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The appropriateness and completion of developmental supports for youth and young adults with serious mental health (MH) conditions during the transition to adulthood are the focus of this paper. This paper presents evidence that current policies and practices are generally inappropriate and foreshortened at the critical juncture when youth with serious MH conditions are on the threshold of becoming functioning adults in our society. Based on the research literature on youth development (both for adolescents with and without serious MH conditions) and on current system configurations and exemplary practices, this paper puts forward a framework for judging federal policies and programs and for developing recommendations for change.

Youth with Serious Mental Health Conditions Struggle to Become Adults

Typical Biopsychosocial Development

Adolescence

During adolescence and young adulthood individuals experience intense developmental changes on all fronts: cognitive, moral, social, identity formation, and physical development. Family life cycle changes are also associated with children's passage into adulthood.

The *cognitive development* which typically occurs during adolescence evolves from 1) more concrete to more abstract representations; 2) more singular to more multidimensional thoughts; 3) more absolutism to more relativism; and 4) little to increasing self-reflection and self-awareness (reviewed in Keating, 1990). Adolescents also develop a future time perspective, which allows them to plan, set objectives, and anticipate consequences (Klineberg, 1967).

Moral development evolves from early ethical choices based on simplistic, present-oriented, externally reinforced concepts of concrete rights and wrongs to an internalized set of complex abstract principals which can be applied more universally (Gillian, 1982; Kohlberg, 1968). Moral behavior in adolescence is based on increasingly sophisticated abilities for empathic responses to others (Hoffman, 1982).

Adolescent *social development* is marked by the growing importance of peer relations, and expansion of social networks. Friendships become more complex, and involve mutuality, intimacy, and loyalty (Damon, 1983; Selman, 1980; Youniss, 1980).

The tremendous physical changes and growth which mark *puberty* are also a hallmark of adolescence. Sexuality becomes central, introducing intense physical sensations, new types of intimacy, different roles in peer groups, and important health and life considerations.

One of the tasks particularly associated with adolescence is *identity formation* (Erikson, 1968). Adolescents strive for a balance between personal needs and desires and cultural and societal rules. They must differentiate themselves from their parents in complex and subtle ways and become autonomous (Josselson, 1980). This often involves questioning authority, experimentation and boundary pushing. Personal identity is conceptualized by means of a set of statements, beliefs, and feelings about the self and the self's behavior. The less developed identity formation is, the lower the self-esteem (Bunt, 1968), and the more confused individuals

are about their own distinctiveness from others and the more they have to rely on external sources to evaluate themselves” (Marcia, 1980 p. 159). Lower self-esteem is also associated with immature identity formation (Bunt, 1968). Identity formation is generally resolved between ages 18 and 22 in western cultures (Offer et al., 1970). Identity formation lays the foundation for basic choices such as occupation, life goals, involvement in committed relationships, childbearing and rearing, types of friendships, and gender roles (Erikson, 1968).

There is also a typical *family developmental cycle* associated with the time that youth begin and move into independence (Carter & McGoldrick, 1989). The complex changes in family relationships reflect a delicate balance between the growing need for independence from family and the continued need for their emotional support and guidance (Karpel & Strauss, 1983). Parental tasks, during their children’s adolescence involve refocusing on midlife marital and career issues, sometimes with a shift in focus toward caring for the older generation. As adolescents move into adulthood, parents also renegotiate the marital system as a dyad (rather than involving children so closely). The family structure also changes to include in-laws and grandchildren. The tasks for the family in this stage are to accept a multitude of exits from and entries into the family system.

