# A Guided Pathway to Success:

# Addressing the Needs of Youth and Young Adults with Serious Mental Health Conditions in Texas

Texas Institute for Excellence in Mental Health
The University of Texas at Austin
School of Social Work
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The University of Texas at Austin
Texas Institute for Excellence in Mental Health
*School of Social Work*

## Authors:

Deborah A. Cohen, Ph.D.
Molly A. Lopez, Ph.D.
Vanessa Vorhies Klodnick, Ph.D.
Laura Stevens, M.Ed.

## Contact:

Texas Institute for Excellence in Mental Health
School of Social Work
The University of Texas at Austin
1717 West 6th Street, Suite 335
Austin, Texas 78703
Phone: (512) 232-8309
Fax: (512) 232-0617
http://blogs.utexas.edu/mental-health-institute/

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# Background

The goal of this policy paper is to explore the unique issues faced by youth and young adults with mental health conditions as they enter adulthood, as well as the challenges faced by behavioral health systems working to meet the needs of this population. The paper will examine the current landscape of public mental health services provided to youth and young adults and review current national best practices. Lastly, recommendations will be made for enhancing the current system in Texas to continue to increase the effectiveness of services as new research-based practices are developed. For the purposes of this paper, the term "transition-age youth" or TAY will be used to reference youth and young adults between 16 and 25 years of age.

**Transition Age Youth with Serious Mental Health Conditions.** Fifty percent of adults with a mental illness report their symptoms began in their early teens, and seventy-five percent report their symptoms began during young adulthood (Kessler, Berglund, Demler, et al., 2005). It is estimated that six to twelve percent (2.4 to 5 million) of 18- to 30-year-olds in the United States have a serious mental health condition (SMHC), adversely affecting their ability to complete their education and engage in competitive employment. Youth and young adults with a SMHC lag behind the general population in several positive transition outcomes (i.e. high school completion, employment, higher education, and independent living) and have greater involvement in the criminal justice system (Wagner & Newman, 2012). Young adults who are served in the child mental health system and have co-occurring involvement with the child welfare and/or juvenile justice system have the highest risk for negative outcomes, including homelessness, chronic unemployment, and reliance on public benefits (Osgood, Foster, Flanagan, & Ruth, 2005; McMillen, et al., 2005; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002). These negative outcomes compound a difficult entrance into the competitive labor market, and reduce the likelihood of young adults with a SMHC becoming economically secure and leading independent lives in the community. Employment and other forms of engagement in meaningful community life are generally recognized as instrumental in helping individuals recover from SMHCs (Liberman, Kopelowicz, Ventura, & Gutkind, 2002). Chronic unemployment has a high societal cost, making improving the transition programming and policies for youth and young adults with SMHCs a compelling public policy interest. These youth and young adults are capable of becoming productive members of the competitive workforce, but they are in need of targeted supports to ensure they achieve their career goals.

**Challenges to Accessing Services.** This period of transition to adulthood is typically a time of many changes, including a growing need for independence, all of which can put young people at risk for unemployment, a lack of supportive adult relationships, homelessness or housing instability, involvement in the criminal justice system, and unplanned pregnancies. Research has shown that there is a large decline in mental health utilization between 16- and 17-year-olds, with 34 people per 100,000 accessing annually, and 18- and 19-year-olds, with only 18 per

100,000 people using services (Pottick, Bilder, Vander Stoep, et al., 2008). SAMHSA reports that only one in every two 18- to 25-year-olds with SMHC report accessing a mental health service in the last year (SAMHSA, 2014). The services developed for individuals with SMHCs were developed for children or adults and have not been adapted to meet the unique needs of this age group. Young people find them difficult to access, stigmatizing, not engaging, unhelpful, or irrelevant to them. And many states have very real administrative barriers that prevent youth served in the child mental health system from effectively transitioning to the adult system (Davis & Sondheimer, 2005). The negative outcomes experienced by young people with mental health challenges who have been involved in at least one child-serving system (e.g., special education) come with a large societal cost and suggests the need to better manage this transition gap.

