Where are Bridges Needed?

Relationships Between Youth and Adult Services Before Strengthening the Transition System

Report on the Interrelationships of Agencies in a Center for Mental Health Services Partnerships for Youth Transition Grant Site

The Center for Mental Health Services

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EXECUTIVE SUMMARY

This report summarizes the nature of the relationships between organizations and agencies in Clark County, WA, that could form a system of services to support youth and young adults with serious mental health conditions during the ages of the transition from adolescence to adulthood (ages 14-25). Clark County was the recipient of a *Partnerships for Youth Transition* grant from the Center for Mental Health Services, Division of Service and Systems Improvement, Child, Adolescent, and Family Branch. The purpose of these grants are to plan, design, and implement youth transition programs for youth with serious mental health conditions up to age 25, and their families. Services for individuals ages 14-25 span child and adult service systems, and those that support the development of young adult functioning span many different systems (e.g. vocational rehabilitation, substance abuse, education). Understanding how this vast array of services and systems interact helps to identify where bridges between them currently exist, where they need to be strengthened, and where they need to be built, in order to provide comprehensive and continuous transition supports. While each locale has its own particular set of services, policies, and organizing forces, it is hoped that Clark County is representative of many small metropolitan areas, and that the nature of the findings in this county provides insight into systems in other sites.

The Clark County system was assessed prior to implementation of their model plan. A key informant from each of the 103 organizations in the system was interviewed using an established technique, called Social Network Analysis, to determine the nature of their organizations' relationship with each other organization in the system, and to obtain their ratings of the quality of services in their organization and the system in general. The following is a summary of the findings.

- The opportunity for an adolescent to continue in a particular service, without a change in program or staff, as they aged from 17-22, was rare. The vast majority of organizations and specific services served only a youthful population, or only an adult population, and provided no opportunity to continue the treatment or service across the adult age threshold.

- Health services offered the greatest age continuity in services with almost half of these organizations serving 14-25 year olds with no break in service or staff, compared to 3-20% of organizations in other types of services.

- Generally, the "systemness" of these organizations was typical of those found in human services. They made referrals to each other and exchanged information for client planning purposes to the same extent that most human service systems

do. The system was moderately centralized (activities typically flowed through a smaller subset of organizations, rather than equally through all subsets).There was a common configuration of a "core" of organizations that typically interacted with one another, then smaller groups of organizations that interacted together, however, the central core was unusually interconnected and large.

- Identifying groups of organizations that interacted with other organizations in similar ways revealed a youth system that was very well interconnected, and an adult system that was not well interconnected. Direct communication and referrals between the youth and adult system was very limited, mostly flowing through a small subset of organizations that served both youth and adults.

- Respondents generally rated their own organization better in quality of care than they rated the system, and rated both their own organization and the system low on dimensions that uniquely reflected the service needs of the transitioning population.

Exemplary practices that support the transition to adulthood call for a developmentally appropriate, comprehensive, and continuous array of services that can support youth across the transition ages. The findings in this report suggest the following changes would be advantageous:

- **Remove Age Barriers**
  - When continuity of services are therapeutically important, services should have the flexibility to continue beyond typical adult/child defining age limits, rather than beginning or ending based on age.
  - Adult services would benefit from the capacity to serve those who are underage, as part of a strategy to engage young people in services which they might continue in as they mature into adulthood.
- **Increase Intersystem Coordination**
  - Staff members of organizations should meet for client planning purposes when a young person exits the services of one organization and enters the services of another. Policies towards this end would be helpful.
  - Youth and adult organizations should interact more to exchange the expertise of each system, and to build knowledge about how to serve this age group that spans both systems.

- **Increase Relationships Within Adult Systems.** Increased interactions among organizations within adult systems, to learn about and engage each other in

addressing transition support needs, and exchanging expertise, would enhance the development of appropriate transition supports.

- **Increase Referrals from Youth to Adult Systems.** It is likely that the absence of referrals from youth to adult systems stem from a variety of causes (see above), but a measure of improved services will certainly include an increase in the number of these referrals.

It is likely that these changes will result from some essential change agents: leadership, prioritization of the issue, sufficient funding. With these ingredients the specific challenges of building bridges across and within youth and adult systems can be overcome and result in a solid transition support system.

INTRODUCTION

Poor Young Adult Functioning

As youth with serious mental health (SMH) conditions enter adulthood their ability to assume adult role functioning is deeply compromised (reviewed in Davis, & Vander Stoep, 1997; Vander Stoep, Collins, & Davis, 2000). This is particularly true for those involved with public services systems (Vander Stoep et al., 2000). Only about half finish high school, fewer are employed, more are in trouble with the law, and more are pregnant than their same age peers. They are also at great risk of homelessness and extreme poverty. Standard services are failing these youth, their families, and society.

Insufficient Transition Support Services

While all the factors that contribute to the poor adult outcomes among these youth have not been identified, one likely source is an absence of services that are designed to help them take on the mantle of adulthood. These services, referred to here as *transition support services*, can be offered in any system that youth are involved with during the transition years (roughly ages 16-30). Ideally, they would be available in the child as well as in the adult system, since no children's systems serve individuals beyond age 22, and many end services at age 18.

Child Systems

Transition support services, in the form of transition planning and related services within special education, and independent living and related services in child welfare, are broadly available to many adolescents served by those systems. Specific knowledge about how to apply those general transition services specifically to the population with SMH conditions is growing within special education (i.e. Cheney, 2004; Bullis & Fredericks, 2002), but there is little evidence for its growth within child welfare or juvenile justice systems. Rigorous evaluation of the new special education approaches have not been conducted, and the availability of these programs, nationally, is unclear.