Policy and practice implications. During the years that adolescents remain within the context of a supportive home environment, they gain the social, emotional, and independent living skills that will allow psychosocial facets to catch up with their precocious physical maturity. Typical biopsychosocial development during adolescence and young adulthood has several implications for policies and services for anyone in this age group:

- 1. Services and supports, and their functional expectations or goals, should be matched to each individual’s level of development, which will not be uniform across all areas of development.*
- 2. As youth move towards increased maturity, their role in their treatment or service decisions should be increasingly central and guiding. The central and critical role of family needs to be supported, though modified as youth mature.*
- 3. Services should accommodate the critical role of peers and friends. For example, expecting young adults to feel comfortable in a group setting that primarily includes much older adults is inappropriate.*
- 4. Policies and practices need to provide a safety net for the experimentation and boundary pushing that is part of identity development. For example, the provision of services needs to be unconditional and not denied because of experimentation.*

The New Adulthood

Adolescent psychosocial developmental changes accumulate slowly over time. These developmental changes underlie functional capacities, which also, then, build slowly over time. In western industrial society, completion of the task of becoming functioning adults has become increasingly complicated, extended, and disorganized compared to the orderly progression typical into the 1960s. During the first half of the 20th century, young men and women moved in an orderly fashion from completing their schooling and living with family to entry into work, marriage and parenting. These were also the defining activities of adulthood. The overwhelming majority of individuals had completed their schooling, started working, moved out of the family home, and married and had a child by age 25 (Fussell & Furstenberg, 2005). For a host of reasons, both identified and not, the orderly pathway to adulthood has become increasingly

disorderly since the 1970s, and has expanded in its time frame. Many more young adults live at home with their parents rather than moving to their own residence, or move back and forth from their own to their family's home. More young people continue their schooling after completing some level of schooling, having worked for a while, or are working and going to school at the same time. Marriage and child bearing occurs later in life than ever before, and for most women it is now preceded by a period of working and often living on their own. Thus, the linearity of movement into adult roles has disappeared, and the age by which most young people have completed schooling, moved out of the family home, obtained steady work, married and had children has moved back towards age 30 and older (Settersten, Jr, Furstenberg, & Rumbaut, 2005).

The age by which most young people have attained adult status by completing schooling, moving out of the family home, obtaining steady work, marrying and having children has moved back towards age 30 and older.

While this shift in patterns may represent an opportunity for some young people to explore various career, education, and life options and to enjoy the freedoms of single life (Arnett, 2000), some of the underlying causes of the shift represent greater hurdles for those with fewer resources (Foster & Gifford, 2005). One of the factors that has contributed to the delayed entry into full time work and completion of schooling are various changes in the economy. Essentially there has been a decline in the availability of jobs requiring less education, and an increase in the number of jobs that require higher educational levels, reflecting the shift from a manufacturing based to a service and information based economy (Blank, 1997; Danziger & Gottschalk, 1995; Levy, 1998). Furthermore, the value of the minimum wage has declined since the 1970s, resulting in many young people working for wages that do not cover their basic needs.(Corcoran & Matsudaira, 2005). These changes have put new demands on families to support their young adult children for longer periods of time so that they can obtain the education needed for higher paying jobs that support independent living (Schoeni & Ross, 2005). The great shifts in young adulthood have been comprehensively studied and described in Settersten, Jr, Furstenberg, and Rumbaut (2005). The conclusion of the authors of this edited volume is that *social policy is greatly outdated in addressing the current needs of young adults*, particularly those who are most vulnerable—i.e., youth from impoverished families, youth involved with foster care or juvenile justice systems, and youth with disabilities (Settersten Jr, 2005).

Economic shifts have made entry into adult status increasingly difficult and tenuous for vulnerable populations, including those with disabilities, those from impoverished families, or youth who have been involved with foster care or juvenile justice systems.

Policy and practice implications. The changing picture of typical young adulthood in our society provides some guidelines for what services and supports should help young people with serious MH conditions achieve:

1. *Supports are needed that encourage young people with serious MH conditions to pursue post secondary and post baccalaureate education and training*

2. *Supports are needed to ensure employment that will sustain independent living.*
3. *Supports are needed to help families provide a safety cushion for youth well into their 20s.*
4. *Supports need to be continuous (as needed) beyond age 18 or 21, and a more reasonable age at which to reduce supports (assume adult functioning) needs to be determined.*

Social policy is greatly outdated in addressing the current needs of vulnerable young adults in our society.

