are students who take charge of their IEP meetings and Peer Support Specialists who guide youth with MHN in navigating service systems.

Family Involvement and Support

As noted in the *Guideposts for Success* in Chapter 3, family involvement and support are critical to the success of youth with mental health needs. An effective transition system must actively involve and work effectively with families, which may include nontraditional arrangements such as tribal elders, court-appointed guardians, and grandparents who are raising a youth. Families will need information and support in locating appropriate services and navigating through service tunnels, as well as assistance in understanding their rights and other legal issues such as confidentiality, privacy laws (see Exhibits 4.2 and 4.3 on pages 4-19 and 4-20), and extending guardianship for a youth with MHN if that becomes necessary. Policies must sustain the family’s supportive role, a role that changes over time as the youth matures and one that becomes increasingly important in preparing the youth for adulthood.

Caring Adults

As noted in Chapter 3, the role of youth service practitioners and other caring

adults is important to the transition success of youth with mental health needs; it may, in fact, be the most critical piece of an effective program. These adults support youth in brokering services in multiple service tunnels, determining career goals, and placing and supporting youth in competitive employment and postsecondary education. An effective transition system encourages and supports the involvement of caring adults such as mentors.

A major role for youth service practitioners is to work closely with each youth with MHN and his or her family members in order to coordinate necessary and appropriate mental health and social services. To aid in this process, transition programs should develop connections with social service agencies at an administrative level through agreements outlining the ways in which agencies will work together to benefit youth with MHN. These policies then can be implemented at the individual level.

This means that a strong system of brokers must be developed. The failed approach of the past, where the youth was referred from one agency to another agency for services without the two organizations sharing information on the progress of the youth or the youth not having a lead point of contact or case manager simply doesn't work. Having someone available to assist the youth and family in navigating the multiple systems needed for transition success is essential. In order to make this a reality, the next set of design features are of high importance.

Critical Process Design Features

Interagency Coordination and Collaboration

Collaborative, cross-agency cooperation (both statewide and in local communities) is becoming necessary to maximize available expertise and to leverage funding for youth service delivery. Agencies may wish to begin their cross-agency planning process by resource mapping, a type of environmental scanning that is a useful means of identifying, recording, and disseminating related resources and services that comprise the youth services delivery system. By detailing current capacities, needs, and expertise, an organization or group of organizations can begin to make strategic decisions about ways to broaden their collective capacity. The beginning point can be to identify providers of youth services and their funding resources. Resource mapping allows states and communities to identify service gaps and service overlaps. This information is essential for aligning assessment services and for strategic planning. A number of resource mapping resources are included in Appendix A.

Interagency strategic planning processes should address program evaluation and reporting requirements for outcome measures and continuous improvement data. The often elaborate reporting requirements of federally funded partners will need to be factored into data sharing and data management agreements. These

agreements should also take into account confidentiality and privacy issues.

Data privacy practices of health, education, and human services organizations determine a portion of what must be addressed in any collaborative initiative among agencies and institutions. Two federal data privacy laws, the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPAA), establish strict federal standards concerning the use of education, health, and human services information.

(Sidebar) RENEW: Sustaining a Grant-Funded Project

RENEW is an evidence-based career and education project created by the Institute on Emotional Disabilities at Keene State College in 1996 from a grant by the U.S. Department of Education, Rehabilitation Services Administration. RENEW is designed to assist youth and young adults who are at risk of dropping out or who have serious emotional or behavioral challenges to finish high school, obtain employment, and successfully enter adulthood. To date, RENEW has worked with 467 young people who have been able to achieve significant success in schools, jobs, and further education.

After the successful completion of the grant, The Alliance for Community Supports (ACS), a private, non-profit corporation, was formed to continue the services provided by RENEW. RENEW is funded by private youth contracts and several state initiatives.

RENEW collaborates with the University of New Hampshire's Institute on Disability, Justice Works, the Office of Public Defender, and a steering committee comprised of community and public agencies and schools on a re-entry project for youth with disabilities involved in delinquency hearings or in out-of-district placements. RENEW and the University of New Hampshire's Institute on Disabilities are also part of the NH State Department of Education's statewide initiative to change the way schools deal with at-risk and ED students and to reduce dropout rates and academic failure.

RENEW uses community-based education practices such as "Real World Learning" and has a nationally recognized youth leadership program. A person-centered planning program called "Futures Planning" guides the process. Wrap-around, family supports, and a holistic approach are key RENEW tools. RENEW also teams with the Granite State Federation of Families and CARE NH to support RENEW families and their teens.

On March 6, 2006 RENEW celebrated its tenth anniversary of serving at-risk youth in the state of New Hampshire. For more information, refer to <http://www.allianceforcommunitysupports.com>.

(End of Sidebar)

FERPA is a federal law that protects the privacy of student education records. The law applies to all schools, colleges, and universities that receive funds under applicable programs of the U.S. Department of Education. Exhibit 4.2 provides an overview of FERPA.

HIPAA, which took effect in April of 2003, includes a set of federal privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals, and other health care providers. These new standards were developed by the Department of Health and Human Services to provide individuals with greater access to their medical records and more control over how their personal health information is used and disclosed. Exhibit 4.3 provides an overview of the HIPAA Privacy Rule.

In addition to FERPA and HIPAA, many states have enacted data privacy laws to protect individuals from misuse of confidential information by public and private entities. In general, private and confidential information about youth may not be shared or used in any form without the expressed and written consent of the affected individuals and those authorized to represent them.

Youth service organizations should have a working knowledge of the data privacy laws and regulations governing the operations of their respective organizations. These laws and regulations govern formal data management policies regarding (a) storage, protection, and security of confidential youth information; (b) receipt and sharing of youth information; (c) the intended uses of privileged information; (d) procedures for obtaining written authorization from youth (or family members) to authorize the receipt, sharing, and use of information;

(e) prevention of potential misuses of confidential information; and (f) destruction of all electronic and written records after defined time intervals. Exhibit 4.4 is a sample interagency data-sharing agreement.

Once the organizations providing youth services are identified and a plan is made to align services, understandings or agreements between agencies must be developed in order to ensure that services are provided as planned. Formal interagency agreements such as Memoranda of Understanding (MOUs) are not new, but to date there is little evidence that they have been used to build common infrastructures. Agencies that are party to these agreements will be breaking new ground in the alignment and provision of assessment services. Table 4.2 represents a composite of elements commonly found in MOUs.

Once interagency agreements are in place, some policy decisions necessarily will need to be made at the individual organizational level. Policies guiding the screening of youth for potential mental health challenges by youth service professionals, for example, may entail a description of the circumstances that trigger the screening process, permission policies and forms to be completed by

parents or legal guardians, identification and training of staff who will administer the screens, a list of approved screening instruments, procedures for referring youth for full mental health evaluations, a list of approved professionals to whom to refer the youth for evaluation and therapy, and guidelines for reporting and implementing the service recommendations based on the evaluation results. Table 4.3 on the following page suggests roles and responsibilities for different stakeholders.

The Systems of Care (SOC) approach is one example of an effort on the part of youth, families, and the agencies that serve them to support children with mental health needs in an integrated manner. This approach has been used as a catalyst for changing the way public agencies organize, purchase, and provide services for children and families with multiple needs. The SOC approach is characterized by multi-agency sharing of resources and responsibilities and by the full participation of professionals, families, and youth as active partners in planning, funding, implementing, and evaluating services and system outcomes.

The SOC approach facilitates universal access because it enables cross-agency coordination of services regardless of where or how children and families enter the system. Agencies work strategically, in partnership with families, youth, and other formal and informal support systems, to address the unique needs of children and youth. To do so effectively, participants in SOC must

- agree on common goals, values, and principles that will guide their efforts;
- develop a shared infrastructure to coordinate efforts toward the common goals of safety, permanency, and well-being; and
- work within that infrastructure to ensure the availability of a high-quality array of home, school, and community-based services to support families and preserve children safely in their homes and communities.

The SOC approach is not a “program” or “model.” Rather, it is an approach for guiding processes and activities designed at the system, policy, and practice levels to meet the needs of children and families who are in need of supports. States and communities must have the flexibility to implement this approach in a way that works for each community. SOCs are not static; they evolve over time as community needs and conditions change.

Table 4.2: Memoranda of Understanding Components

The components of an MOU will vary according to its purpose, the needs of the signatory parties, and regulatory requirements. The following list was compiled from a wide variety of MOUs, none of which contained every item listed below.

Basic Information

- Parties to the MOU (Organization names, addresses, contact persons,

- phones, faxes, e-mails)
- Purpose of the MOU
- Duration of the MOU
- Authorized signatures, dates, titles

Setting the Stage

- Joint vision
- Key principles
- Commitments (e.g., specific screens and/or assessments, information exchange, cross referrals)
- Key practices (e.g., adherence to WIA Section 188 Disability Checklist service plan)

Description of Duties and Responsibilities

- Shared or coordinated service responsibilities
- Individual organizational service responsibilities
- Methods of referral
- Exchange of information
- Management structure

Measuring Progress

- Performance measurement standards
- Evaluation and review processes
- Reporting and recordkeeping requirements

Financial Options

- Budget and methods of payment
- Non-financial cooperative agreements
- Subcontracting arrangements

MOU Management Issues

- Modification, amendment, or assignment
- Renewal and termination
- Dispute process
- Assurances and certifications (often required or provided by funding sources)

Optional Attachments

- Confidentiality and information releases
- Cross referral forms
- Resource sharing agreement
- Governance agreement

For examples of memoranda of understanding and resource agreements, visit the New York Association of Training and Employment Professionals

(NYATEP) website at <<http://www.nyatep.org/pubsresources/samplemous.html>>.