Unfortunately, the absence of transition support services for youth with SMH conditions in other child systems is not counterbalanced by their availability in the child mental health system. Nationally, state child mental health (CMH) systems rarely offer services designed to help youth prepare for adulthood (referred to here as transition support services). As of 2001, the state CMH system in only one state provided or coordinated a comprehensive array of transition support services for the adolescents they served statewide, and those services ended at age 21. Most commonly, state CMH systems offered 1one or two types of transition support programs (i.e. independent living preparation, vocational counseling) in one or two sites within the state, while almost a quarter offered no transition support services (Davis & Sondheimer,

2005). This level of support is insufficient to prepare youth for the demands of adulthood. Moreover, *no state MH system has been successful in continuing to provide comprehensive transition supports into the age solely served by adult mental health systems for most youth from the child mental health system*.

Child and Adult System Disconnect

The public agencies available to youth with SMH conditions during transition ages are in part organized according to the age group served. The child system is comprised of child welfare, juvenile justice, special education, and child MH. Substance abuse, vocational rehabilitation, corrections, homeless services and adult MH services comprise the adult system. Many of these agencies have no counterpart in the other system (e.g. special education has no adult counterpart, vocational rehabilitation has no child counterpart). This type of organization presents a tremendous challenge to providing continuous transition supports as youth "age out" of the child system. State MH agencies usually have child and adult subsystems, which would theoretically provide for care continuity. However, eligibility or priority population criteria for child and adult MH services are misaligned, with adult criteria generally defined more narrowly (Davis & Hunt, 2005). This misalignment results in some portion of the CMH population losing services as they enter adulthood because they do not meet adult population criteria (Davis & Koroloff, submitted; Davis, 2003).

For young adults who are eligible for adult MH services, those services often do not address the unique developmental needs of the younger adult population, such as helping them finish high school, connecting them with young people their own age, or simply expecting and responding appropriately to the experimentation, commonly seen in all youth at this age, that is needed for mature "identity formation" (Davis & Hunt, 2005). Thus, access does not guarantee availability of appropriate services.

Taken together, it appears that adolescents with SMH conditions are largely unable to access supports and services that would help them prepare for adult functioning and are even less likely to access them once they are old enough for adult services.

Myriad System Barriers

The causes of insufficient transition support services within state mental health systems appear to be myriad (Davis, 2001). Interviews of lead state CMH administrators revealed that almost all expressed considerable frustration in trying to improve the system's capacity to address transition needs (Davis, 2001). Thus, the general absence of transition supports did not appear to be caused by a lack of awareness of the problem; rather, these administrators described a laundry list of what they view as intransigent system obstacles, described below. On the other hand, as a group, adult MH administrators expressed completely opposite views about the value of separate or special services for young adults. Thus, one of the likely reasons

for the absence of transition support services within adult MH systems is that the problem created by their absence is largely unrecognized in the adult system.

Insufficient Funding

Funding shapes barriers in several ways. Commonly, tight budgets, which have become even tighter in recent years, produce an unwillingness to fund what are viewed as specialty groups or services. The transitioning population and their needed supports are considered a specialty (Davis, 2001). Even in well-funded states most CMH administrators felt that new funds were needed to improve transition supports, and new funds were extremely hard to come by (Davis, 2001). These administrators estimated that the cost to add transition support services to existing adolescent or adult programs or to continue serving youth to the age of 25 in either the child or adult system was substantial. They felt that some funding for these efforts could be achieved by cost-shifting within current programs, but felt strongly that significant new funds would be needed (Davis, 2001). The validity of this perception was bolstered by the finding that states that had made substantial inroads to developing transition support systems had uniformly obtained new funds either from their legislatures or from federal mental health block grant dollars (Davis, 2001).

Impact of Funding on Services

Funding underwrites the ultimate barrier: the inability to ensure continued services once an adolescent matures beyond the upper age limit for CMH services. In most states, funding of adult and child MH is separate (Davis, 2001). Each system has developed its own set of programs and standards regarding who can access those services. It is unclear to what extent target population definitions shape program development or vice versa, but it is clear that for youth that do not fit the eligibility or target population definitions for adult MH services, there is little or no funding spent on services they could access. Providing appropriate services for a previously unserved population generally requires additional funds unless funding for another population is reduced.

Multi-Level Influences on Funding

The two largest sources of funding for state MH systems are state general funds, allocated through the legislature, and Medicaid. Decisions about how these funds are used occur at the Federal level (e.g. Medicaid eligibility and other regulations), state legislatures (e.g. legislative mandates regarding populations served or services provided), state level administrators (e.g. state level MH administrators set policy or funding guidelines), or regional administrators (i.e. states such as Ohio have very strong local control of policy and funding decisions). In addition, states have numerous options within Federal Medicaid regulations, but those decisions are often not made within the MH system.

Fragmentation of MH funding and funding policy is clearly an impediment to comprehensive and continuous transition supports. The degree and impact of fragmented funding only increases with the added involvement of other systems, such as child welfare, special education, vocational rehabilitation systems, each with their own funding streams and service mandates.

It is clear that obtaining funds for transition support services within state mental health systems has been an extraordinary achievement to date.

Insufficient Leadership

CMH administrators asserted that it was only through dogged leadership and advocacy that the laundry list of barriers could be overcome. They reported that leadership and advocacy were needed to obtain funding, to apply the funding to a vision, to develop a strategic plan for change, and to maintain support for the changes. Without leadership that holds a vision and develops a strategic plan for change, funding alone is insufficient. Put simply, without leadership, programs perish.