## Current Status of the Texas System

The Texas public mental health system serves youth and young adults within two somewhat distinct systems. The children's mental health system serves youth from age 3 to 17, with eligibility ending on the 18th birthday. The adult mental health system serves individuals 18 and older. Funding appropriated to the state mental health authority from the Texas Legislature is distinguished between two funding strategies and performance measures are targeted to these groups individually. Within public mental health agencies, these distinctions continue with separate adult and child programs and staff. In many instances, children, youth, and young adults are served in different clinic locations in facilities with contrasting appearances. The focus of the child system is on establishing new skills and helping children master developmental milestones, while the adult mental health system is more targeted to rehabilitation and restoring previous functioning. While there are many valid reasons for developing separate systems that meet the unique developmental needs of children and adults, there are very few programs within the state that are tailored to meet developmental needs of both older adolescents and young adults and "bridge the gap" between the systems.

In the development of the Texas Recovery and Resilience system redesign, implemented in Fiscal Year 2014, the redesign committees recognized the unique needs of this population and wanted to include services and supports that would be developmentally appropriate for transitioning adolescents. However, at the time, there were few models to guide specialized services and supports for this population. DSHS chose to utilize the Preparing Adolescents for Young Adulthood (PAYA) model, due to its availability at no cost and use by other state mental health systems. In addition, there was no requirement for staff training associated with its use. This skill development curriculum focuses on key independent living skills, such as money management and job seeking, health care, and housing. It is formatted as a workbook that can be completed individually or with support and discussion from a mental health provider. Current data systems do not allow for tracking how frequently this curriculum is used with adolescents in the public mental health system.

In addition to PAYA, national interest in interventions to engage young people following their initial episode of a psychotic condition led Texas to pilot a research-based program for this population. Positive findings from the NIMH RAISE trial combined with other early intervention first episode psychosis (FEP) research led to a 5% set-aside to the SAMHSA Mental Health Block Grant in 2014 to support initial steps to expansion. In 2015, the set-aside was increased to 10%. The Coordinated Specialty Care (CSC) model was initially piloted at the Harris Center for Mental Health and Intellectual Disability and Metrocare in 2015. The model will be expanded to eight new community mental health centers by the end of 2016. The state is also participating in a pilot initiative of supported employment with transition-age youth through the Texas System of Care.

**Description of Transition-Age Youth**. An examination of state administrative data for fiscal years (FY) 2014-2015 and 2015-2016 was conducted to further understand how Texas is serving this population of young people. Data for fiscal year 2016 was limited to three quarters, due to the timing of the analysis. The primary question was "how well did the existing child and adult mental health systems serve transition-age youth with mental health conditions?" Transition-age youth were defined as those between the ages of 16 and 25 on the first day of the state fiscal year. There were 30,939 transition age youth served in non-crisis levels of care in FY15 and 31,350 in FY16. This represented 44,086 unique transition-age youth across the two fiscal years. The youth are equally proportioned between males (50.2%) and females (49.8%). The youth are 33.0% Hispanic and 67.0% non-Hispanic. They were 72.3% White, 22.7% Black, and 5.0% mixed or other races. The primary diagnostic categories of those transition-age youth served in the system are illustrated in Table 1. Data on diagnostic categories was presented for FY15, due to the use of different diagnostic systems across the two fiscal years.

*Table 1. Diagnostic Categories of Transition Age Youth in Fiscal Year 2015*

| | **18-25 Year Olds in Adult System n=21,759** | **16-17 Year Olds in Child System n=9,180** | **Total (16-25 Year Olds) n=30,939** |
|---|---|---|---|
| Substance Related Disorders | 14 (<1%) | 5 (<1%) | 19 (<1%) |
| Schizophrenia | 3,477 (16.0%) | 119 (1.3%) | 3596 (11.6%) |
| Bipolar Disorder | 8,085 (37.2%) | 915 (10.0%) | 9000 (29.1%) |
| Major Depression | 8142 (37.4%) | 1972 (21.5%) | 10114 (32.7%) |
| Mood Disorder NOS | 346 (1.6%) | 1282 (14.0%) | 1628 (5.3%) |
| Anxiety Disorders | 216 (1.0%) | 506 (5.5%) | 722 (2.3%) |
| Conduct or other Behavioral Disorders | 118 (<1%) | 869 (9.5%) | 987 (3.2%) |
| Attention Deficit Disorders | 338 (1.5%) | 1876 (20.4%) | 2214 (7.2%) |