(End of Table 4.2)

Table 4.3: Roles and Responsibilities by Organizational Level

State

- Resource mapping and strategic planning across state agencies and stakeholders
- Development or amendment of Memoranda of Understanding (MOUs) between state agencies, including cost sharing for service centers throughout the state
- Coordination of state and federal program evaluation and reporting requirements, including selection of specific forms and procedures
- Development of policy guidelines for use by regions and localities
- Guidance for regions and localities regarding information dissemination
- Training to state and local personnel managers on global issues such as confidentiality, data-sharing, etc.

Region/Locality

- Resource mapping and strategic planning across regional/local agencies and stakeholders
- Development of MOUs between local agencies not covered by state MOUs, including locally determined services and coordination
- Implementation of state policy guidelines
- Coordination of services between partners, such as identification of qualified personnel to conduct specific screens, referral procedures for in-depth evaluations, and selection of administering organizations
- Information dissemination and guidance to organizations
- Training to local and organizational personnel on issues such as principles guiding appropriate screening and service delivery, etc.

Organization

- Internal resource mapping and strategic planning
- Development of agreements with agencies and organizations not covered by state or regional/local MOUs, including the provision of assessment services not provided by state service centers or regional/local providers
- Development of service schedules and administration policy internally and with partners
- Selection of unique screening instruments and development of policy guidance for screening and referrals to in-depth evaluations not covered by state or local policy

- Guidance and training of youth service practitioners as needed
- Provision of person-centered planning and direct services to customers

(End of Table 4.3)

Resource Management

Resources and funding are always problematic in developing cross agency collaborations. A number of potential funding streams for transition services for youth with mental health needs are available at the federal, state, and local levels. Federal funding streams that may support activities and services identified in the *Guideposts for Success for Youth with Mental Health Needs* (see Table 3.1 on page 3-3) include those of the Workforce Investment Act, the Rehabilitation Act, Medicaid, mental health systems, and several work incentives under the Social Security Administration such as the Medicaid Buy-in and Plan for Achieving Self-Support (PASS).

The challenge of accessing funding from very large funding sources such as Medicaid and federal mental health programs is sorting through the funding streams and understanding both the complexities and opportunities they present. For example Jackson and Muller found that while Medicaid is now a significant source of funding for mental health services, many providers are not familiar with the needs of youth or adults with MHN and how to serve them. Other service providers may not be aware that Early Prevention, Screening, Diagnosis, and Treatment (EPSDT) may be used to provide services for the 18 to 21 year age group, according to Davis & Hunt.

Resource mapping is especially useful in resolving funding issues, since it can be used to identify and organize information concerning organizations that provide youth services, funding sources and resources dedicated to youth services, and locations of service gaps and overlaps. Once the information is collected and organized, partnerships and collaborative arrangements may be made. Interagency agreements may be developed to specify which agencies will provide different types of services and how they will be funded.

Funding strategies may include “blending” and “braiding.” Blending combines funds into one funding stream by relaxing the regulations of the original funding sources to permit programmatic flexibility. Mechanisms are developed to pool dollars from multiple sources, making them in some ways indistinguishable.

Braiding taps into existing categorical funding streams and uses them to support unified initiatives in a flexible and integrated manner. Braided funds produce greater efficiency and effectiveness by reducing the reliance on any one funding source. Braided funds are not commingled since organizations maintain control of their funds while coordinating services with their partners. Braiding also provides seamless funding to families and youth while allowing dollars to be traced back to their source for accountability and reporting purposes.

For more information on funding strategies, see NCWD/Youth's *Blending and braiding funds and resources: The intermediary as facilitator*, is available in Word and pdf versions at <<http://www.ncwd-youth.info/resources & Publications/information Briefs/issue18.html>>.

A basic tenet of behavioral interventions is that to be effective, they should be administered consistently and continually over time. Unfortunately, most programs for youth with MHN run for a set period of time or are interrupted at various points because youth age out of the youth system and encounter a transition cliff. These service disruptions do little over the long term to promote vocational and career achievements. Therefore, it is important that strategies to provide continuing services without breaks are examined and implemented.

A critical issue for transition programs for youth with MHN is the development of creative funding and program options for services during and after high school and in the community setting. Transition programs for youth with MHN must often locate and connect with a number of service providers or agencies with different administrative and funding guidelines. Strategies such as resource mapping, partnership development, and blending and braiding of funds will be necessary to address this challenge.

Innovative strategies for funding mental health services at the state level are underway. California, for example, recently passed a funding initiative (Proposition 63) that places a 1% tax surcharge on individuals making more than one million dollars a year to support state and local mental health systems. This surcharge will create an \$800 million fund that will be used to support county mental health services, consumer participation, and innovative programs.

Information on potential federal funding sources is contained in *Moving on: Federal programs to assist transition-age youth with serious mental health conditions* at <<http://www.bazelon.org/publications/movingon/index.htm>>. This website provides fact sheets on 57 federal programs that offer services supporting youth with MHN as they transition to employment and adulthood. Information on individual, discretionary, and formula or block grants, as well as on program services and relevance, is also available.

Managing resources is one of the biggest challenges of any system, especially one where the demand for services exceeds the supply. The *Guideposts for Success* and the *Guideposts for Success for Youth with Mental Health Needs* can be used as frameworks for local resource mapping exercises to determine where existing resources are deployed, and where the service gaps and overlaps are. Policymakers and youth service providers can then decide how the gaps can be filled and the overlaps eliminated. This process will require some creative thinking about the routing of funds and the roles of staff. These steps can be taken while larger policy and regulatory change is underway.

Policymakers should exercise informed judgment in the budgeting and resource allocation process. This guide can help policymakers make the difficult decisions that will affect the transition to independence and employment for youth with mental health needs.

(Sidebar) The Pennsylvania Community on Transition (PACT) Mental Health Practice Group

In 1998, the Governor of Pennsylvania issued an executive order titled “Interagency Committee to Coordinate Services Provided to Individuals with Disabilities.” The order resulted in a Memorandum of Understanding among the Pennsylvania Departments of Education, Public Welfare, Labor and Industry, and Health that described financial responsibilities, coordination of services, an interagency coordinating committee, and other parameters necessary for the provision of services to youth with disabilities. The intent of the MOU was to shift from isolated, single-agency activities to cross-systems efforts in the areas of Policy and Regulation Development, Strategic Planning, Service Delivery Systems, Data Collection, Program Initiatives, and Professional Development.

What began as a four-department/ten-office Training Team on the MOU has evolved into a cross-agency Community of Practice (CoP) on secondary transition. A Community of Practice is defined as “groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis” (Wenger, McDermott, & Snyder, 2002, p.4). The foundation of this effort in Pennsylvania is built on shared work and knowledge to assist youth and young adults with disabilities to achieve their desired post-school outcomes.

The vision of the Pennsylvania Community on Transition (PACT) is that all Pennsylvania youth and young adults with disabilities will successfully transition to the role of productive, participating adult citizens; be empowered to recognize their talents, strengths, and voice; and have equal access to resources that will promote full participation in the communities of their choice.

The PACT mission is to build and support sustainable community partnerships that create opportunities for youth and young adults with disabilities to transition smoothly from secondary education to the postsecondary outcomes of competitive employment, education, training and lifelong learning, community participation, and healthy lifestyles. The foundation of its work depends on steadfast leadership, cross-system policy development, and fidelity to evidence-based, quality-driven practices.

In order to support the work of the PACT state leadership team, practice groups are being developed in the areas of community participation; competitive employment; healthy lifestyles; postsecondary education, training, and lifelong

learning; juvenile justice and child welfare; mental health; transportation; and youth engagement. Each Practice Group defines its own work and may focus on developing the meaning of the outcome or issue, cross-agency terminology, solutions to outcomes and issues, effective practices, and policy and program changes at the local, state, and national levels. Listservs, websites, conference calls, regional sessions, and state events are being created to connect and support practice group participants, who may be anyone interested in supporting youth and young adults in successfully achieving post-school outcomes.

The specific purpose of the Mental Health Practice Group is to promote the academic achievement and well-being of all Pennsylvania youth and young adults through the development of a comprehensive, cross-community, behavioral health support system. This effort will emphasize the utilization of evidence-based school mental health services in conjunction with existing school-wide and community mental health programs and services. Growing evidence shows that school mental health programs improve educational outcomes by decreasing absences, decreasing discipline referrals, and improving test scores, thus enabling youth and young adults to better achieve their desired post-school outcomes. This group will also explore and promote mechanisms to effectively assist youth and young adults in the smooth transition into needed adult services and supports.

The Mental Health Practice Group, which is also part of the national IDEA (Individuals with Disabilities Education Act) Partnership Transition Community of Practice, is currently developing goal statements and a plan of action for providing the key supports and services needed by youth with mental health needs in the state. Pennsylvania is also participating in the National Community of Practice on Collaborative School Behavioral Health. Information on these efforts can be found at the IDEA Partnership website in the Communities of Practice section at <http://www.ideapartnership.org>.

For additional information, please contact the following:

- Rick Boyle, Educational Consultant, PA Training and Technical Assistance Network office, Pittsburgh, rboyle@pattan.net, 412-826-2336, ext. 6863
- Ron Sudano, Educational Consultant, PA Training and Technical Assistance Network office, Pittsburgh, rsudano@pattan.net, 412-826-2336, ext. 6868
- Julie Barley, PA Dept. of Public Welfare, Office of Mental Health and Substance Abuse Services, jbarley@state.pa.us

(End of Sidebar)

Cultural and Linguistic Competence to Address Institutional Bias

As noted in Chapter 3, part of the tunnel problem is the institutional bias encountered by many youth seeking services. Discrimination may occur based on a number of personal characteristics such as race, culture, language, age, gender, and disability. Discrimination against people with mental health needs has a number of sources including ignorance, myths, attitudinal barriers, and the stigma associated with these disorders.