Structural Impediments

In the absence of adequate leadership, policy, and funding, systems available to serve youth with SMH conditions during the transition to adulthood will remain fragmented and incomplete. Shaped by the fiscal and regulatory incentives imposed on service providers by public agencies (purposely or coincidentally), most programs have a specific age focus (i.e., they serve only adolescents or only adults), service focus (i.e. they only provide housing services), and/or population focus (i.e., they only serve child welfare youth, or those with developmental disabilities). These programs are like single tiles of a large mosaic. Providing continuous, comprehensive services for individuals who need transition supports requires fitting the tile pieces into the larger picture that forms the mosaic of needed services for that individual, while minimizing missing, overlapping, and misshapen pieces, and emphasizing the importance of keeping the same tiles over time (service continuity).

The degree to which the mosaic can form a complete and attractive picture depends not only on the availability of enough appropriate components, but also on the infrastructure of the system, and in particular, on the relationships between programs that promote proper fitting of the pieces. For example, programs need to refer their clients to one another and should communicate about referred clients. Client referral and sharing information for client planning purposes are two kinds of relationships. Examination of these kinds of relationships reveals system "structure", or how organizations in a system are connected to one another.

When the array of programs that are needed for continuous and comprehensive transition supports do not exist, do not communicate, or are culturally inappropriate, gaps occur. "Culture" here refers to the culture of the program (e.g., the processes, activities and physical environment of a given agency), which for youth in transition, are most commonly inappropriate for this particular age, this kind of disability, or both.

While there is evidence regarding leadership and funding issues, to date, no published studies have examined the infrastructure of transition systems. An understanding of structural and cultural impediments to the needed transition supports for youth with SMH conditions or serious mental illnesses (SMI) can help guide efforts to identify and remove those impediments. Removing impediments in existing services may relatively inexpensively improve transition support systems in a meaningful way.

The goal of this report is to focus attention on specific structural system impediments that are likely to exist in many geographic sites, and to stimulate discussion of how to eliminate or minimize their impact on appropriate transition support systems.

RATIONALE

Examining One Critical Site

On October 1, 2002, the Federal Center for Mental Health Services (CMHS), with Federal agency and private foundation partners, funded five sites across the country to build programs that offer comprehensive transition supports that can help adolescents with SMH conditions, and their families, through the age of 25. As described above, these kinds of programs did not exist anywhere in the country within state child/adult mental health systems, as of July 2003 (Davis & Sondheimer, 2005; Davis & Hunt, 2005). This grant program, called Partnerships for Youth Transition (PYT), remedies some of the most difficult system barriers that interfere with transition system building. The funded sites all have the kind of leadership and advocacy that is necessary for significant change. The PYT grant program provides those leaders and advocates funding for direct services and infrastructure building, technical assistance to help shape the vision and problem-solve, and time to establish programs and collect data to help bolster arguments that they should continue.

Clark County, WA

Clark County, Washington was chosen as the system to study for this project. It is one of the five CMHS PYT grant sites. It is a suburban metropolitan area (pop. 345,000), that had implemented a CMHS children's system of care grant, and that had community leaders who were clearly interested in creating system change for the transitioning population of youth with SMH conditions. These characteristics made it a good choice for structural analysis. Being a suburban metropolitan area, rather than a rural or urban area, was felt to render the findings generalizable to many sites in the country. Having had a CMHS system-of-care grant also linked the findings from this site to current visions of good system configuration and to the more than 100 such currently or previously funded sites around the country. The dedication to the goal of creating a transition system also made it likely that change would occur that would stand in contrast to the baseline findings reported here. Thus, it is hoped that the findings of

this study will have implications for other sites across the country. Future study of the changes produced at this site by the PYT grant will also be able to use the current findings as a baseline.

Systems, however, are shaped by more than the urbanization of their setting and their grant history. Thus, the following description is offered to aid in the interpretation of the current findings. The Washington State Mental Health Division is located within the State's Department of Health and Social Services (DHSS). Authority for mental health services within the State is decentralized to eight Regional Support Networks (RSN). Each RSN can serve multiple counties and has a single lead RSN administrator. There may also be a separate administrator for children's MH and adult MH if the region is large enough. The RSN that serves Clark County primarily provides mental health services through contracting with private providers. Access to those contracted services is controlled directly by the RSN, through a care coordinator that regulates access to services.

The State's child welfare, vocational rehabilitation, and juvenile justice agencies are also decentralized to the regional or county level, with a local administrator leading each of these agencies. There are eight school districts in the county and 16 high schools. There is one community college in the county, as well as a branch campus of Washington State University serving upperclassmen. The county's population is largely non-Hispanic white (86%), and the median household income in 1999 was $48,376, with 7% of families living below poverty level. The county borders the Portland, Oregon metropolitan area, and many residents commute to jobs or schools in Portland.

County MH services are funded by Medicaid. At the time of baseline data collection Medicaid funding was undergoing change. At baseline, county MH services were offered to those with Medicaid, and a small number of those without. Shortly after baseline, any client of the county MH system had to be Medicaid eligible, meet medical necessity criteria, and be seeking Medicaid reimbursable services in the MH system.

The county MH administrator has considerable discretion in the disbursement of funds, development of policy and contract language, as long as it is consistent with Federal and State Medicaid regulations.

Thus, Clark County is representative of many local systems that have considerable local autonomy, and whose MH systems are largely shaped by Medicaid funding.