Note: Diagnostic data is presented using the DSM-IV, based on individuals served in FY15.

As noted in Table 1, the diagnostic picture of transition age youth served in the Child system are very different than those of youth served in the Adult system. While many of these differences are related to differences in developmental psychopathology, such as the greater use of diagnoses reflecting externalizing behaviors, it also corresponds to the more diagnostically-based prioritization for the target population within the adult mental health system. Ninety-one percent of all of the youth age 18 or older had a diagnosis within the three primary categories of Bipolar Disorder, Schizophrenia, or Major Depression. While services are not limited to individuals with these diagnoses, local authorities have used these criteria as part of the prioritization for services.

**Access to Services.** Youth ages 16 and 17 served in any community-based service represent approximately 20.0% of the children served in the public mental health system. As would be expected, this is a larger proportion of the population served than predicted from Texas census data, where 16- and 17-year-olds represent 13.3% of the children in the state. Since mental health challenges are more likely to arise in adolescence or result in more significant impairment than in early childhood, research has shown that higher proportions of adolescents use mental health services (Pottick, et al., 2008). However, this finding shifts when examining the representation of young people in the adult service system. Youth between the ages of 18 to 25 represent only 14.0% of the individuals served in the adult mental health system, while they make up 15.9% of the total adult population in Texas. This reduction in service use following transition from the child to the adult system has been shown in national research, as well (Pottick, et al., 2008). DSHS estimates adult prevalence of severe and persistent mental illness (SPMI) to be 2.6% of the adult population (MH Block Grant, 2013). Using this estimate, 81,906 adults age 18 to 25 have a SMHC. DSHS has served 29,352 individuals within this age range, representing 36% of the need met. However, it should be noted that national estimates for SMHC in transition-age youth are generally greater, ranging from 6 to 12% of the entire transition-age population (Davis & Vander Stoep, 1997).

*Table 2. Use of Public Mental Health Services by Transition-Age Youth*

| | **Used any Service in FY16 within Age Range** | **Estimated Prevalence of SPMI/SED in Texas within Age Range** | **% of Need Met in Public Mental Health for Transition-Age Youth** |
|---|---|---|---|
| Youth age 16-17 | 12,032 | 55,359 | 21.7% of need met |
| Adults age 18-25 | 29,352 | 81,906 | 35.8% of need met |

In addition to the transition-age youth use of any mental health services, it is important to examine the level of services that individuals receive, as certain services are intended to last longer or be more intense. An analysis was undertaken to identify the highest level of services that each youth received in the child or adult service systems. Level of care was ordered based on

the overall intensity of the package of services, rather than the intensity that may be related to any particular interventions. These were ordered in the following way, from least intense to most intense:

Child
* Assessed, no services (C8/C9)
* Crisis Services (C0)
* Transitional Services (C5)
* Medication Management (C1)
* Targeted Services (C2)
* Complex Services (C3)
* Intensive Family (C4)
* YES Waiver

Adult
* Assessed, no services (A8/A9)
* Crisis Services (A0)
* Transitional Services (A5)
* Basic Services (A1M/A1S)
* Basic Services with Counseling (A2)
* Intensive Services (A3)
* Early Psychosis (AEO)
* Assertive Community Treatment (A4)

Results suggested that a large proportion of transition-age youth had limited engagement in the service system. As illustrated in Table 3, a significant proportion of young people received services only in the crisis system (16.9% of children; 25.8% of adults). In both the adult and child systems, the most common service package authorized reflected basic rehabilitative and skills development services. Few young people were served in more intensive, team-based service packages and access to the specialized programming for early onset psychosis was limited.