Discrimination occurs despite the fact that access for people with disabilities is driven, in large part, by some very specific standards embedded in multiple laws and implementing regulations, such as the Americans with Disabilities Act, Sections 504 and 508 of the Rehabilitation Act, and Section 188 of Title I of the Workforce Investment Act. Section 188, which implements the WIA's non-discrimination and equal opportunity provisions, is applicable to programs, services, and activities receiving financial assistance under the title. Because of the stringency of Section 188 coupled with Sections 504 and 508 of Title IV, the WIA legislation is arguably one of the strongest civil rights laws on the books.

The consequences of services and policies that are not culturally and linguistically competent are serious and may result in inappropriate services or lack of any services — with potentially life-altering results. For example, in some cultures it is considered rude to disagree with a person in authority; therefore, a young person or a family member may answer “yes” to every question he or she is asked in order to be polite. Youth or family members who are English language learners may misunderstand spoken or printed questions or instructions in interviews, on career inventories, or in other situations that may ultimately result in decisions that send them down the wrong service tunnel or that deny them services altogether.

A number of guidelines and resources have been developed to ensure that programs and services are culturally competent, but change occurs slowly in most institutions and agencies. The National Mental Health Information Center suggests that culturally competent workforce development agencies and youth service providers

- appoint board members from the community so that voices from all groups of people within the community participate in decisions;
- actively recruit multiethnic and multiracial staff;
- provide ongoing staff training and support for developing cultural competence;
- develop, mandate, and promote standards for culturally competent services;
- insist on evidence of cultural competence when contracting for services;
- nurture and support new community-based multicultural programs and engage in or support research on cultural competence;
- support the inclusion of cultural competence on provider licensure and certification examinations; and

- support the development of culturally appropriate assessment instruments, psychological tests, and interview guides.

The Agency for Healthcare Research and Quality found that linguistically competent organizations provide readily available, culturally appropriate oral and written language services to English language learners through a number of practices such as bilingual staff, trained interpreters, and materials translated by qualified translators.

A number of resources that address cultural competence are available, such as the SAMHSA's Systems of Care website at <<http://www.systemsofcare.samhsa.gov>> and Georgetown University's National Center for Cultural Competency website at <<http://gucchd.georgetown.edu/nccc/index.html>>. These and additional resources are listed in the Policy and Systems Change section of Appendix A.

Professional Preparation and Development of Youth Service Professionals

The range of settings in which youth receive workforce development services is wide, and the responsibilities of the staff serving them call for both general and specialized knowledge. Youth service practitioners play an important role in connecting all youth to workforce preparation opportunities and support. Youth service practitioners must keep pace with constant changes in the labor market, economic shifts, new technologies, and the evolving needs and culture of today's youth. Yet, throughout the field of workforce development, there seems to be little professional training available for youth service practitioners and no formal system for accessing the training that is available.

The demands on youth service practitioners in the workforce development arena are great. They must be able to serve a diverse group of youth effectively, which requires a broad range of knowledge, skills and abilities. NCWD/Youth has synthesized 10 emerging competencies of effective youth service practitioners as the centerpiece of an effective workforce development system. The competencies are

1. knowledge of the field;
2. communication with youth;
3. assessment and individualized planning;
4. relationship to family and community;
5. workforce preparation;
6. career exploration;
7. relationships with employers and between employer and employee;
8. connections to resources;
9. program design and delivery; and
10. administrative skills.

Practitioners serving youth with mental health needs will need additional competencies in order to serve this population effectively. Specifically, in order to ensure that these youth receive comprehensive coordinated service delivery consistent with the

Guideposts for Success for Youth with Mental Health Needs, these practitioners must develop knowledge and expertise with regard to

- behavioral action plans such as SAMHSA's Recovery Action Plans;
- health insurance options including Medicaid buy-in incentives;
- pediatric to adult health care issues such as the "medical home" concept, mental health screening for both youth and families, and youth choice in deciding medications and treatment;
- school-based mental health services including the role of the IEP team, training in mental health issues for IEP team members, the importance of parent involvement in transition planning, and mental health screens as part of the school health curriculum;
- funding sources and their eligibility requirements;
- strategies for combating workplace discrimination for youth with MHN and other issues under the Americans with Disabilities Act;
- accessing services for youth with mental health needs under the SSI disabled children's program, Ticket to Work and Medicaid Work Incentive Programs, and Vocational Rehabilitation;
- strategies for combating disincentives in systems serving youth with MHN such as organizational culture, red tape, and "creaming";
- actively involving youth in the decisions affecting their lives including training Peer Support Specialists;

locating and maintaining safe and affordable housing, developing transportation plans including acquiring driver's licenses, and other post-placement supports in the community and the workplace; and a "team of teams" approach to coordinating services and supports from a large number of agencies and programs such as child welfare, parole and probation, juvenile justice, foster care, schools, GED and Adult Education, community colleges, health care providers, transition service providers, and more.

The success of all policies is ultimately dependent on the knowledge, skills, and abilities of the direct service providers. Professional organizations representing the various youth service practitioners therefore have a critical role to play in helping to establish the new roadmap. Many have developed codes of ethics to guide their behavior and ensure high standards. (For a sampling of ethics codes see Resources on page A-1). These organizations need to be involved in the development of new competency standards for their members, the promulgation of new training materials, and the promotion of cross agency staff training. Pre-service preparation institutions must also be partners in the development of these competencies through cross disciplinary programs of study.

Professional development funding must be recognized as a high priority by policy makers at all levels of government. Its importance precludes it from being treated as an optional budget line item.

Conclusion

The road to independence and self-sufficiency for youth with MHN need not be a dead end. Obstacles such as the transition cliff and ineffective service tunnels can be eliminated through thoughtful systems change processes that incorporate sound policies and practices. Systems change initiatives have already begun in a growing number of states and communities across the country.

Practitioners and policymakers have key roles to play in ensuring that youth with mental health needs have a fair chance at achieving the American dream of independence and self-sufficiency. The road will not be easy, but the information in this guide should help ensure that it leads to successful transitions to productive and rewarding adult lives.

Please see Appendix B for the list of references.

Exhibit 4.1: Supporting Research

The following section contains research specifically related to effective transition *systems* for youth with mental health needs. Chapter 3 contains research related to direct *services* for youth with mental health needs.

Bureau of Labor Statistic projections for the period 2004-2014 show that total employment is expected to increase 13% during that decade. Two-thirds of the 18 million new jobs that will be created over the next 10 years will be in occupations that require a postsecondary education or training degree or certificate (Bureau of Labor Statistics, 2006).

Data from the National Longitudinal Transition Study 2 show that youth with mental health needs are employed in high school at a slightly higher rate than youth in the general population in a one-year period (Wagner & Cameto, 2004).

Research suggests that the teenage years can be an effective time to intervene with this population as their impending entry into adulthood may initiate a strong desire to learn positive work and academic skills (Albee, 1982; Hobbs & Robinson, 1982; Kazdin, 1993; Petersen & Leffert, 2002). There is substantial reason to believe that many of these youth can succeed as adults in our society if they receive appropriate services and support.

Emerging service models indicate that coordinated educational, vocational, mental health, and social services can prepare young people with MHN to enter and succeed in the workplace, and — ultimately — to assume adult roles (Bullis & Fredericks, 2002; Cheney, 2004; Clark & Davis, 2000).

Components of effective transition programs for youth with MHN can be drawn from (a) educationally based transition programs for youth with disabilities (Aspell, Bettis, Test, & Wood, 1998; Benz & Lindstrom, 1997; Izzo, Cartledge, Miller, Growick, & Rutowski, 2000; Kohler, 1993; Rusch, DeStefano, Chadsey-Rusch, Phelps, & Szymanski, 1992); (b) labor and employer oriented programs (Fabian, Luecking, & Tilson, 1994; Timmons, Podmostko, Bremer, Lavin, & Wills, 2004; Luecking, Fabian, & Tilson, 2004); (c) mental health and social service programs (Clark, 1998; Dryfoos, 1990, 1991, 1993; Kazdin, 1985, 1993); and (d) supported work programs for adults with severe and persistent mental illnesses (Bond, 1998).

Although elements of these programs have been integrated into school and community-based programs specifically for youth with MHN (Bullis & Cheney, 1999; Bullis & Fredericks, 2002; Cheney, Hagner, Malloy, Cormier, & Bernstein, 1998; Clark & Davis, 2000; Siegel, 1988), to date there have been few controlled studies of the long-term impact of transition programs for this population (Cheney & Bullis, 2004). The absence of such research is probably due to substantial procedural obstacles in evaluating multi-faceted service programs for youth with

MHN (Kazdin, 1985, 1993) and the small number of transition programs for this specific population.

Dryfoos (1990, 1991, 1993) provides a clear and detailed discussion of the systemic foundation of comprehensive programs for youth with MHN. Reviews of effective programs for youth with MHN (Dryfoos, 1990, 1991, 1993; Kazdin, 1985, 1993) suggest that most effective programs are based in the schools. Specifically, high schools should provide social services, vocational experiences, and focused academic instruction (Dryfoos, 1991, 1993).

The American Youth Policy Forum conducted a national review of 50 evaluations of youth interventions and identified nine basic principles of effective youth programming and practice, including the participation of caring and knowledgeable adults, viewing youth as valuable resources and contributors to their communities, and high community involvement (James, 1999). Woyach (1996) identified 12 principles for effective youth leadership programs, including experiential learning and opportunities for genuine leadership and service to others in the community, country, and world.

NCWD/Youth conducted an extensive literature review on youth leadership and development and found a number of characteristics and outcomes of effective youth development and youth leadership programs. Outcomes included increased self-esteem, better life skills, fewer psychosocial problems, increased academic achievement, increased safety, better communications with their family, better problem-solving skills, positive engagement with their community, appreciation of cultural differences, and increased self-efficacy, self-advocacy, and self-determination. Program characteristics included experiential learning, service learning, mentoring, personal planning, collaborative teamwork, community projects, and opportunities to serve in leadership roles in the organization. At the administrative level, NCWD/Youth found that youth leadership organizations involved youth in every facet of the organization, including administration and program delivery, as a means practicing leadership skills (Edelman, Gill, Comerford, Larson, & Hare, 2004).