Development in Individuals with Serious Mental Health Conditions

Adolescence

This section describes the developmental characteristics of youth with serious MH conditions prior to entering the transition to adulthood.

Important Sociodemographic Characteristics. There are several important sociodemographic features of youth and young adults with serious MH conditions that are important to keep in mind when contemplating federal policy and programs.

Population Size. There are at least 6.5 million youth in transition with a psychiatric disorder and 1 to 3.2 million of them with serious emotional disturbance (SED) or serious mental illness (SMI) (Davis & Vander Stoep, 1997; Vander Stoep, Davis, & Collins, 2000). The number of these young people that have received public services is significant (Davis & Vander Stoep, 1997). Moreover, all adolescents with SED, conservatively 4-9% of the population (Costello et al., 1998; Friedman et al., 1996), eventually transition into adulthood.

Ethnicity. There appear to be differences in the rates of serious MH conditions among racial or ethnic groups, and in the rates of these groups in service settings (Knitzer, 1983; Meinhardt & Vega, 1987; Kelly et al., 1977; Silver et al., 1994; Valdes et al., 1990; Berlin, 1982; Silver et al., 1992). Overall, serious MH conditions affect all ethnic groups, and policies need to be sensitive to the cultural practices of these groups.

Socioeconomic Status. It is clear from the description of typical adulthood that the socioeconomic status of families can play a crucial role in influencing the transition to adulthood. Prevalence surveys of children with SED, as well as mental illness in adults, show overrepresentation of individuals in lower socioeconomic classes (Bernard & Clarizio, 1981; Costello, 1989; Frazier & DeBlassie, 1984; Touliatos & Lindblom, 1980). A disproportionate number of households of youth with serious MH conditions served by public systems live below the poverty level, depend at least in part on public assistance, and come from single-parent households and households with lower parental educational attainment (Wagner et al., 1990; Silver et al., 1992; Wagner et al., 1992).

Developmental Progress. An essential characteristic of this population is the ongoing changes in every area of biopsychosocial development. This includes cognitive, moral, social, and sexual development, and identity formation. Studies have shown that adolescents with serious MH conditions are developmentally delayed in all areas of psychosocial development (reviewed in Davis & Vander Stoep, 1997). They are not biologically delayed, being as sexually

active as their non-disabled peers, but their psychosocial immaturity leaves them less prepared for the social negotiations needed for safe and responsible sexual behavior. Overall, they are less prepared than their non-disabled peers to take on the mantle of adulthood at age 18.

With the exception of sexual development, as a group, youth with serious MH conditions are delayed in every area of biopsychosocial development.

Complex Family Relations. In addition to the socioeconomic characteristics of families, described above, many young people who have serious MH conditions have been in out-of-home settings for treatment or protection. These separations can hinder parents' abilities to guide their children into adulthood. Many young people with serious MH conditions have been served in the foster care system (McMillen et al., 2005). Their transition into adulthood is complicated by a history of legally and logistically severed ties with their natural families, and often tenuous ties to foster or adoptive families (Foster & Gifford, 2005). Legally, it is a time when young people can refuse to involve their parents in treatment, thus complicating the relationship between providers and parents. Yet families are usually the single best resource for young people during their transition years; they are the constant factor during this period of upheaval.

Policies should support families and encourage them to be an emotional and practical resource for their children throughout the transition years.