This report delineates structural strengths and impediments in the transition services network of Clark County, WA prior to implementation of their PYT grant-supported changes.

Social Network Analysis

Social Network Analysis (SNA) is a methodology that describes what organizations are in a network or system, the characteristics of each of those organizations, and the strength and direction of each organization's relationship to the other organizations in the network (Van de Ven & Ferry, 1980; Morrissey et al., 1994). Inter-organizational relationships are described for four dimensions; sending and receiving client referrals, meeting for client planning purposes, and meeting to discuss issues of mutual interest. Briefly, data collection efforts consist of

completing a structured interview with one to two informants within each network organization (Van de Ven & Ferry, 1980). Providers' self-report on inter-organizational networks has been shown to be valid and reliable (Calloway et al., 1993).

SNA data collection methodology was established for mental health organizational systems by Morrissey, Calloway, and colleagues (1994 & 1997). It has been used to successfully assess the contribution of service integration to client outcomes for a variety of populations including homeless adults with mental illness (Rosenheck, et al., 2002) and children with serious emotional disturbance (Johnsen, Morrissey, & Calloway, 1996).

METHODOLOGY

Overview

- Administrators from every program and agency that provided any services that could be relevant and accessible to youth with SMH conditions or SMI during the transition to adulthood were interviewed.
- Respondents answered questions about their program or agency, their relationship to other programs or agencies in the transition network, their views of the quality of their services, and those of the broader system.
- Answers about relationships with other agencies or programs were analyzed to describe to what extent possible relationships actually existed, the degree to which the system was centralized, and what kinds of agencies and programs formed subsystems and what subsystem relationships revealed.
- Answers about programs' or agencies' services were analyzed to determine the kinds of services available and the degree to which continuity of care was available.
- Answers about quality of services were analyzed to determine to what extent respondents thought their program/agency and the system served youth in transition well.

Details

Identifying Network Members and Interviewing Representatives

An initial task in studying inter-organizational networks involves "bounding the system" or identifying network members. For the present project, knowledgeable community informants (including key informants from the local DCS and from provider and advocacy

groups) were provided a list of program types often found in child or adult service delivery networks including; mental health, substance abuse, educational, health and medical, child welfare, housing, vocational, recreational, and legal/advocacy services. Community informants were then asked to generate a list of the specific agencies or programs (both referred to herein as organizations) in Clark County that served individuals between 14 and 25 years old with SMH conditions or SMI. To qualify for study inclusion, organizations did not have to serve individuals throughout the age range, but needed to serve individuals somewhere within the range. Examining this age range clarifies organizational responses before and after statutorily defined transition points (often at ages 18 and 21). Interviewees were selected from three of the eight school districts in Clark County. Of 107 organizations initially identified, four were eliminated that had either no longer offered services in the area or were in fact contained within other organizations. Thus, the final transition services network consisted of 103 organizations, 100% of which participated in interviews.

Once the network was bounded, project staff identified a key informant within each organization and scheduled interviews. That key informant was an organizational "boundary spanner" who had both extensive knowledge of the organization and global knowledge of inter-organizational relationships between that organization and organizations in the area. Informants were interviewed by one of four interviewers, the project coordinator, or one of the three trainers. Interviewers were trained by co-investigators Johnsen, Starrett, and Davis. All interviewers received two days of training which included review of each questionnaire item, observation of trainers interviewing actual respondents, supervised interviews of actual respondents, and observation of others' supervised interviews, with debriefing after each interview.

Each interview lasted one to two hours. The interview instrument is described below. Data were collected in September and October, 2003, prior to initiation of the implementation stage of the grant in October, 2003.

Instrument

The structured interview consists of three sections.

Part I Asked for information about the organization, the services it provided, and individuals who served within the organization.

Part II

- A Asked for information about the interaction of the organization with each organization in the network in: 1) meeting for client planning purposes, 2) meeting to discuss issues of mutual interest, and 3) sending and receiving referrals.
- B Addressed the type of services offered by the program and the age continuity of offered services. For example, if a program offered vocational counseling, the interviewee was asked to indicate the age groups that were offered vocational counseling, and then to indicate whether the age groups were served continuously (i.e. if the service was provided to 14-17 year olds and 18-20 year olds, would an individual have to change staff or locations as they matured from the first to the second age group?).

Part III

This section asked for interviewee's ratings of: 1) their own program and 2) the larger system. Ratings were requested on a variety of dimensions that reflect general quality of care, and some new items that were added to specifically address quality of services for transition-aged youth, that were developed from the guidelines for the Transition to Independence Process system (Clark et al., 2000).

Data Analysis

SNA requires the generation of organization-by-organization matrices for each of the types of relationships (referrals and information exchanges). Interagency linkages were assessed using responses to questions about the working relationships between the respondent's agency or program and the other organizations in the services network. Respondents answered the following questions using a five-point Likert-type scale (ranging from 1, Not at All to 5, Very Often): *How often does your agency/program refer clients to (or receive clients from) this other agency/program* (the to and from form 2 questions) *? How often do staff in your program/agency meet with staff in this other program/agency for client planning purposes? How often do staff or administrators in your agency/program and these agencies/programs meet together to discuss issues of mutual interest?* Answers to these four questions were the basis for describing four types of networks within the transition network;

1. **Client receive network**
2. **Client send network**
3. **Information exchange network**
4. **Client planning network**

For each type of these four types of relations, the five possible Likert-type responses were dichotomized and arrayed in a 0-or-1 data matrix in which 1 represented the existence of a relationship between the two organizations, and 0 indicated no relationship. A summed 103x103 matrix, in which 103 denotes the number of agencies in the transition network, was created by adding the corresponding cell values for each of the 4 questions. For example, for organization A and B, organization A makes referrals to B (score 1), but B does not refer to A (score 0), they meet for client planning purposes (score 1), but not to discuss issues of mutual interest (score 0). The value for their summed cell would be 2 (1+0+1+0). Cell values in this matrix can range from 0 to 4, with higher numbers indicating stronger interagency linkage. Several measures can be derived from these matrices.