In response to the disenfranchisement of youth with MHN from the public educational system, there has been a dramatic increase in the number of alternative programs and schools (Lange & Sletten, 2002). Alternative educational placements typically include smaller student-to-staff ratios, allow for more personal relationships between students and staff, and provide flexible scheduling and personalized assistance. Many such programs require students to attend class for only part of a day, leaving open the possibility of using the rest of the day for community-based instruction, including structured competitive job placements (Tobin & Sprague, 2000). At the local level, for example, Cheney and his colleagues (Cheney, Hagner, Malloy, Cormier, & Bernstein, 1998), in a transition project for youth and young adults with MHN, established a cadre of social service partners from various agencies in Manchester, New Hampshire. At

regular meetings of this group, project staff presented case studies of the difficulties each participant experienced in accessing services. These individual cases provided the impetus for policy changes that improved the service flow for individuals and created durable systemic changes in the social service system in that region.

Family involvement in the life of youth with MHN is critical to their transition success (Friesen & Stephens, 1998; et al., 2001a, 2001b; Osher, Van Kammen, & Zaro, 2001; Stroul & Friedman, 1994). Family members offer the most long-term and enduring support to youth with MHN, as well as the encouragement necessary for the young person to succeed in employment (e.g., assisting with transportation) and other transition outcomes (e.g., assisting the youth to enroll in postsecondary education). Families of youth with MHN must assist their youth in navigating a complex array of services in service systems that may be foreign to families who may not have worked with those programs earlier in their children's lives (Dunkle, 1995; Institute for Educational Leadership, 2001b; Richardson & House, 2000).

Family members also need to be prepared for their youth's attainment of the age of majority, which is usually 18 years of age although this varies from state to state. If the family does not extend their guardianship over their son or daughter past majority age, they may not have access to information on their youth's transition experiences. Since many youth with MHN have average to above average intelligence as well as the ability to control their MHN through various treatment approaches, effective strategies for continued family involvement or guardianship should be explored (Friesen & Stephens, 1998; Holden, et al., 2001a, 2001b; Osher, et al., 2001).

Studies of resilient adults with MHN (Cicchetti & Garmezy, 1993; Garmezy, 1991; Murray, 2002; Rutter, 1985, 1987, 1993b; Todis, Bullis, D'Ambrosio, Schultz, & Waintrup, 2001; Werner & Smith, 1989, 1992) point to the critical role of one or more responsible adults in changing their life trajectories during their teenage years. The critical role of a transition specialist or committed staff person in the execution of individualized transition services for youth with MHN has also been identified repeatedly in the literature (Benz, Yovanoff, & Doren, 1997; Bullis, Tehan, & Clark, 2000; Clark, 1998).

Clark (1998) suggested that effective transition specialists should be organized, be able to accommodate scheduling changes, have practical knowledge of local employment opportunities, establish personal connections with employers (Fabian, Luecking, & Tilson, 1994; Luecking, Fabian, Tilson, 2004), and focus on supporting youth with MHN to achieve major transition outcomes rather than providing individual therapy or counseling. Several model demonstration programs for youth with MHN have suggested that a reasonable caseload for a transition specialist is 12 to 15 youth at a time (Bullis & Fredericks, 2002; Cheney, Hagner, Malloy, Cormier, & Bernstein, 1998; Clark, 1998).

The most effective way for youth with MHN to practice and learn work skills is in a real competitive employment setting instead of the classroom or in a make work situation (Benz, Yovanoff, & Doren, 1997; Hazasi, Gordon, & Roe, 1985; Kohler, 1993). There are comprehensive and clear descriptions available to guide professionals in approaching and recruiting employers to hire youth with disabilities and to be involved in transition programs (Fabian, Luecking, & Tilson, 1994; Luecking, Fabian, Tilson, 2004) that are based largely on needs assessments, focus groups, service experience, and program evaluation data. There are also statements of employer perceptions of building school-to-work partnerships between the public schools and competitive employers (Center for Workforce Development, 1994, 1999a, 1999b). There has not, however, been systematic research on the characteristics of employers who are apt to hire people with disabilities (Gillbride, Stensrud, Vandergoot, & Golden, 2003) or become involved in transition programs for youth with MHN, or on the structure of the cooperative arrangements between transition programs and employers that offer the most effective services (Bullis, 2004).

Surveys of employers who hired youth with MHN through community and school-based transition programs (Bullis, Fredericks, Lehman, Paris, Corbitt, & Johnson, 1994; Bullis, Moran, Todis, Benz, & Johnson, 2002) indicate that employers who agreed to hire youth with MHN typically did so because of three reasons: (a) past positive experiences with supported work or transition programs, (b) an altruistic commitment to help young people in their community, and (c) a history of personal or family experiences reflective of the problems experienced by the youth with whom they work (e.g., the employer had problems as a youth, or had a son or daughter with problems, so the employer wanted to help other youth with similar problems). Interestingly, no employers who responded to those surveys indicated that they hired a youth because of fiscal incentives, such as the Targeted Job Tax Credits, saying that such programs were too cumbersome and time-consuming to use.

From these results, as well as guidelines for working with competitive businesses in school-to-work programs (Institute for Educational Leadership, Center for Workforce Development, 1994, 1999a, 1999b; Fabian, Luecking, & Tilson, 1994; Luecking, Fabian, Tilson, 2004), it appears likely that transition specialists will need to interact with the business owners and managers in their locales and “sell” those employers on hiring a youth with MHN.

Resource mapping focuses on what states and communities have to offer by identifying assets and resources that can be used for building a system. It is not a “one-shot” drive to create a published list or directory, but rather a catalyst for joint planning and professional development, resource- and cost-sharing, and performance-based management of programs and services (Crane & Skinner, 2003).

Discrimination against people with mental health needs may be a result of

stigma, myths, and attitudinal barriers (Dew & Alan, 2005).

Please see Appendix B for the list of references.

Exhibit 4.2: Family Educational Rights and Privacy Act (FERPA)

The Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. §1232g; 34 CFR Part 99) is a federal law that protects the privacy of student education records. The law applies to all schools that receive funds under an applicable program of the U.S. Department of Education.

FERPA gives parents certain rights with respect to their children's education records. These rights transfer to the student when he or she reaches the age of 18 or attends a school beyond the high school level. Students to whom the rights have transferred are "eligible students."

- Parents or eligible students have the right to inspect and review the student's education records maintained by the school. Schools are not required to provide copies of records unless, for reasons such as great distance, it is impossible for parents or eligible students to review the records. Schools may charge a fee for copies.
- Parents or eligible students have the right to request that a school correct records that they believe to be inaccurate or misleading. If the school decides not to amend the record, the parent or eligible student then has the right to a formal hearing. After the hearing, if the school still decides not to amend the record, the parent or eligible student has the right to place a statement with the record setting forth his or her view about the contested information.
- Generally, schools must have written permission from the parent or eligible student in order to release any information from a student's education record. However, FERPA allows schools to disclose those records, without consent, to the following parties or under the following conditions (34 CFR § 99.31):
 - school officials with legitimate educational interest;
 - other schools to which a student is transferring;
 - specified officials for audit or evaluation purposes;
 - appropriate parties in connection with financial aid to a student;
 - organizations conducting certain studies for or on behalf of the school;
 - accrediting organizations;
 - to comply with a judicial order or lawfully issued subpoena;
 - appropriate officials in cases of health and safety emergencies; and
 - state and local authorities, within a juvenile justice system, pursuant to specific state law.

Schools may disclose, without consent, "directory" information such as a student's name, address, telephone number, date and place of birth, honors and awards, and dates of attendance.

However, schools must tell parents and eligible students about directory information and allow parents and eligible students a reasonable amount of time to request that the school not disclose directory information about them. Schools must notify parents and eligible students annually of their rights under FERPA. The actual means of notification (special letter, inclusion in a PTA bulletin, student handbook, or newspaper article) is left to the discretion of each school.

For additional information or technical assistance, you may call (202) 260-3887 (voice). Individuals who use TDD may call the Federal Information Relay Service at 1 (800) 8778339 or at the following address:

Family Policy Compliance Office
U.S. Department of Education 400 Maryland Avenue, SW
Washington, DC 20202-4605

U.S. Department of Education Policy Guidance
<<http://www.ed.gov/policy/gen/guid/fpco/ferpa/index.html>>

Exhibit 4.3: Health Insurance Portability and Accountability Act Privacy Rule

The *Standards for Privacy of Individually Identifiable Health Information* (Privacy Rule) establishes, for the first time, a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services (HHS) issued the Privacy Rule to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Privacy Rule standards address the use and disclosure of individuals' health information — called “protected health information” — by organizations subject to the Privacy Rule — called “covered entities” — as well as standards for individuals' privacy rights to understand and control how their health information is used. Within HHS, the Office for Civil Rights (OCR) has responsibility for implementing and enforcing the Privacy Rule with respect to voluntary compliance activities and civil money penalties.

A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being. The Rule strikes a balance that permits important uses of information, while protecting the privacy of people who seek care and healing. Given that the health care marketplace is diverse, the Rule is designed to be flexible and comprehensive to cover the variety of uses and disclosures that need to be addressed.

Protected Health Information. The Privacy Rule protects all “individually identifiable health information” held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information “protected health information (PHI).”

“Individually identifiable health information” is information, including demographic data, that relates to

- the individual's past, present, or future physical or mental health or condition;
- the provision of health care to the individual; or
- the past, present, or future payment for the provision of health care to the individual;

and that either identifies the individual or could reasonably be believed to lead to the identification of the individual. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, and Social Security Number).