Multi System Involvement. Youth with SED or SMI can be found in every public system that serves children. Most obviously, state child mental health services are tailored to children with SED, and many children with serious MH conditions are served within the Medicaid system. As of December, 2003, 41% of 13-17 year olds receiving SSI payments were youth with "other" mental disorders

(http://www.ssa.gov/policy/docs/statcomps/ssi_children/2003/ssi_children03.pdf, Table 8; *this "other" category includes all MH disorders, and a few diagnoses that are not typically considered MH conditions*). Of the roughly 5.7 million students served under the Individuals with Disabilities Education Act in school year 1999-2000, approximately 8% were special education students with emotional disturbance (U.S. Department of Education, 2001). Estimates of the proportion of youth in child welfare with significant MH conditions range from about 40-60% (Blower et al., 2004; McMillen et al., 2005; Thompson & Fuhr, 1992). This proportion is about 70% to 80% among youth in the juvenile justice system when conduct disorders and substance abuse disorders are included, and about 40% to 50% when those disorders are excluded (Teplin et al., 2002).

In summary, adolescents with serious MH conditions approach the transition to young adulthood from a marked disadvantage. Many come from socioeconomically disadvantaged backgrounds, facing the added stresses brought on by poverty. These youths are often developmentally immature. This immaturity can delay their readiness for school completion, employment, and independent living. Social immaturity, in combination with psychiatric

disabilities can result in social isolation, vulnerability to predatory relationships, or problems in maintaining employment. Reduced social skills can also interfere with maintaining independent housing, by such means as an inability to find or keep roommates. Reduced social competence and the sequelae of victimization impede healthy sexual development. Lastly, families of transitional youth often have depleted financial and emotional resources to aid and support movement towards independence.

Adulthood

Understanding the context of the current environment is important in analyzing the efficacy of current transition policies and programs, and shapes consideration of needed improvements.

Mental Health Conditions Continue and Develop During the Transition to Adulthood. If mental health conditions were temporary, beginning and ending within a relatively short time frame, supports for the transition to adulthood could be short-term and limited to the period of disability. However, the argument that transition supports need to be continuous throughout the transition stage, roughly ages 14/16 to 25/30, stem from the long term nature of these conditions. Serious MH conditions generally continue into adulthood. For example, adolescents who have attention-deficit/hyperactivity disorder (Ingram, Hachtman & Morgenstern, 1999), schizophrenia (Hollis, 2000), major depressive disorder (Lewinshon et al. 1999; Rao et al., 1995; Bardone et al., 1996), simple phobia (Pine et al., 1998), or conduct disorder (Bardone et al., 1996) are likely to have the same disorder in young adulthood. Studies have also found that adolescent disorders, including anxiety disorders, affective disorders, and conduct disorders, are strongly predictive of other adult disorders (e.g. Kasen et al., 2001; Peterson et al., 2001; Pine et al., 1998; Biederman, Faraone, & Kiely, 1996; Bardone et al., 1996; Rao et al., 1995; Pollack et al., 1990, 1992).

Serious mental health conditions in adolescence generally remain into adulthood, and young adulthood is a high-risk period for developing new disorders.

Young adulthood is also a time when serious mental health conditions are likely to develop for the first time. Many young people experience their first onset of schizophrenia (an der Heiden & Hafner, 2000; Rasanen et al., 1999), bipolar (Kennedy et al., 2005; Bellivier, et al., 2003; 2001), or major depressive disorder (Jaffee et al., 2002; Eaton et al., 1997) between ages 18-30. Again, these conditions most likely continue for several years.

Further, as youth enter young adulthood comorbidity with substance use disorders increase so that by ages 21-25, almost half (49%) have substance abuse or dependence disorders (Greenbaum in Davis & Vander Stoep, 1997). Estimates of the rates of suicide attempts or suicide completions have not been made specifically for youth in transition. However, the background and precipitating factors associated with increased risk of suicide, such as histories of abuse, rupture of intense relationships, and events that lower self-esteem (Contreras, 1981), are common in this population (reviewed in Davis & Vander Stoep, 1997).