Density is a relatively simple measure of overall network: # of actual ties/ # of possible ties. Density values can range from 0 (no ties) to 1 (all possible ties realized).

Centrality is the degree of hierarchy in an overall network. Centralized systems have an organization or organizations through which activities pass, with less interaction among other organizations, whereas decentralized systems do not have a set of organizations through which most agencies interact, but rather subsystems of the network interact with a limited number of other subsystems with which the remaining subsystems also have few relations, and no subsystem is more important than any other. Like density, system centrality scores range from 0-1 with 0 being highly decentralized and 1 being highly centralized.

K-Cores are a useful technique to identify agencies that are in the core and agencies that are at the periphery of networks (Johnsen et al., 1996). Each K-core identifies a set of organizations with at least *k* relationships with other members of the set. Organizations in the most central core have the greatest number of ties with other organizations in the central core. Each core then has progressively fewer numbers of ties with other members in their cores, and is increasingly peripheral.

Block Modeling is a technique used to describe large systems with many cores. One way to simplify the relationships in a system is to look for organizations that are structurally equivalent: organizations that tend to relate to other organizations in a similar way and therefore play similar roles within the network in a particular dimension (i.e. meeting for client planning purposes). Organizations within a block do not necessarily interact with each other, the similarity is in the way they interact with other organizations, which may or may not include organizations within the block. This method simplifies a 103x103 matrix into a smaller matrix of 4x4, 8x8, or 16x16. The size of the best fitting matrix is determined by the degree of variance explained balanced by the size of the matrix. For example, if a network can be simplified to a 4x4 matrix, and explains 60% of the variance, it is a better simplification than an 8x8 matrix that explains 65% of the variance.

The density and centralization of the system as a whole was calculated using the UCINET program, a network software program, and block modeling was calculated using a structural equivalence approach (CONCOR).

Descriptive statistics were used to describe the age continuity of services and answers to questions about service quality.

RESULTS

General Description

Overall, the organizations in the Clark County Transition Network embodied the broad spectrum of service sectors initially targeted, with organizations represented in each service delivery sector (see Table 1, column 2). Of a menu of 55 services types (e.g. case management, groups homes, parent training) that might be provided to adolescents or young adults, 53 were available in the Clark County area to at least some of those with SMH conditions or SMI for some ages between 14 and 25. Two very specific types of services (Clubhouses and Multisystemic Therapy) were not available. The types of services most commonly offered were case management, vocational counseling, and wraparound services. Psychiatric hospitalization (public or private) was least frequently offered. Participating organizations were on average, quite well-established, and fairly large.

Table 1. Types of Services Provided and Ages Served in the Transition Network Organizations (n=103) in Clark County, WA.

Service Type	%*	# Organizations Serving each Age Group**				
		Youth	Adult	14-25	14/25	Other
MENTAL HEALTH SERVICES						
Outpatient	32	10	8	10	5	0
Home based	18	5	4	4	4	0
Wraparound	35	16	10	5	5	0
Medication management	24	10	7	4	3	1
Emergency	22	9	3	8	3	0
Drop-in Center	10	5	4	1	0	0
Respite	15	10	3	1	0	1
Partial hospitalization	8	0	7	0	1	0
Inpatient hospitalization	3	0	2	0	1	0
State psychiatric hospital	1	0	1	0	0	0
Private psych. hospital	1	0	0	0	1	0
Case management	39	18	8	8	0	6
Consumer Op. Services†	4	1	2	0	1	0
Supported Employment	19	4	13	2	1	0
Psychosocial Rehab.	11	0	10	1	0	0
Clubhouse	0	0	0	0	0	0
ACT† Team	8	1	6	0	1	0
Mentoring	17	14	0	2	0	2
MultiSystemic Therapy	0	0	0	0	0	0
Therapeutic Foster Care	5	4	0	0	0	1
Residential treatment	12	3	8	0	1	0
Residential respite	8	6	2	0	0	0
Supervised housing	12	4	6	0	0	2
Group home	4	1	2	0	0	1
SOCIAL SERVICES						
Child Protective Services	6	5	0	0	1	0
Foster care	5	5	0	0	0	0
Income Support	5	1	3	1	0	0
IL† Preparation	26	17	6	2	1	1
Parent training	28	15	5	9	0	0