The Privacy Rule excludes from protected health information employment records that a covered entity maintains in its capacity as an employer, and

education and certain other records subject to, or defined in, the Family Educational Rights and Privacy Act, 20 U.S.C. §1232g.

De-Identified Health Information. There are no restrictions on the use or disclosure of de-identified health information. De-identified health information neither identifies nor provides a reasonable basis to identify an individual. There are two ways to de-identify information: 1) a formal determination may be made by a qualified statistician; or 2) the removal of specified identifiers of the individual and of the individual's relatives, household members, and employers is required, and is adequate only if the covered entity has no actual knowledge that the remaining information could be used to identify the individual.

Covered Entities. The Privacy Rule, as well as all the Administrative Simplification rules, apply to health plans, to health care clearinghouses, and to any health care provider that transmits health information in electronic form in connection with transactions for which the Secretary of HHS has adopted standards under HIPAA (the "covered entities"). For help in determining whether you are covered, use the decision tool available online at <http://www.cms.hhs.gov/hipaa/hipaa2/support/tools/decisionsupport/default.asp>.

To view the entire Rule, and for other additional helpful information about how it applies, see the OCR website: <http://www.hhs.gov/ocr/hipaa>. In the event of a conflict between this summary and the Rule, the Rule governs.

Excerpted from "OCR Privacy Brief: Summary of the HIPAA Privacy Rule" Office for Civil Rights

U.S. Department of Health and Human Services
<http://www.hhs.gov/ocr/privacysummary.rtf>

Exhibit 4.4: Sample Inter-Agency Data-Sharing Agreement

State of _____

REQUESTER

Agency Name _____

Data User _____

Title _____

Address _____

Phone _____

DATA PROVIDER

Agency Name _____

Custodian _____

Title _____

Address _____

Phone _____

I. PURPOSE

In this section, both parties must state in non-technical language the purpose(s) for which they are entering into the agreement, i.e., how the data will be used, what studies will be performed, or what the desired outcomes are perceived to be as a result of obtaining the data. The source of the data will come from any and all public health or claims databases. The data will only be used for research and/or analytical purposes and will not be used to determine eligibility or to make any other determinations affecting an individual. Furthermore, as the data will be shared within a State, it will be subjected to all applicable requirements regarding privacy and confidentiality that are described herein.

II. PERIOD OF AGREEMENT

The period of agreement shall extend from _____

to _____.

III. JUSTIFICATION FOR ACCESS

A. Federal requirements: Section 1902(a)(7) of the Social Security Act (as amended) provides for safeguards which restrict the use or disclosure of information concerning Medicaid applicants and recipients to purposes directly connected with the administration of the State plan. Regulations at 42 CFR 431.302 specify the purposes directly related to State plan administration. These include

(a) establishing eligibility; (b) determining the amount of medical assistance; providing services for recipients; and (d) conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the plan.

If the State Medicaid agency is a party to this agreement, specifically as the provider of information being sought by the requestor, it must be demonstrated in this section how the disclosure of information meets the above requirements.

An example of permissible data matching/sharing arrangements is the matching of data with a registry of vaccines or diseases for the purposes of improving outreach or expanding Medicaid coverage of populations being served under Medicaid.

States should identify any additional requirements that are needed for the release of additional data in this section.

B. State requirements: Cite specific State statutes, regulations, or guidelines (See Appendices)

IV. DESCRIPTION OF DATA

In this section, the parties provide specific detailed information concerning the data to be shared or exchanged.

V. METHOD OF DATA ACCESS OR TRANSFER

A description of the method of data access or transfer will be provided in this section. The requestor and its agents will establish specific safeguards to assure the confidentiality and security of individually identifiable records or record information. If encrypted identifiable information is transferred electronically through means such as the Internet, then said transmissions will be consistent with the rules and standards promulgated by federal statutory requirements regarding the electronic transmission of identifiable information.

VI. LOCATION OF MATCHED DATA AND CUSTODIAL RESPONSIBILITY

The parties mutually agree that one State agency will be designated as “Custodian” of the file(s) and will be responsible for the observance of all conditions for use and for establishment and maintenance of security agreements as specified in this agreement to prevent unauthorized use. Where and how the data will be stored and maintained will also be specified in this section.

This agreement represents and warrants further that, except as specified in an attachment or except as authorized in writing, that such data shall not be disclosed, released, revealed, showed, sold, rented, leased, loaned, or otherwise have access granted to the data covered by this agreement to any person. Access to the data covered by this agreement shall be limited to the minimum number of individuals necessary to achieve the purpose stated in this section and to those individuals on a need-to-know basis only.

Note that, if all individually identifiable Medicaid data remains within the purview of the State Medicaid agency, matching with any other data is permissible. Any results of the data matching which contains individually identifiable data cannot be released outside the agency unless the release meets the conditions of Section III.

Any summary results, however, can be shared. Summary results are those items which cannot be used to identify any individual. It should be noted that the stripping of an individual’s name or individual identification number does not preclude the identification of that individual, and therefore is not sufficient to protect the confidentiality of individual data.

VII. CONFIDENTIALITY

The User agrees to establish appropriate administrative, technical, and physical safeguards to protect the confidentiality of the data and to prevent unauthorized use or access to it. The safeguards shall provide a level and scope of security that is not less than the level and scope of security established by the Office of Management and Budget (OMB) in OMB Circular No. A-130, Appendix III — Security of Federal Automated Information System, which sets forth guidelines for security plans for automated information systems in federal agencies.

Federal Privacy Act requirements will usually not apply if this agreement is entered into by state agencies and no federal agencies are involved. The same applies to the Computer Matching and Privacy Protection Act of 1988. However, State laws, regulations, and guidelines governing privacy and confidentiality will apply.

It is strongly suggested that the guidelines presented in the Model State Vital

Statistics Act be applied. The guidelines are available from the U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Center for Health Statistics, Hyattsville, Maryland (DHHS) Publication No. (PHS) 95-1115.

Where States have enacted laws based on this model, the actual provisions of the statute take precedence.

VIII. DISPOSITION OF DATA

(Sample Language)

The requestor and its agents will destroy all confidential information associated with actual records as soon as the purposes of the project have been accomplished and notify the providing agency to this effect in writing. Once the project is complete, the requester will

1. destroy all hard copies containing confidential data (e.g., shredding or burning);
2. archive and store electronic data containing confidential information off line in a secure place, and delete all on line confidential data; and
3. erase all other data or maintain it in a secured area.

IX. DATA-SHARING PROJECT COSTS

In this section, it should be stated in detail how the costs associated with the sharing or matching of data are to be met. If these can be absorbed by the “salaries and expenses,” and the partner providing the requested data is agreeable to absorbing such costs, this should be noted here. If there are extra costs to be assumed, the parties need to specify here how they will be met. If the requesting party is to bear the burden of specific extra costs, or the party providing the data is unable or unwilling to bear such, these special requirements are to be formalized in this section.

X. RESOURCES

The types and number of personnel involved in the data sharing project, the level of effort required, as well as any other non-personnel resources and material, which are required, are to be listed here.

XI. SIGNATURES

In witness whereof, the Agencies’ authorized representatives as designated by the Medicaid Director and Health Commissioner attest to and execute this agreement effective with this signing for the period set forth in Article II.

Name _____

Title _____

Date _____

Name _____

Title _____

Date _____

Source: Centers for Medicaid and Medicare Services
<<http://www.cms.hhs.gov/states/letters/smd10228.asp>>

Appendix A: Resources

Resources are organized in the following order.

1. Mental Health and Disability
2. School-based Preparatory Experiences
3. Employment and Career Preparation
4. Youth Development and Leadership
5. Connecting Activities (Individual and Support Services)
6. Family Involvement and Support
7. Policy and Systems Change

Ordering or downloading information is provided where available.

1. Mental Health and Disability

Address Discrimination and Stigma Center (ADS Center)

<<http://www.stopstigma.samhsa.gov/>>

Provides practical assistance in designing and implementing anti-stigma and anti-discrimination initiatives by gathering and maintaining best practice information, policies, research, practices, and programs to counter stigma and discrimination; and by actively disseminating anti-stigma and antidiscrimination information and practices to individuals, states, and local communities, and public and private organizations.

Center for Mental Health Services Research

<<http://www.umassmed.edu/cmhsr/>>

An internationally recognized academic center that conducts research on the nature, structure, effectiveness, and regulation of services for individuals with mental health conditions, and develops and disseminates knowledge to improve the lives of these individuals, their families, and other community members.

Center for Psychiatric Rehabilitation

<<http://www.bu.edu/cpr>>

A research, training, and service organization dedicated to improving the lives of persons who have psychiatric disabilities by improving the effectiveness of people, programs, and service systems. Initiates programs and consults with existing ones to increase the likelihood that people with MHN can live independently, hold a job, and participate in training and learning opportunities.

Directory of Consumer-Driven Services

<<http://www.cdsdirectory.org/>>

A project of the National Mental Health Consumers' Self-Help Clearinghouse. Provides consumers, researchers, administrators, service providers, and others with a comprehensive central resource for information on national and local consumer-driven programs with a proven track record in helping people recover from mental illnesses.

Disabilities Studies and Services Center at AED

<<http://www.dssc.org/>>

A department of the Academy for Educational Development (AED) focused on designing programs that meet the unique information, technical assistance, training, and research needs of professionals and programs that serve to improve the lives of infants, toddlers, children, youth, and adults with disabilities and their families. DSSC administers the following entities:

- National Information Center for Children and Youth with Disabilities (NICHCY) <<http://nichcy.org/>>
- Federal Resource Center for Special Education (FRC) <<http://www.federalresourcecenter.org/frc/>>
- Comprehensive School Reform Demonstration (CSR D) Alignment Study <<http://www.dssc.org/CSR D/>>
- Family Center on Technology and Disability <<http://www.fctd.info/>>
- Healthy & Ready to Work (HRTW) National Center <<http://www.hrtw.org/>>

Guide to Substance Abuse and Disability Resources, Second Edition

<<http://www.ncddr.org/du/products/saguide/>>

Developed by the National Center for the Dissemination of Disability Research and the Rehabilitation Research and Training Center on Drugs and Disability to help researchers, professionals, and people with disabilities find research and training materials on substance abuse and disabilities.