Functioning. If serious MH conditions did not impact young adult functioning then transition supports might not be needed. However, in general, studies of adolescents with serious MH conditions who received child MH or special education services, uniformly demonstrate extremely poor functioning during young adulthood (reviewed in Davis & Vander Stoep, 1997, Vander Stoep, Davis & Collins, 2000). Among youth with SED who had been in either public mental health services or special education, fewer than half completed high school. They were consistently less likely to be employed than their peers; their income hovered around poverty level; fewer lived with their families and many lived in institutions; and homelessness and arrests were high. The young women were also more likely to become pregnant and were less likely to be married than their peers (Vander Stoep et al., 2000b).

The literature on the functioning of young adults in adult MH services also indicates poor levels of functioning (Sheets, Prevost & Reihman, 1982; Pepper & Ryglewicz, 1984; Holcomb & Ahr, 1986; 1988; Test et al., 1985; Test, Burke, & Wallisch, 1990). The presence of psychiatric disorders exerts a disruptive influence on the transition to adulthood in community samples as well (Kessler, Foster, Saunders et al., 1995; Kessler, Walters, & Forthofer, 1998). The changes during transition can both be interfered with by mental illness as well as contribute to the development of a mental illness (Meich et al., 1999).

Given the challenging picture of adulthood in our current society, youth and young adults with serious MH conditions are in desperate need of policy change that will ameliorate the increased difficulty of functioning as adults by age 30.

Transition Completion. In order for services to allow for *completed* adult development, policies need to allow for *continuous* services throughout development, or minimally to the age when most individuals could be expected to function reasonably as adults. Currently, policies or programs for children or adolescents end at age 18 or 21. It is clear that these ages are too restrictive to promote completed development. What might be a more reasonable time frame? A well-informed answer to this question would require research that demonstrates what kind of stable adult functioning can be expected among those with serious MH conditions, and at what age most of these individuals attain that level of functioning. While a well-designed longitudinal study has not been conducted, analyses using data from the National Comorbidity Study (NCS; Kessler et al., 1994) are suggestive. This study of over 8,000 households in the U.S. was designed to be a nationally representative study. Individuals in the study ranged from age 15-54. Individuals were interviewed once. Within individuals with a current psychiatric diagnosis, Davis and Williams (2005) examined the proportion of individuals at each age who had achieved an adult developmental milestone (such as getting married), and identified the age at which the rate of change ended or stabilized. After examining various life domain issues (social, family, school, work, etc.), it appeared that individuals with psychiatric diagnoses generally reached adult functional status between ages 25-32. Of particular interest for policies that assume or encourage independent functioning, working and living above the poverty level stabilized at ages 26 and 28, respectively. It is important to note that the NCS sampled individuals living in households; this did not include anyone residing in hospitals, residential or group treatment settings, jails/prisons, homeless shelters, or boarding rooms. Given that studies of service-based populations suggest that these youths would be overrepresented in these settings, it is reasonable

to assume that the NCS population is generally higher functioning than those that cause greatest concern for policy makers. It is likely that their entry into adult functioning is further delayed.

Policies that would fully accommodate the delayed development of youth and young adults with serious mental health conditions should assume limited independence, at least until age 25 and more reasonably until age 30.

Policy and practice implications;

1. *Policies that provide supports to individuals based on their immature status should set the upper age limit of those supports to somewhere between ages 25 and 30 for youth with serious MH conditions.*
2. *Policies aimed at supporting those living in poverty or with disabilities, and specifically with serious MH conditions, will likely have the biggest impact on the transitioning population.*
3. *Since functioning is impaired in every domain of adult functioning, policies need to encourage comprehensive and coordinated supports of youth with serious MH conditions in transition to adulthood.*
4. *Policies need to sustain the supportive role that is increasingly demanded of families in preparing their children for adulthood through the time that youth are expected to have limited independence.*

System Challenges to Exemplary Practices

Exemplary transition support practices require a policy framework that allows for continuous, developmentally appropriate services, guided by youth and young adult input, that address the comprehensive needs of youth and young adults with serious MH conditions and their families.