Service Type	%*	# Organizations Serving each Age Group**				
		Youth	Adult	14-25	14/25	Other
SCHOOLS AND COLLEGES						
High School	20	21	0	0	0	0
Vocational School	12	12	0	0	0	0
2-year college	2	2	0	0	0	0
Vocational rehabilitation	14	5	8	1	0	0
Tutoring	26	22	3	0	0	2
Transition planning	28	22	4	1	0	2
GED preparation	17	15	2	1	0	0
Special Ed. advocacy	29	25	1	2	1	1
VOCATIONAL SERVICES						
Vocational counseling	35	19	11	5	1	0
Vocational training	27	14	11	2	1	0
Sheltered Employment	5	3	2	0	0	0
SUBSTANCE ABUSE SERVICES						
Detox tx†/residence	5	0	3	2	0	0
Inpatient SA† tx	2	1	0	1	0	0
Comorbid MH/SA svs†	19	5	11	2	2	0
HEALTH SERVICES						
Family planning	11	6	1	4	0	0
Public Health clinic	2	0	0	2	0	0
HOUSING AND HOMELESS SERVICES						
Homeless Shelter	5	4	0	0	1	0
Mobile outreach	7	2	0	2	3	0
JUSTICE SYSTEM SERVICES						
Corrections facility/jail	3	1	1	1	0	0
Juvenile detention facility	4	4	0	0	0	0
Legal aid	2	1	1	0	0	0
Legal advocate	5	2	2	1	0	0
Probation	4	3	1	0	0	0
OTHER SERVICES						
Recreation programs	31	21	5	5	1	0
Advocacy	28	12	5	9	2	1
TOTAL	--	**386**	**192**	**99**	**41**	**21**

* % = % of organizations offering the service

**Individuals are served in age groupings as follows: *Youth*, up to ages 18 or 21, *Adult*, over ages 18 or 21, *14-25* all age groups continuously, *14/25* all age groups, but with breaks in staff or program at specific ages

†Consumer Op.=consumer operated, ACT=Assertive Community Treatment, IL=independent living, tx=treatment, SA=substance abuse, svs=services

Continuity of Service

These analyses focus on information obtained from the list of services in Table 1, and the ages of individuals that respondents indicated could receive those services. Respondents were asked about each service, ages served, and ages served without any break in the service (change of staff/program). Age groups consisted of : (a) 14-17 years, (b) 18-21 years, (c) 22-25 years, and (d) 26 years and older.

The most common services were those that served youth only (N=386, 52.2%), followed by those that served only adults (N=192, 26.0%), only 13.4% served 14-25 year olds continuously (N=99), fewer served the entire age group discontinuously (N=41), and 2.8% used an other age configuration (N=21). Some service sectors, such as schools and colleges or social services were predominantly youth services (see Figure 1). The substance abuse sector was the only sector that offered more adult than other services. Mental health and vocational services had services with a mixture of age groupings. Health services were as likely to be offered continuously across ages as they were to be youth services (See Figure 1).

Age groupings in the services were used to categorize organizations in terms of the primary age of the population served:

- **YOUTH ONLY -** *only individuals up to 18 or 21 in all services in the organization,*
- **ADULTS ONLY -** *only individuals 18 or 21 and older in all services in the organization,*
- **14-25 YEAR OLDS DISCONTINUOUSLY –** *services were offered to all age groups but there was a change in staff or programs mandated at certain ages for more than half of the services in the organizations,*
- **14-25 YEAR OLDS CONTINUOUSLY**, *- at least half of their services served all age groups without a change in staff or physical location*.

No organizations offered all of their services to 14-25 year olds continuously. The vast majority of organizations served only adults, or only youth (see Figure 2). Fewer served both groups, though almost a quarter provided half or more of their services continuously to 14-25 year olds.

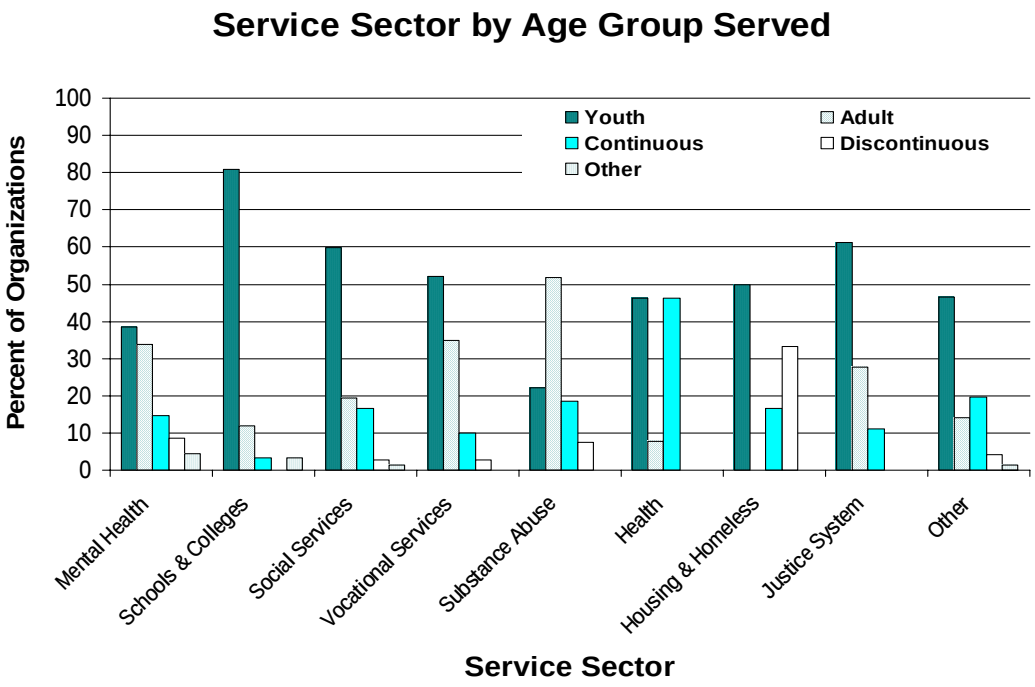

Figure1. Proportion of age groupings within each service sector for organizations in the transition system in Clark County, WA. *Youth*=up to ages 18 or 21, *Adult* =18 or 21 and older, *Continuous* = ages 14-25 without requiring a break in staff or program based on age, and *Discontinuous* =ages 14-25 but require a change in staff or program based on age.