HEATH Resource Center

<<http://www.heath.gwu.edu/>>

A national clearinghouse on postsecondary education for individuals with disabilities. Contains online resources, including financial aid information, fact sheets, newsletters, a counselor's toolkit, and a section on student voices.

Matrix of Children's Evidence-Based Interventions

<<http://www.systemsofcare.samhsa.gov/headermenus/docsHM/MatrixFinal1.pdf>>

This 2006 report from the Center for Mental Health Quality and Accountability contains information on 92 prevention, intervention, and treatment programs for children and youth with MHN that have some evidence of effectiveness. Settings include home, school, community, and clinics.

Mental Health — It's Part of All Our Lives

<<http://allmentalhealth.samhsa.gov>>

Debunks myths and provides facts about mental illnesses including details of specific mental illnesses, real life stories, and a mental health services locator.

National Alliance on Mental Illness

<<http://www.nami.org>>

The nation's largest grassroots mental health organization dedicated to improving the lives of persons living with serious mental illness and their families. NAMI organizations are found in every state and in over 1100 local communities across the country, and they work collaboratively on advocacy, research, support, and education. NAMI's quarterly magazine, *Beginnings*, and its guide, *Parents and Teachers as Allies*, are free to education professionals.

National Mental Health Association

<<http://www.nmha.org/>>

The country's oldest and largest nonprofit organization addressing all aspects of mental health and mental illness. Works to improve the mental health of all Americans, especially the 54 million people with mental disorders, through advocacy, education, research, and service. Has more than 340 affiliates nationwide.

Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

<<http://www.samhsa.gov>>

Focuses attention, programs, and funding on improving the lives of people with or at risk for mental and substance abuse disorders. Core priority areas include co-occurring mental and substance abuse disorders, criminal justice, children and families, mental health system transformation, homelessness, and disaster readiness and response. Centers and services include the following:

- Center for Substance Abuse Treatment
<<http://csat.samhsa.gov/>>
- Center for Substance Abuse Prevention
<<http://prevention.samhsa.gov/>>
- Center for Mental Health Services
- National Mental Health Information Center
- Mental Health Services Locator
<<http://www.mentalhealth.samhsa.gov/>>
- Resource Center to Address Discrimination and Stigma
<<http://www.stopstigma.samhsa.gov/>>

2. School-based Preparatory Experiences

Antisocial Behavior in Schools: Evidence-based Practices

By H.M. Walker and F.M. Gresham Available from Wadsworth Publishing and on-line book sellers

Second edition (2004) contains practical strategies for preventing and remediating antisocial behaviors of students including universal intervention and school safety issues.

Center for Mental Health in Schools at UCLA

<<http://www.smhp.psych.ucla.edu/>>

Aims are to improve outcomes for young people by enhancing the field of mental health in schools by integrating health and related concerns into the broad perspective of addressing barriers to learning and promoting healthy development. Addresses a number of topics including systemic concerns, policy, research, programming, staff development, and a wide range of psychosocial and mental health concerns.

Center for School Mental Health Analysis and Action

<<http://csmha.umaryland.edu>>

Analyzes diverse sources of information, develops, and disseminates policy briefs, and promotes the utilization of knowledge and actions to advance successful and innovative mental health policies and programs in schools.

Coalition for Community Schools

<<http://www.communityschools.org/>>

An alliance of national, state, and local organizations in K-16 education, youth development, community planning and development, family support, health and human services, government, and philanthropy, as well as national, state, and local community school networks. Advocates for community schools as the vehicle for strengthening schools, families, and communities to improve student learning through strategies such as wraparound services including those for youth with mental health needs.

National Association of School Psychologists

<<http://www.nasponline.org>>

Represents and supports school psychology through leadership to enhance the mental health and educational competence of all children. Resources include position papers, fact sheets, certification program, and more.

National Association of State Directors of Special Education

<<http://www.nasdse.org>>

Houses several initiatives that address mental health issues in schools, including the IDEA Partnership's National Community of Practice on Collaborative School Behavioral Health and Project Forum's policy forum on collaborative state

initiatives for school mental health and Positive Behavioral Supports.

National Center on Secondary Education and Transition

<<http://www.ncset.org>>

Coordinates national resources, offers technical assistance, and disseminates information related to secondary education and transition for youth with disabilities in order to create opportunities for youth to achieve successful futures.

National Standards & Quality Indicators: Transition Toolkit for Systems Improvement

<<http://www.nasetalliance.org>>

Developed by the National Alliance for Secondary Education and Transition, this toolkit contains information and tools to provide a common and shared framework for helping school systems and communities identify what youth need in order to achieve successful participation in postsecondary education and training, civic engagement, meaningful employment, and adult life.

Office of Special Education Programs, U.S. Department of Education

<<http://www.ed.gov/about/offices/list/osers/osep/index.html>>

Focused on improving results for children and youth with disabilities. Funds several initiatives relating to youth with MHN including the following:

- Technical Assistance Center for Positive Behavioral Interventions and Supports
<<http://www.pbis.org/main.htm>>
- National Center on Education, Disability, and Juvenile Justice
<<http://www.edji.org>>
- National Center for Students with Intensive Social, Emotional, and Behavioral Needs (Project REACH)
<<http://www.lehigh.edu/projectreach>>

Proactive Culturally Responsive Discipline

By Kathleen A. King, Nancy J. Harris-Murri, and Alfredo J. Artiles

<http://www.nccrest.org/Exemplars/exemplar_culturally_responsive_discipline.pdf>

Describes how an urban middle school in Arizona used proactive discipline to reduce the numbers of discipline problems and the disproportionate representation of culturally and linguistically diverse students in special education.

Strategies for Teaching Students with Learning and Behavior Problems

By Candace S. Bos and Sharon S. Vaughn Available from Allyn & Bacon and on-line booksellers

Sixth edition (2006) contains practical teaching strategies with sections on approaches to teaching and learning, socialization and classroom management, transition planning, communicating with parents and professionals, and coordinating instruction.

3. Employment and Career Preparation

Career Planning Begins with Assessment: A Guide for Professionals Serving Youth with Educational and Career Challenges

<http://www.ncwd-youth.info/resources_&Publications/assessment.html>

Contains information on selecting career-related assessments, referring youth for additional assessment, test accommodations, legal issues, ethical considerations, policy considerations, collaboration among programs, and interagency assessment systems.

Employer Engagement

<<http://www.ncset.org/topics/employer/?topic=2>>

Explores how schools and employers can partner to provide youth with opportunities to learn about work and prepare for future careers. Includes an introduction, frequently asked questions, related research, emerging and promising practices, web links, and other resources.

Job Accommodation Network

<<http://www.jan.wvu.edu>>

Provides information and resources to support employees with disabilities and their employers on the worksite.

In Their Own Words: Employer Perspectives on Youth with Disabilities in the Workplace

<<http://www.ncset.org/publications/essentialtools/ownwords/default.asp>>

First-person narratives from employers who have employed youth with disabilities describing their experiences and providing advice for other employers and programs serving youth with disabilities.

Mental Health Information for Business

<<http://www.allmentalhealth.samhsa.gov/business.html>>

Located on the Substance Abuse and Mental Health Services Administration's website, this page contains information for businesses that employ or want to employ people with mental health needs. It contains a toolkit for developing

mental health-friendly workplaces, information on mental health services, and more.

National Business Group on Health

<<http://www.businessgrouphealth.org>>

The only national non-profit organization representing the perspectives of large employers on important health care and related benefits issues, including disability, health/productivity, related paid time off, and work/life balance. Online resources include An Employer's Guide to Behavioral Health Services: A Roadmap and Recommendations for Evaluating, Designing, and Implementing Behavioral Health Services, containing strategies and recommendations for creating a system of affordable and effective behavioral health services for employees.

National Collaborative on Workforce and Disability for Youth

<<http://www.ncwd-youth.info>>

The source of information about employment and youth with disabilities. Its partners – experts in disability, education, employment, and workforce development – strive to ensure the provision of the highest quality, most relevant information available. Provides a number of accessible resources and publications including Pro-Bank, an online database of promising programs and practices in the workforce development system that effectively address the needs of youth with disabilities.

National Youth Employment Coalition

<<http://www.nyec.org>>

Improves the effectiveness of organizations that seek to help youth become productive citizens by tracking, crafting, and influencing policy; setting and promoting quality standards; providing and supporting professional development; and building and increasing the capacity of organizations and programs.

The 411 on Disability Disclosure: A Workbook for Youth with Disabilities

<http://www.ncwd-youth.info/resources_&Publications/411.html>

Designed to help youth and the adults working with them learn how to make informed decisions about disclosing their disability and understand how that decision may affect their education, employment, and social lives.

Training and Technical Assistance for Providers

<<http://www.t-tap.org>>

A national technical assistance and training effort designed to increase the capacity of Community Rehabilitation Programs (CRPs) and other community-

based service providers that operate programs resulting in segregated work outcomes and non-work options for people with disabilities in the Special Minimum Wage program established under the Fair Labor Standards Act in order to provide integrated employment outcomes and increase the wages of people with disabilities through the use of customized employment strategies and individual choice.

TransCen, Inc.

<<http://www.transcen.org/>>

A non-profit organization dedicated to improving educational and employment outcomes for people with disabilities by developing, implementing, and researching innovations regarding school-to-adult life transition and career development for people with disabilities.

Workforce Investment Act Section 188 Disability Checklist

<<http://www.dol.gov/oasam/programs/crc/section188.htm>>

Guidelines from the Office of Disability Employment Policy, U.S. Department of Labor, for ensuring nondiscrimination, equal opportunity, and meaningful participation of people with disabilities in One-Stop Career Centers and other WIA programs and activities.