Policies requirements include;

1. *Provision of continuity of care from ages 14 or 16 to ages 25 or 30.*
2. *Provision of continuity of care across the many systems that offer relevant services.*
3. *Promotion of a density of developmentally-appropriate services from which individualized service and treatment plans can be constructed.*
4. *Support of expertise in this age group and disability population.*

Current systems and policies present several challenges to systems' capacities to be exemplary.

Age Discontinuity

Because the transition stage encompasses ages that only child or only adult systems serve, transition systems need to span both systems. Several features of these separate systems must be understood in order to consider the impact of policies and programs on the capacities of exemplary transition systems.

Age Limits

The systems that youth and young adults with serious MH conditions are involved with are typically organized into separate adult and child components. Special Education services end by age 22 or whenever a young person leaves secondary school; child welfare services end by age 18 or 21 depending on state policy; juvenile justice systems typically end their involvement when a youth turns 18; and vocational rehabilitation and substance abuse services may reach out to 16 year olds, but more typically serve those 18 and older. Adult corrections involve anyone with an adult charge, but most typically those ages 17-18 and older. Pediatric health services usually end some time in adolescence. And while state MH systems are one of the few systems designed to serve both children and adults, currently, all states except one (AR), separately administer their child and adult service systems (Davis & Hunt, 2005).

Because the transition stage encompasses ages that only child or only adult systems serve, the policy and programmatic underpinnings that separate child and adult systems must be examined and evaluated.

Different Eligibility or Target Population Definitions

Having a serious MH conditions is not a requirement for receiving most public child services, thus, youth aging-out of systems such as foster care or juvenile justice, who have serious MH conditions, must meet the eligibility requirements or target population definitions for public adult MH services in order to access the adult MH system. Eligibility for special education services is defined in federal law, and is quite different from the CMHS definitions of serious mental illness that guide adult state MH systems. Within state MH systems, analysis of the eligibility or target population definitions for their child and adult system revealed that not a single state defined their adult policy in a way that would include all youth that met criteria established by the child policy (Davis & Koroloff, submitted; <http://www.umassmed.edu/cmhsr/uploads/Brief14YouthTrans.pdf>). In general, adult eligibility or target population policies were more narrow than child policies. There are also age-based differences in Medicaid eligibility (as described in the Bazelon analysis). The Social Security “Blue Book” listing of disabilities, which defines those who qualify for Medicaid by virtue of disability, as well as those who qualify for Social Security benefits, defines 11 categories of mental disorders in children (under 18), and only 9 categories in adults. Most notably, Attention Deficit Hyperactivity Disorder is a disability category in children, and is not in adults. Analysis of the federal definitions of SED and SMI revealed a striking similarity in diagnostic requirements, but different definitions of functional impairment mean that youth meeting the definition of SED may fail to meet the definition of SMI (Davis & Koroloff, submitted). One of the potential effects of these disparities are that youth in public child systems with serious MH

conditions, who continue to need services as adults are denied them because they do not meet the adult policy criteria.

Different Cultures, Practices, and Funding

Issues of system fragmentation apply both across agencies (e.g. mental health and education), as well as across child and adult systems (i.e. child and adult MH). Both state child and adult MH administrators described the difficulty that system fragmentation presents in providing good transition support services (Davis, 2001; Davis & Hunt, 2005). Administrators raised various issues about fragmentation, most commonly between child and adult MH systems, but also between MH and other systems. These issues included separate funding streams, separate administrations with separate regulations and policies, and separate practices. They also described the deleterious effects of territoriality, chiefly protecting funding or resources, on the system's capacity to provide good transition support services.