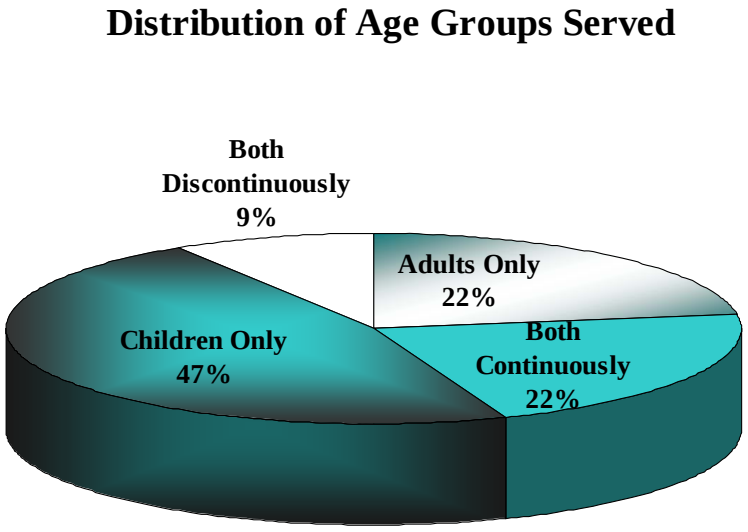

Figure 2. Distribution of organizations categorized by age groups served (n=103). *Youth*=up to ages 18 or 21, *Adult* =18 or 21 and older, *Continuous* = ages 14-25 without requiring a break in staff or program based on age, and *Discontinuous* =ages 14-25 but require a change in staff or program based on age.

Relationships Between Organizations

Density, Centrality, and Hierarchy. *The methods for deriving the figures provided below are described in the Data Analysis section of the Methods (above).* Generally, these measures of "systemness" indicated that this overall system is typical of those found in human services (e.g. Johnsen et al., 1996; Morrissey et al., 1997). Density scores for each question ranged from .28 (receive referrals) to .44 (participate in client planning meetings). Centrality scores ranged from .41 (participate in client planning meetings) to .57 (receive referrals). The K-cores revealed a system considerably more cohesive than many other child or adult MH service systems that we have studied. Two thirds of the network members are in the highest K-core for the *client planning* and *send referral networks*. For the client planning network, with a K-43, each of the members of this highest K-core (N=69) interact with at least 43 other members of the network. For the *information exchange network* each of the members of the highest K-core (N=61) interact with at least 38 other members. For the "send referral network", the K-41, means that each of the members of this K-core (*N*=69) have ties with at least 41 others in the network. The "receive referral network" has a lower proportion of members at the highest core, with a bit less than 50% in the highest K-core, which is a K-32. Overall, the K-cores reveal a relatively high level of interconnectedness with a sizable proportion of the network (50-67%) as members of the highest core.

Block Modeling. In examining the inter-organizational network, application of the structural equivalence algorithms led to an eight position solution (8x8 matrix) for each relationship dimension. This solution explained one-third of the variation within the network. These positions and their membership, which were the same across each relationship dimension, are described in Table 2. A label was created for each block, or position, based on the dominating types of service sectors those organizations represented, and the ages served. Type of service was determined by the type of the majority of services offered by each organization, as indicated in the service type section analyzed above. Age served was determined using the same age guidelines described above. For example, in position #2, all 11 of those MH agencies served only youth.

Table 2: Structural positions within transition network

			Service Sector (N)					
Position	**Label**	**N**	**Education**	**MH**	**Justice**	**Child Welfare**	**Vocational**	**Multiple/ Other**
1)	Child Education	16	9	3	1	0	0	4
2)	Child MH	16	0	11	1	1	0	3
3)	Rural Child Education	20	11	0	0	0	0	4
4)	Adult Mixed	9	2	0	0	1	1	4
5)	Child/Adult MH	10	2	5	0	0	1	2
6)	Adult Vocational	6	0	0	0	0	6	0
7)	Child/Adult MH	8	0	4	1	0	0	3
8)	Adult MH	16	0	14	0	0	0	2

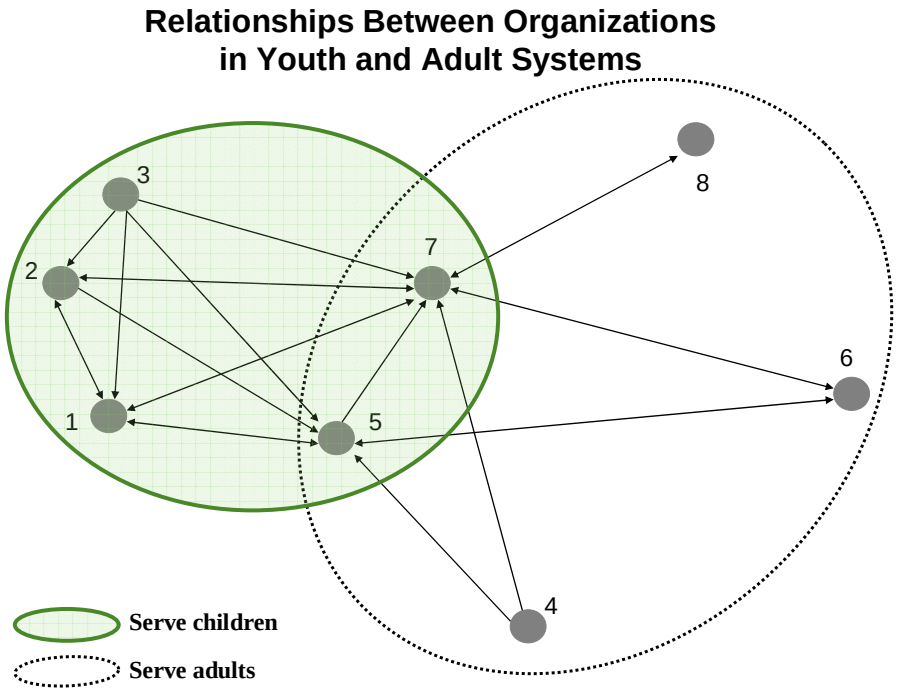

Figure 3. Critical linkage points between youth and adult systems in exchange of information for client planning purposes.