*Table 3. Authorized Level of Care for Transition-Age Youth*

| **Child Level of Care** | **Number (%)** | **Adult Level of Care** | **Number (%)** |
|---|---|---|---|
| Assessed, no services (C8/C9) | 166 (1.4%) | Assessed, no services (A8/A9) | 1,041 (3.4%) |
| Crisis Services (C0) | 1,906 (15.6%) | Crisis Services (A0) | 6,645 (21.9%) |
| Transitional Services (C5) | 160 (1.3%) | Transitional Services (A5) | 1,191 (3.9%) |
| Medication Management (C1) | 2,037 (16.7%) | Basic Services (A1M/A1S) | 16,246 (54.4%) |
| Targeted Services (C2) | 5,020 (41.2%) | Basic Services with Counseling (A2) | 1,550 (5.1%) |
| Complex Services (C3) | 2,377 (19.5%) | Intensive Services (A3) | 3,212 (10.6%) |
| Intensive Family (C4) | 149 (1.2%) | Adult Early Onset (AEO) | 91 (0.30%) |
| YES Waiver | 383 (3.1%) | Assertive Community Treatment (A4) | 475 (1.6%) |

Note: The table represents the most intense level of care authorized in the year.

**Transition Between Systems.** To examine potential challenges related to youth "aging out" of the child mental health system, data was explored on the 8,961 youth who reached 17 years of

age in FY15 or FY16 while receiving children's mental health services (excluding crisis services). Of these youth, 1,607 (17.9%) used adult mental health services in the following year. The vast majority (78.8%) of these youth successfully transitioning into the adult system were authorized for Basic Services with Skills Training (A1S).

**Foster Care Alumni**. While not a focus of this review, the Texas child welfare and juvenile justice systems have also demonstrated challenges in meeting the needs of transition-age youth diagnosed with SMHCs. The Texas Foster Care Alumni Study (Casey Family Programs, 2012) found that 39% of the young adults interviewed who had exited the Texas foster care system met criteria for at least one mental illness in the past year, with Post Traumatic Stress Disorder (PTSD), major depression, and social phobia as the most common. Less than half of the alumni (48%) had completed high school and 47% were currently employed. One in ten alumni were currently incarcerated and 68% of the men had been arrested since exiting care. While the Texas child welfare system has created several new transition programs to aid young people aging out of the foster care system since this study, foster care alumni with SMHCs are likely to continue to need additional outreach, assertive treatment, and practical support to complete their education or vocational training, maintain safe housing and achieve competitive employment.

**Criminal Justice System**. Youth in Texas who become involved in the juvenile justice system are mandated to be released or transferred to the adult criminal justice system by age 19, Therefore, the available transition programs within the Texas Juvenile Justice Department (TJJD) target a narrow range of youth. Youth in Texas who are age 17 or older at the time a crime is convicted are treated in the adult criminal justice system. Some communities in Texas offer youthful offender diversion programs, which recognize the potential benefit of providing rehabilitative services to transition age youth, in order to promote positive development and reduce involvement in the criminal justice system. While promising practices in our state, these programs are generally housed in urban areas and target specialized populations, such as youth at risk of gang affiliation or involved in family violence incidents. Transition-age youth with SMHC who become involved in the adult criminal justice system are likely to lack access to intensive care coordination models.

## Best Practices in Systems for Transition-Age Youth

A growing literature on best practices to engage youth and young adults in mental health services highlights the importance of focusing efforts on a young person's goals within the employment, education, and independent living domains (Dresser, Clark, & Deschenes, 2015; Ellison, et al., 2015). System changes to support these practices begin with preparing the workforce with developmentally appropriate strategies for engaging youth and young adults diagnosed with SMHC. Therefore, this section reviews a recent online training program for providers working with transition-age youth. Following this, mental health programs specifically designed for

transition-aged youth. Four models have promising research support: The Transition to Independence Process (TIP) model, the Coordinated Specialty Care (CSC) model, the Transition-aged Youth Adapted Individual Placement and Supports model of Supported Employment and Education, and near-age peer support. The overlap between each of these models and their unique qualities will be discussed below.