Different Investment in Transition Supports

Within state MH systems, there appears to be different levels of commitment to the preparation of youth and young adults for adult functioning between child and adult systems. Though transition services within state child MH systems are sparse, every state's child MH system (with rare exception) have discussions underway about the need to improve transition support services. About three quarters of states' child MH systems offered at least one transition support service (Davis & Sondheimer, 2005). This was not true for adult services. Half of the states did not offer a single program specifically tailored to young adults. Those that did offer young adult programs most commonly did so in only one part of the state. Most types of transition supports were offered more often in child rather than in adult MH systems (Davis & Hunt, 2005). While administrators from both the child and adult MH systems reported similar system challenges to improving transition supports, child administrators typically expressed that improvements were needed, while this was not true for adult administrators. Thus, overall, child MH systems appear to be more invested in preparing youth for adulthood than are adult MH systems.

Policy and practice implications;

1. *Funding, administrative, policy, and practice bridges are needed between public systems and across child and adult systems that promote and permit continuity of care and transition support throughout the transition to adulthood (ages 14 or 16 to ages 25 or 30).*
2. *Policies should encourage public child and adult systems to take responsibility for ensuring that the specific developmental needs of 16-30 year olds in their systems are addressed.*

Density

As described above, the density of transition support services within state MH systems is insufficient to meet the needs of youth and young adults with serious MH conditions in their systems. Only 9 states offered any type of transition support services on a statewide basis within the child MH system, and only 2 states had made a systematic attempt to improve young adult services within their adult MH system. It is unlikely that youth with serious MH conditions

receive all their needed transition supports in non-MH systems. Studies of service utilization after youth age out of various children's systems indicate that few of these youth access any services even when they want them (Evans, McNulty & Banks, 1996; Greenbaum, 2000; Silver, 1995). In general, young people with serious MH conditions and parents report that services that could support their movement into adulthood aren't available, or aren't appealing in any system (Adams, Nolte & Schalansky, 2000; Davis & Vander Stoep, 1996). Recent findings from the 2nd National Longitudinal Transition Study have demonstrated improvement in educational services supporting the transition to post secondary school life for special education students with SED (Wagner, Cameto, & Newman, 2003; Wagner, Newman, & Cameto, 2004). Yet, findings from this study also suggest that they are under-referred to MH services; their educational experiences and transition plans do not match their work life goals; and there is relatively little attention to the specific services needs of special education students with SED in the literature (Wagner & Davis, submitted).

Policy and practice implications;

- 1. Policies need to encourage the rapid development of services and supports for adolescents and young adults with serious MH conditions to help prepare them for adult functioning.*
- 2. Those services and supports need to be developmentally appropriate and appealing to this population, and available regardless of the system with which they are involved.*

Expertise

The knowledge base about the transition to adulthood for youth and young adults with serious MH conditions is scientifically limited. While research has grown in the typical transition to adulthood, as evidenced by the volume by Settersten and colleagues (2005), research on the population with serious MH conditions is sparse, but growing. The absence of evidence-based practices also reflects the lack of research attention to this developmental stage. Thus practice implications are implications rather than tested practices.

Further, few individuals have learned the existing clinical or scientific knowledge base. Professional training of psychologists, social workers, and physicians is largely organized into child specialists and everyone else (usually serving adults). Thus, individuals shaping current systems either have the developmental training that comes with child specialization or has little developmental training. Moreover, developmental psychology courses emphasize child development, which does not include consideration of the transition into adulthood, while adult development often emphasizes geriatric issues. Thus, training genuine expertise in working with transition aged youth and young adults is currently not provided at the undergraduate or graduate level. This creates the burden of developing expertise among working staff and professionals. State child MH administrators from states that had made significant progress in addressing transition needs described that the lack of expertise hindered their efforts to develop transition support services (Davis, 2001). When funding was found for transition supports, there was no local expertise in working with the population. Helpers tend to define themselves as either adult or child workers and are often uncomfortable with this in-between age group. Colleges and universities that train the professionals that provide human services and education don't typically offer training in the non-traditional approaches that appear to work best with this population (Clark et al, 2000). Thus expertise needs to be developed and shared.