4. Youth Development and Leadership

Boys and Girls Clubs of America

<<http://www.bgca.org>>

Contains program descriptions of services to promote and enhance the development of boys and girls up to age 18.

MENTOR

<<http://www.mentoring.org>>

Provides information, research, and resources to ensure that every child, including those with disabilities, who wants and needs a mentor has the right one.

National Mentoring Center

<<http://www.nwrel.org/mentoring>>

Located at the Northwest Regional Educational Laboratory, this national training and technical assistance provider for mentoring programs across the United States focused on quality assurance and improving agency capacity.

National Youth Development Information Center (NYDIC)

<<http://www.nydic.org/nydic>>

NYDIC's website contains information on youth development in the areas of funding, research, program development, career development, evaluation, policy, and more. A project of the National Collaboration for Youth.

National Youth Leadership Network

<<http://www.nyln.org>>

A youth-led network of approximately 300 youth leaders with diverse disabilities from across the U.S. and its territories (e.g. Guam and Puerto Rico).

Organized Chaos

<<http://www.ocfoundation.org/1000/index.html>>

A website specifically for teens and young adults for learning about Obsessive Compulsive Disorder from each other and from treatment providers. Provides tools to overcome the isolation OCD often fosters and a forum for creatively expressing personal trials, tribulations and triumphs. The main core of the website is the *Organized Chaos Webzine*. Located on the Obsessive Compulsive Foundation website.

Public/Private Ventures

<<http://www.ppv.org>>

Improves the effectiveness of social policies, programs and community initiatives, especially as they affect youth and young adults, by developing and disseminating model policies, financing approaches, curricula and training materials, communication strategies, and learning processes.

The National 4-H Council

<<http://www.fourhcouncil.edu>>

Contains information on youth leadership and youth development programs for youth with and without disabilities.

The Forum for Youth Investment (the Forum)

<<http://www.forumforyouthinvestment.org>>

Promotes a "big picture" approach to planning, research, advocacy, and policy development among the broad range of organizations that help constituents and communities invest in children, youth, and families.

The Youthhood

<<http://www.youthhood.org/youthhood/index.asp>>

A website for youth which helps them start thinking about what to do with the rest

of their lives and start planning for the future. Youth can visit the High School, the Job Center, the Hangout, the Health Clinic, the Apartment, and other locations to learn about jobs, having fun, their health, and other important issues.

Youth Development & Youth Leadership

<[http://www.ncwd-youth.info/resources_& Publications/background.php](http://www.ncwd-youth.info/resources_&_Publications/background.php)>

Assists youth service practitioners, administrators, and policy makers in defining, differentiating, and providing youth development and youth leadership programs and activities, which are important components of the Workforce Investment Act (WIA). All effective youth programs have youth development at their core and all effective youth leadership programs build on solid youth development principles.

YouthInfo

<<http://www.acf.dhhs.gov/programs/fysb/youthinfo/index.htm>>

Provides information on positive youth development, a calendar of youth-related events, information on funding, and links to other sites for young people and for youth professionals.

Youth Involvement in Systems of Care: A Guide for Empowerment

<<http://www.tapartnership.org/youth/youthguide.asp>>

A resource for educating professionals and adults who work with young people on the importance of engaging and empowering youth and for building the foundation and framework for the Youth Movement in order to enhance opportunities for young people and to utilize their expertise in system change.

Youth Leadership Forum

<<http://www.dol.gov/odep/programs/ylf.htm>>

A unique career leadership training program for high school juniors and seniors with disabilities. By serving as delegates from their communities at a four-day event in their state capital, youth cultivate leadership, citizenship, and social skills.

5. Connecting Activities (Individual and Support Services)

Accessibility - Equal Access to Transportation

<http://www.dot.gov/citizen_services/disability/disability.html>

Web page on the Department of Transportation website that provides general information, resources, laws and regulations, and useful links related to the transportation of people with disabilities.

Administration for Children and Families

<<http://www.acf.hhs.gov>>

Part of the Department of Health and Human Services responsible for federal programs that promote the economic and social well-being of families, children, individuals, and communities. Contains a Directory of Program Services, available in five languages, that includes eligibility requirements, funding information, and where to find more information.

Americans with Disabilities Act Home Page

<<http://www.usdoj.gov/crt/ada/adahom1.htm>>

Located on the Department of Justice website, provides information and technical assistance on the ADA, including publications, design guidelines, legislation and regulations, mediation, a business connection, and information in Spanish.

Healthy & Ready to Work

<<http://www.hrtw.org>>

Provides information and tools for providers, policy makers, family and youth leaders to support the premise that success in the classroom, within the community, and on the job requires that young people with special health care needs stay healthy. Focuses on understanding systems, assuring access to quality health care, and increasing the involvement of youth in health care decisions and policymaking. Resources are also provided on the topic of health care transition from pediatric to adult services.

Independent Living Research Utilization

<<http://www.ilru.org>>

A national center for information, training, research, and technical assistance in independent living. Its goal is to expand the body of knowledge in independent living and to improve utilization of results of research programs and demonstration projects in this field. In addition to a number of resources, its website contains a directory of independent living centers and councils in each state and the U.S. Territories.

Medicaid Information Resource

<<http://www.cms.hhs.gov/medicaid>>

Provides information on Medicaid, the largest source of funding for medical and health-related services for people with limited incomes. Jointly funded by federal and state governments to assist states in providing medical long-term care assistance to people who meet certain eligibility criteria.

National Council on Independent Living

<<http://www.ncil.org>>

The oldest cross-disability, grassroots organization run by and for people with disabilities. It represents over 700 organizations and individuals, including Centers for Independent Living (CILs), Statewide Independent Living Councils (SILCs), individuals with disabilities, and other organizations that advocate for the human and civil rights of people with disabilities throughout the United States.

Office of Juvenile Justice and Delinquency Prevention

<<http://ojjdp.ncjrs.org>>

Located in the Department of Justice and collaborates with professionals from diverse disciplines to improve juvenile justice policies and practices by supporting states, local communities, and tribal jurisdictions in their efforts to develop and implement effective programs for juveniles. Strives to enable the juvenile justice system to better protect public safety, hold offenders accountable, and provide services tailored to the needs of youth and their families.

Social Security Administration's Office of Support Programs for Youth with Disabilities

<<http://www.ssa.gov/work/Youth/youth.html>>

Provides information helpful to youth with disabilities, their families, their teachers, and others by providing information on youth leadership and development activities, transition, and other related information and links.

The National Consortium for Health Systems Development

<<http://www.nchsd.org>>

A state-driven forum for information sharing and innovation to improve employment policy by facilitating collaboration among local, state, and federal experts. Facilitates state-to-state information sharing among states that are developing comprehensive health and service systems for people with disabilities who want to work. Funded by the Centers for Medicare and Medicaid Services (CMS).

The Transition from Adolescence to Adulthood on Medicaid: Use of Mental Health Services

<<http://www.fmhi.usf.edu/institute/pubs/pdf/ahca/2001-stiles-dailey-mehra.pdf>>

Analyzes changes in Medicaid mental health services for youth with diagnosed mental health needs aged 12 to 23, including policy implications and future research directions.

The Transition to Adulthood among Adolescents who have Serious Emotional Disturbances

<<http://www.nrchmi.samhsa.gov/pdfs/publications/TransitionstoAdulthood.pdf>>

An overview of characteristics, challenges, and issues facing youth with SED as they transition from adolescence to adulthood including system gaps and the particular challenges of homeless youth.

6. Family Involvement and Support

Family Involvement Network of Educators at Harvard Family Research Project

<<http://www.gse.harvard.edu/hfrp/projects/fine.html>>

A national network of higher education faculty, school professionals, directors and trainers of community-based and national organizations, parent leaders, and graduate students who are interested in promoting strong partnerships between children's educators, their families, and their communities. Resources include a guide to online resources on family involvement.

Federation of Families for Children's Mental Health

<<http://www.ffcmh.org>>

Family-run organization dedicated exclusively to helping children with mental health needs and their families achieve a better quality of life by developing and sustaining a nationwide network of family-run organizations, changing how systems respond to children with mental health needs and their families, and helping policy-makers, agencies, and providers become more effective in delivering services and supports that foster healthy emotional development for all children.

Parent Training and Information Centers

<<http://www.taalliance.org/PTIs.htm>>

Located in each state, these centers provide training and information to parents of infants, toddlers, children, and youth with disabilities and to professionals who work with children.

PACER (Parent Advocacy Coalition for Educational Rights) Center

<<http://www.pacer.org>>

Expands opportunities and enhances the quality of life of children and young adults with disabilities and their families, based on the concept of parents helping parents. Provides a large number of resources and publications, including a large section on emotional and behavioral disorders, in order to secure a free and appropriate public education for all children across the nation.

Parents and Teachers as Allies: Recognizing Early-onset Mental Illness in Children and Adolescents, Second Edition

<<http://www.nami.org>>

Helps parents and teachers identify key warning signs of mental illness in children and youth and discusses the resulting issues as an educational tool for advancing mutual understanding and communication.

Service System Supports during the Transition from Adolescence to Adulthood: Parent Perspectives

<[http://www.nasmhpd.org/general_files/publications/ntac_pubs/reports/Transition SII.pdf](http://www.nasmhpd.org/general_files/publications/ntac_pubs/reports/Transition%20SII.pdf)>

A report from the National Association of Mental Health Program Directors of parent input on supports from a number of adult and youth service systems, their helpfulness, and policy considerations.

What Families Should Know about Adolescent Depression and Treatment Options

<<http://www.nami.org>>

Describes adolescent depression and its causes, symptoms, treatment options, medications, and related issues.