**Promoting Positive Pathways to Adulthood.** The Research and Training Center for Promoting Pathways to Positive Futures (Pathways RTC) recently released a free, online training program designed to increase the capacity of direct care providers working with youth and young adults between the ages of 14 and 29 who have mental health challenges and their families. The 10 hour-long modules are available free of charge and incorporate didactic information, interactive questions, and video clips of young adults and providers. Providers are eligible for continuing education units (CEUs) following completion of each module. The training program includes the following modules:

- Module 1: Partnering with Youth and Young Adults
- Module 2: Promoting Recovery
- Module 3: Increasing Cultural Awareness and Building Community Support
- Module 4: Fostering Resilience and Family Supports
- Module 5: Promoting Cross-Cultural and Intergenerational Relationships
- Module 6: Promoting Individualized and Developmentally Appropriate Services
- Module 7: Developing Healthy Relationships
- Module 8: Planning Partnerships with Providers of Other Services and Collaborating to Bridge Service Gaps
- Module 9: Promoting Support from Family, Peers, and Mentors
- Module 10: Using Evidence-Supported Practices and Individualizing Interventions

This training program provides a core set of competencies for engaging transition age youth, regardless of the level or type of supports the youth with SMHC may require.

**Transition to Independence Process (TIP) model.** The Transition to Independence Process (TIP) model is the only research-informed model designed specifically for transition-age youth with SMHC. The model focuses on building skills related to education, employment, independent living, and personal well-being. The TIP approach matches well with person-centered recovery planning and is a natural fit for the Texas Recovery and Resilience (TRR). An individual plan is developed through a strengths discovery process, which empowers each young person to partner with mental health providers and their natural supports (e.g., self-identified family, teachers, mentors) to develop their own vision of the future (e.g., goals and objectives).

***Key Elements of the TIP Program:***

- Engages young people in a relationship with a caring adult to plan for their own future;
- Tailors services and supports to be accessible, coordinated, developmentally appropriate, and built on strengths;
- Acknowledges personal choice in the participant's need to find their own way;
- Ensures a safety net of support, including family, to reduce risks;
- Strengthens young people's competencies to assist them in achieving greater self-sufficiency and confidence;
- Helps youth maintain a focus on outcomes; and
- Involves youth, parents and other community partners in the TIP system at all stages and levels.

The values and philosophy behind the TIP model are a significant strength; however, the model lacks the specificity and guidance for how programs and providers should support transition-aged youth as they strive to obtain employment, independent housing, and other young adult milestones.

**Coordinated Specialty Care (CSC) Model for First Episode Psychosis.** A majority of individuals with serious mental illness, such as schizophrenia, bipolar disorder, and major depression, experience the first signs of illness during adolescence or early adulthood. For psychotic disorders (e.g., schizophrenia), peak initial onset occurs between 15 and 25 years of age, and many individuals do not receive appropriate care for years. Research has shown that reducing the time to appropriate treatment can reduce the overall long-term disability faced by individuals with psychosis. Over the past six years, the U.S. has conducted two large research trails, through NIMH's Recovery After an Initial Schizophrenia Episode (RAISE), providing support for the Coordinated Specialty Care (CSC) model.

Coordinated Specialty Care is a collaborative, team-based, recovery-oriented model of care that incorporates natural supports as members of the treatment team. Coordinated Specialty Care emphasizes shared decision making to guide treatment planning and medication adherence and uses a person-centered planning approach to engage individuals and their families over the course of treatment. Coordinated Specialty Care shares some similarities with the Assertive Community Treatment (ACT) approach, including a multi-disciplinary treatment team, small client to staff ratio, and a large range of therapeutic and supportive services. The primary difference is that CSC targets a younger, non-disabled population and aims to be time-limited. CSC also heavily involves an individual's self-identified family in the treatment process, which has been shown to enhance outcomes.