Policy and practice implications;

- 1. Policies and programs should encourage rapid development of the scientific knowledge base for transition services and supports for individuals with serious MH conditions.*
- 2. Policies and programs should encourage training in transition expertise among those who work with this population.*

SUMMARY

Taken together, it is clear that individuals with serious MH conditions need better supports during the transition to adulthood, and that current federal policies and programs have not done enough to encourage this. Implications from the existing scientific knowledge base, though limited, provide guidance for the evaluation and improvement of federal policies and programs that could better serve this population.

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Appendix A
Transition to Independence Process System

The following description is taken *verbatim* from Hewitt B. “Rusty” Clark’s web site: <http://tip.fmhi.usf.edu/systemdesc.htm>. For more information about this system, see the web site.

The Transition to Independence Process (TIP) system was developed to engage youth and young adults in their own futures planning process, provide them with developmentally-appropriate services and supports, and involve them and their families and other informal key players in a process that prepares and facilitates them in their movement toward greater self-sufficiency and successful achievement of their goals related to each of the transition domains employment, career-building education, living situation, personal-effectiveness and quality of life, and community-life functioning.

The TIP system is operationalized through seven guidelines and their associated elements that drive the practice level activities and provide a framework for the program and community system to support these functions.

TIP System Guidelines

1. Engage young people through relationship development, person-centered planning, and a focus on their futures.
2. Tailor services and supports to be accessible, coordinated, developmentally-appropriate, and build on strengths to enable the young people to pursue their goals across all transition domains.
3. Acknowledge and develop personal choice and social responsibility with young people.
4. Ensure a safety-net of support by involving a young person’s parents, family members, and other informal and formal key players.
5. Enhance young persons’ competencies to assist them in achieving greater self-sufficiency and confidence.
6. Maintain an outcome focus in the TIP system at the young person, program, and community levels.
7. Involve young people, parents, and other community partners in the TIP system at the practice, program, and community levels.

Transition Facilitators

- To ensure the continuity of planning, services, and supports, the TIP system is implemented with the assistance of transition facilitators who work with the young people, their parents, family members, and other informal, formal, and community supports.
- The term transition facilitator is used to emphasize the function of facilitating the young person’s future, not directing it.
- Different sites and service systems use similar terms such as transition specialist, resource coordinator, mentor, transition coach, TIP facilitator, service coordinator, or life coach.
- The role of transition facilitators with young people, their parents, family members, community representatives, and other informal and formal key players will be described in detail throughout this manual.

Independence and Interdependence

The TIP system promotes independence. However, the concept of “interdependence” is central to working effectively with young people. This concept nests the focus of independent functioning (e.g., budgeting money, maintaining a job) within the framework of young people learning that there is a healthy, reciprocal role of supporting and receiving support from others (i.e., social support network for emotional, spiritual, and physical support).

Transition Process Values

Whether they are explicit or implicit, the values held by transition staff and by administrators in a service system determine how the program operates and affects features of the program, such as support strategies, processes for establishing goals, focus of services, responsiveness to young people, involvement of parents, funding plans, hiring and training of staff, and support of staff and young people who are contributing. Based on an extensive review of community-based transition programs helping youth and young adults move into the world of adult responsibility, Clark, Unger, and Stewart (1993) identified program values that appeared to be essential in guiding quality transition programs. These transition process values are similar, but not identical, to those underlying the children’s system of care model (Stroul & Friedman, 1986) and the wraparound process (VanDenBerg, 1993). These transition values are infused throughout the TIP system guidelines. Thus, if personnel who are working with young people and their informal and formal key players are functioning in accordance with the TIP guidelines and the site’s program managers, administrators, and policy makers are supporting and facilitating this work, the result should be an effective, quality TIP system.