Wraparound Process User's Guide

<<http://www.rtc.pdx.edu/nwi/NWIWork&Prod.htm>>

Provides a comprehensive description of what a family can expect from the wraparound process. This guide from the National Wraparound Initiative is also helpful for service providers and policymakers.

7. Policy and Systems Change

Baldrige National Quality Program

<<http://www.quality.nist.gov>>

Contains the Baldrige performance excellence criteria, a framework that any organization can use to improve overall performance by examining its performance and improvement in its key business areas: customer satisfaction, financial and marketplace performance, human resources, supplier and partner performance, operational performance, and governance and social responsibility. Its website contains criteria for performance excellence in business, education, and health care.

Bazon Center for Mental Health Law

<<http://www.bazon.org>>

A national legal advocate for people with mental disabilities. Works through precedent-setting litigation and public policy to advance and preserve the rights

of people with mental illnesses and developmental disabilities. Its precedent-setting litigation and advocacy have outlawed institutional abuse, won protections against arbitrary confinement, and opened up public schools, workplaces, housing, and other opportunities for people with mental disabilities to participate in community life.

Building, Developing, and Going to Scale: Grant Funded Programs for Youth in Transition

<[http://www.ncwd-youth.info/resources & Publications/technicalassistance.php](http://www.ncwd-youth.info/resources_&Publications/technicalassistance.php)>

Six modules (Collaboration and Relationship Building; The Critical Choice – Pilot vs. Prototype; Leadership, Communications, and Outreach; The Fundamentals of System Building, Developing, and Going to Scale; The Practical Tools for System Building, Developing, and Going to Scale (such as resource mapping); and Sustaining and Expanding Effective Practices) that will help support innovative, collaborative youth development efforts. Not a step-by-step approach but a straightforward overview of the complex and deliberate tasks associated with improving the well-being of youth with disabilities.

Building Systems of Care: A Primer

<http://gucchd.georgetown.edu/programs/ta_center/object_view.html?objectID=2500>

Provides information to state and local stakeholders engaged in developing systems of care for children with behavioral health disorders and their families. Contains essential components of the system-building process and incorporates examples from systems of care around the country and useful resources materials. Can be ordered through the National Technical Assistance Center for Children's Mental Health website.

Center for Effective Collaboration and Practice

<<http://cecp.air.org/center.asp>>

Supports and promotes a reoriented national preparedness to foster the development and the adjustment of children with or at risk of developing serious emotional disturbance. It is dedicated to a policy of collaboration at federal, state, and local levels that contributes to and facilitates the production, exchange, and use of knowledge about effective practices. Its cultural competency page is located at <<http://cecp.air.org/cultural/default.htm>>.

Codes of Ethics

Many professional associations, particularly those who work with the public or with vulnerable populations, have codes of ethics to guide their behavior and ensure high standards. A sampling of codes follows.

- American Counseling Association

http://www.counseling.org/Content/NavigationMenu/RESOURCES/ETHICS/ACA_Code_of_Ethics.htm>

- American Public Health Association
<<http://www.apha.org/codeofethics/ethics.htm>>
- Independent Sector (nonprofits)
<http://www.independentsector.org/members/code_main.html>
- National Association of Workforce Development Professionals
<<http://www.nawdp.org/code.htm>>
- National Education Association
<<http://www.nea.org/aboutnea/code.html>>

Essential Tools: Community Resource Mapping

<<http://www.ncset.org/publications/essentialtools/mapping/default.asp>>

A guide that provides step-by-step instructions on understanding, planning, and engaging in the coordination of community resources that support the transition of youth with disabilities into adult life. Designed for use at the federal, state, and local levels to provide numerous practical tools and resources for initiating a resource mapping process.

Guidelines for Culturally Competent Organizations Minnesota Department of Human Services

<http://www.dhs.state.mn.us/main/groups/agencywide/documents/pub/DHS_id_016415.hcsp>

Guidelines for social services organizations, community-based mental health and human services providers, and others who wish to answer the question: How do we become more culturally competent?

Juvenile Justice and the Transition to Adulthood

<<http://www.pop.edu/transad/news/briefs.htm>>

Policy Brief #20 from the MacArthur Foundation Research Network on Transition to Adulthood that discusses issues facing youth in the juvenile justice system, a large number of whom have mental health needs, and strategies for better serving them.

Knowledge, Skills and Abilities of Youth Service Practitioners: The Centerpiece of a Successful Workforce Development System

<http://www.ncwd-youth.info/resources_&Publications/background.php>

Reviews the current state of practice within the workforce development system in reference to competencies – the combined knowledge, skills, and abilities – of youth service practitioners. Looks at how and by whom 1) required content is established, 2) training and education based upon that content are provided, and

3) credentials are given. Also outlines some possible action steps to build stronger connections among organizations.

Mental Health Needs of Youth and Young Offenders

<<http://www.juvjustice.org/resources/fs002.html>>

Coalition for Juvenile Justice's summary of facts and policy recommendations for serving youth with mental health needs in the juvenile justice system.

National Association of Workforce Development Professionals

<<http://www.nawdp.org>>

Professional association for individuals working in employment and training and related workforce development programs. Dedicated to enhancing the professionalism of the field and developing the professional skills of practitioners. Resources include publications and a certification program.

National Center for Cultural Competency Georgetown University Center for Child and Human Development

<<http://gucchd.georgetown.edu/nccc/index.html>>

Provides resources and tools to increase the capacity of health and mental health programs to design, implement, and evaluate culturally and linguistically competent service delivery systems, including the mental health system.

National Technical Assistance Center for Children's Mental Health

<http://gucchd.georgetown.edu/programs/ta_center>

Dedicated to helping states, tribes, territories, and communities discover, apply, and sustain innovative and collaborative solutions that improve the social, emotional, and behavioral well being of children and families. Provides a number of online resources.

Resource Mapping

<<http://www.ohiolearningwork.org/resourcemapping.asp>>

Web page on The Learning Work Connection website that defines resource mapping and describes the process used by five Ohio counties to map youth services. Community YouthMapping™ was one of the tools used.

Systems of Care Substance Abuse and Mental Health Services Administration

<<http://www.systemsofcare.samhsa.gov>>

Provides information and resources for meeting the mental health needs of children, youth, and families through partnerships of families and public and

private organizations that build on the strengths of individuals and address each person's cultural and linguistic needs.

The Campaign for Mental Health Reform

<<http://www.mhreform.org>>

A national partnership of organizations representing millions of people with mental or emotional disorders, their families, service providers, administrators, and other concerned Americans. Published Emergency response: A roadmap for federal action on America's mental health crisis (available online).

The Center for Mental Health Policy and Services Research

<<http://www.uphs.upenn.edu/cmhpsr>>

Researches the organization, financing, and management structure of mental health care systems and the delivery of mental health services and provides consultation and technical support to those individuals and programs involved in implementing system change.

The Network for Transitions to Adulthood

<<http://www.transad.pop.upenn.edu/about>>

Examines the changing nature of early adulthood, and the policies, programs, and institutions that support young people as they move into adulthood, by documenting cultural and social shifts and by exploring how families, government, and social institutions are shaping the course of young adults' development. Publications include a series of Policy Briefs. Funded by the John D. and Catherine T. MacArthur Foundation.

Voices of Youth in Transition: The Experience of Aging Out of the Adolescent Public Mental Health Service System in Massachusetts

<<http://www.cqi-mass.org/Youth-in-Transition-Final-Report.pdf>>

Report on a survey of 24 young adults who had received adolescent public mental health services in Massachusetts about transitioning to adulthood. Includes recommendations to improve the transition experience.

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(End of Exhibit 4.1)

Appendix C: Acronyms

ADAAmericans with Disabilities Act

ADDAttention deficit disorder

AD/HDAttention deficit/hyperactivity disorder

BDBehaviorally disordered

BLSBureau of Labor Statistics

CMHSCenter for Mental Health Services

CDSColumbia Depression Scale

CHSColumbia Health Screen

CMHSCenter for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

CTECareer Technical Education

CTTCommunity Treatment Team

DPS-2.....Diagnostic Predictive Scales

DSM-IV-TRDiagnostic and Statistical Manual of Mental Disorders

EBDEmotionally and behaviorally disordered

EDEmotional disturbance

ELLEnglish Language Learner

EPSDT.....Early Prevention, Screening, Diagnosis, and Treatment

DOJU.S. Department of Justice

DOLU.S. Department of Labor

FERPA.....Family Educational Rights and Privacy Act

GADGeneralized Anxiety Disorder

GEDGeneral Educational Development (test)

HIPAAHealth Insurance Portability and Accountability Act

HS/HTHigh School/High Tech

IDEAIndividuals with Disabilities Education Act

IEPIndividualized Education Program

IQIntelligence Quotient

JANJob Accommodation Network

KSAKnowledge, Skills, Abilities

MHMental Health

MHNMental Health Needs

MOUMemorandum of Understanding

NCLBNo Child Left Behind (Act)

NCWD/Youth ..National Collaborative on Workforce and Disability for Youth

NIMHNational Institute of Mental Health

NLTS2.....National Longitudinal Transition Study (2nd)

NMHICNational Mental Health Information Center

OCDObsessive compulsive disorder

OCROffice of Civil Rights

ODEPOffice of Disability Employment Policy, U.S. Department of Labor

PASSPlan for Achieving Self-Support

PHIProtected Health Information

PDPsychiatrically disordered

RTCResidential Treatment Center

SAMHSASubstance Abuse and Mental Health Service Administration, U.S.
Department of Health and Human Services

SLDSpecific learning disability

SOCSystem of Care

SSDISocial Security Disability Insurance

SSISupplemental Security Income

TANFTemporary Assistance for Needy Families

TBITraumatic brain injury

UA.....Universal Access

VRVocational Rehabilitation

WDWorkforce Development

WIAWorkforce Investment Act

WIBWorkforce Investment Board

For More Information, Please Contact:

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