***Key Elements of CSC Model:***

- Promotes core values of recovery, person-centered care, and shared decision-making;
- Actively involves an individual's self-identified family in the treatment process;
- Provides a core array of services and supports through a team-based model;
- Focuses on active engagement and outreach, building relationships with community agencies to respond quickly when a young person with possible psychosis is identified;
- Focuses on a focus on the developmental needs of transition-aged youth and providing youth-friendly services.
- Uses a 24/7 on-call system for all young people and their families to assist in the event of a psychiatric crisis.

The CSC model focuses on providing: psychopharmacology, cognitive behavioral therapy (CBT), intensive case management, supported employment and education, peer counseling, and primary care coordination by a team of 4-6 providers across 30 clients. Each client is assigned a primary clinician who is in charge of case management, care coordination, and in some cases psychotherapy. The use of peer providers is highly encouraged. For rural and frontier regions, team members also serve clients outside of the CSC program, while for more populated catchment areas the primary treatment staff (primary clinician and team lead) will be fully devoted to the CSC program.

**Adaptation of the Individual Placement and Support (IPS) Model.** The primary developmental tasks for transition-aged youth are meeting educational goals, obtaining early employment, and establishing financial independence and housing. Assistance meeting these tasks are important to engaging transition-age youth with SMHC. While services and supports for educational and employment needs are components of the TIP and CSC models, neither have fully delineated models to support implementation of these aspects of care. However, recent research has begun to identify useful adaptations to the Individual Placement and Support (IPS) Supported Employment model to address the needs of youth and young adults. The CSC model identifies IPS as the employment model, however, it does not address aspects of the evidence-based model that may need to be adjusted for the needs of young people.

Traditional IPS was developed to support individuals with SMHC to obtain competitive employment and has been rigorously tested through many RCTs (Crowther, Marshall, Bond & Huxley, 2001; Twamley, Jeste, Lehman, 2003). IPS teams are fully integrated into clinical service settings and focus on rapid job placement based on individual preference and on-going support to the individual and his/her employer. To adapt IPS for transition-age youth with youth-onset SMHC, Ellison et al., 2015 incorporated a supported education specialist role, near age part-time vocational peer mentors, and a career development focus. Ellison et al. (2015) also

made slight modifications to the fidelity model for adapted IPS to better align with the experiences in early implementation. Smart phone and texting were noted as important to keeping transition-age youth engaged in supported employment and education.

***Key Elements of Adapted IPS:***

- Emphasis on career development and exploration;
- Integrate supported employment, supported education and mental health treatment;
- Focus on competitive employment;
- Provide benefits counseling;
- Time-unlimited individualized support;
- Services are made available to all transition-age youth within the agency;
- Individual choice;
- Utilizes near age vocational peer mentors.

**Near-age peer support.** There is growing interest and enthusiasm for the important role that near-age peer support can provide to young people diagnosed with SMHCs. Peer support providers can provide one-on-one coaching, help transition-age youth and their families navigate services and systems, promote participation and self-advocacy during treatment, share their own story of hope and recovery, and support young people's engagement in community activities. While research evidence is limited within this population, the difficulty that mental health systems historically have had in had engaging transition-age youth suggest that peer support services may be a particularly important component of the service array. Based on research experiences and interviews with near-age peer support providers, Jackson et al. (2015) has identified core components of an effective peer support program.

***Important Components of Effective Near-Age Peer Programs:***

- Mental health providers are educated about the benefits of peer support and recovery;
- Training to peer support providers is developmentally appropriate and designed to teach them to work with young people with SMHC;
- Peer support staff are consistently supported by appropriately trained supervisors;
- Active measures are taken to reduce isolation of peer providers and ensure they are seen by colleagues as an important part of the team.

YouthMove (www.youthmove.org), an organization run by young people with lived mental health experiences, advocate for near-age peer support integration in provider practice and administration across the country. By incorporating near-age peers, providers and systems will be more likely to meet the developmental needs of transition-age youth and their families.

## Conclusion and Recommendations

Historically, state mental health systems have been designed to serve child and adult populations through distinctly different systems. However, research has begun to show that young people between the ages of 16 and 25 diagnosed with SMHCs have unique developmental needs, and current systems may not be adequate to engage, retain, and treat these young people. Texas has begun to establish programs to better meet the needs of transition-age youth, such as programs for early onset psychosis, and these early efforts set the stage for further advancing the public mental health system to better serve this population of young people. At present, these pilot programs are small and target a narrow subset of the transition-age population, but lessons learned within these sites will help guide Texas in expanding the capacity of the system to achieve better outcomes for our young people, resulting in long-term cost savings for the state.

We propose the following recommendations to move the State of Texas forward to better meet the needs of transition-age youth:

1. **Consider adoption of a transition-aged youth assessment module that spans the CANS and ANSA.** The State of Texas implemented the widely used Child and Adolescent Needs and Strengths Assessment (CANS) and the Adult Needs and Strengths Assessment (ANSA) in September 2013. Each version of the measure contains items important to the assessment of transition-age youth, but each also excludes developmentally important elements. A transition-aged youth module was developed by Dr. John Lyons and should be considered for adoption to ensure a comprehensive assessment of functioning in key life domains.

2. **Consider funding to support a study of two to four pilot sites for near-age peer support in interested community mental health centers.** Many community mental health centers recognize the value of peer support providers within the behavioral health workforce and Texas is poised to consider exploring near-age peer support. A pilot study would allow for the identification of best practices and barriers in implementation and the gathering of initial data on youth and young adult outcomes.

3. **Develop a transition-aged youth level of care that spans childhood and adulthood (e.g., 16-25).** The transition years are critical to supporting the healthy development and independence of youth diagnosed with SMHC and reducing the risk of future disability. Unique eligibility criteria are necessary to ensure that youth transitioning to adulthood with SMHCs remain eligible and engaged in public mental health services. By removing administrative barriers to services, providers could access appropriate funding streams based on the age of the young person while maintaining a seamless system to the youth and family.

4. **Ensure a transition-age youth level of care includes an array of youth- and family-friendly services and supports.** A young adult and family friendly, evidence-based service array is needed to ensure youth and young adults achieve their personal goals to support independence and reduce their risk for criminal justice involvement. Input from young people and their families, along with a best practice review, should guide the development of an array of available services and supports that are individualized to the needs of the young person.

5. **Create infrastructure to support quality implementation of best practices.** In order to ensure effective implementation of evidence-based practices for transition-age youth, behavioral health organizations and providers must have adequate training, high quality coaching, organizational support and technical assistance, and on-going monitoring of fidelity and service outcomes.

6. **Explore policy and financing changes to allow technology to be used to provide clinical and case management services. (e.g. video conferencing, SMS texting).** Efficiency of service delivery could be improved through permitting the use of video conferencing and SMS texting. This is especially true for young adults who may not want to obtain services within a traditional clinic or are in need of shorter contacts that could be better administered over technology.

## References


Casey Family Programs (November, 2012). *Texas Foster Care Alumni Study Technical Report: Executive Summary Outcomes at Age 23 and 24*. Available at http://www.casey.org/media/StateFosterCare_TX_es.pdf

Clark, H. B. & Davis, M. (2000) Transition to Adulthood: A resource for assisting young people with emotional difficulties. Paul H. Brooks Publishing, Baltimore, MD.

Crowther, R. E., Marshall, M., Bond, G. R., & Huxley, P. (2001). Helping People with Severe Mental Illness to Obtain Work: Systematic Review. *British Medical Journal, 322(7280),* 204-208.

Davis, M., & Sondheim, D. L. (2005). State Child Mental Health Efforts to Support Youth in Transition to Adult. *The Journal of Behavioral Health Services & Research, 32(1),* 27-42.

Davis, M. & Vander Stoep, A. (1997). The transition to adulthood among children and adilescents who have serious emotional disturbances Part 1: Developing transitions. *Journal of Mental Health Administration, 24 (4), 400-427.*

Dresser, K., Clark, H. B., & Deschenes, N. (2015). Implementation of a Positive Development, Evidence-Supported Practice for Emerging Adults with Serious Mental Health Conditions: The Transition to Independence Process (TIP) Model. *The Journal of Behavioral Health Services & Research, 42(2),* 223-237.

Ellison, M. L., Klodnick, V. V., Bond, G. R., Krzos, I. M., Kaiser, S. M., Fagan, M. A., & Davis, M. (2015). Adapting Supported Employment for Emerging Adults with Serious Mental Health Conditions. *The Journal of Behavioral Health Services & Research, 42(2),* 206-222.

Jackson, S., Walker, J. S., & Seibel, C. (2015). *Youth & Young Adult Peer Support: What Research Tells Us About its Effectiveness in Mental Health Services.* Portland, OR: Research and Training Center for Pathways to Positive Futures, Portland State University.

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime Prevalence and Age-of-Onset Distribitions of DSM-IV Disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62(6),* 593-602.

Levin, B. L., Hennessy, K. D., & Petrila, J. (2010). *Mental Health Services: A Public Health Perspective* (3rd ed.). New York, NY: Oxford University Press.

Liberman, R. P., Kopelowicz, A., Ventura, J., & Gutkind, D. (2002). Operational Criteria and Factors Related to Recovery from Schizophrenia. *International Review of Psychiatry, 14(4),* 256-272.

McMillen, J. C., & Raghaven, R., (2009). Pediatric to Adult Mental Health Service Use of Young People Leaving the Foster Care System. *Journal of Adolescent Health, 44(1),* 7-13.

McMillen, J. C., Zima, B. T., Scott, L. D., Auslander, W. F., Munson, M. R., Ollie, M. T., & Spitznagel, E. L. (2005). Prevalence of Psychiatric Disorders among Older Youths in the Foster Care System. *Journal of the American Academy of Child & Adolescent Psychiatry, 44,* 88-95.

Munson, M. R., Jaccard, J., Smalling, S. E., Kim, H., Werner, J. J., & Scott, L. D. (2012). Static, Dynamic, Integrated, and Contextualized: A Framework for Understanding Mental

Health Service Utilization Among Young Adults. *Social Sciences & Medicine, 75(8),* 1441-1449.

Osgood, D. W., Foster, E. M., Flanagan, C., & Ruth, G. R. (2005). *On Your Own Without a Net: The Transition to Adulthood for Vulnerable Populations.* Chicago, IL: University of Chicago Press.

Pottick, K. J., Bilder, S., Vander Stoep, A., Warner, L. A., & Alvarez, M. F. (2008). US Patterns of Mental Health Service Utilization for Transition-Age Youth and Young Adults. *The Journal of Behavioral Health Services & Research, 35(4),* 373-389.

Teplin, L. A., Abram, K. M., McClelland, G. M., Dulcan, M. K., & Mericle, A. A. (2002). Psychiatric Disorders in Youth in Juvenile Detention. *Archives of General Psychiatry, 59(12),* 1133-1143.

Texas Department of State Health Services (2014). Mental Health Block Grant.

Twamley, E. W., Jest, D. V., & Lehman, A. F. (2003). Vocational Rehabilitation in Schizophrenia and Other Psychotic Disorders: A Literature Review and Meta-Analysis of Randomized Controlled Trials. *Journal of Nervous and Mental Disease, 191(8).* 515-523.

Wagner, M., & Newman, L. (2012). Longitudinal Transition Outcomes of Youth with Emotional Disturbances. *Psychiatric Rehabilitation Journal, 35(3),* 199-208.

Wu, P., Katic, B. J., Liu, X., Fan, B., & Fuller, C. J. (2010). Mental health service use among suicidal adolescents: findings from a US national community survey. *Psychiatric Services*, *61*(1), 17-24.