Figure 3 presents a graphic representation of the block model suggested by the structural equivalence analysis for the relationship regarding meeting for client planning. In examining connectedness within this block model, it appears that what one might characterize as the child/youth service delivery network (positions **1,2,3,5** and **7**, circled with a solid line) is relatively well-connected, reflecting ties between all positions in the networks: each position is connected with all others. Position 3 is less connected, because its ties are unidirectional. Geographically, it appeared that many of the organizations in position **3** came from rural areas of the county.

The adult service delivery network (positions **4, 5, 6, 7**, and **8,** circled with a dotted line), was characterized by less connectedness. Positions **5** and **7** serve to link the other adult system positions together. These two positions (**5** and **7**), because they are in both the youth and adult networks, appear to hold key linkage roles between the child and adult service delivery systems. It is through these positions that the child and adult service delivery systems are connected. The remaining adult system has no direct linkage with the remaining youth system.

The block model for the exchange of information for purposes other than client planning was virtually identical to the first model, with the following exceptions; block 3 did not interact with block 2, the connection from block 1 to 2 was lost, and the connection from block 7 to 6 was lost. The block model for exchange of referrals (See Figure 4) is virtually identical to the first model, except that, again, the connection from block 1 to 2 was lost, and a connection from

block 4 to 6 was added, indicating a bit more interconnectedness in the adult system around referrals. In all models, block 8 is an isolated block, with the organizations contained in it unlikely to interact with any other group but those in block 7. It is important to note that block 8 contains the largest number of adult MH organizations in the network.

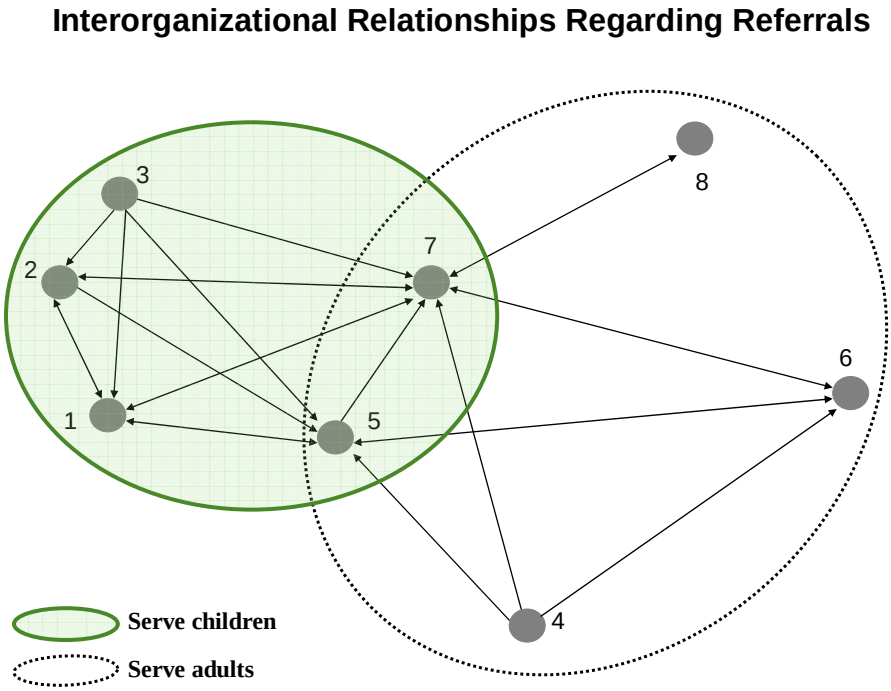

Figure 4. Critical Linkage Points Between Child and Adult Systems in Exchange of Referrals.

Ratings of Organizations and the System

Organizations in good shape, system in bad shape. Respondents reported a consistent perception that their own agency functioned well with regard to services for transition aged youth, but that the system, as a whole did not (see Table 3). For every characteristic that was rated for both the system and the individual's program, the average rating of the system was worse. Largely, the system was uniformly rated poorly, with little variation in average scores, (range=.83, 2.95-3.78), whereas organizations were rated relatively better, but with more variability (range=1.06, 1.84-2.90). Even the best average system rating (mean=2.95) was poorer than the worst average program rating (mean=2.90). Respondents rated their organizations and the system most dissimilarly for three items that reflect bureaucratic complications: avoiding wait lists or long delays, minimizing red tape, and providing timely access to clinical records. Respondents rated their organizations and the system most similarly on involving people of different backgrounds in community-wide planning, followed by having mechanisms for input from youth with SMH conditions into program policies, and fostering a big picture understanding of the service system. The first and third of these items wouldn't be expected to

be high priorities for individual organizations, and indeed the ratings were most similar with the system because respondents rated themselves relatively poorly on these items.

System Ratings. The system received the best ratings for emphasizing the strengths of youth with SMH conditions, ensuring developmentally appropriate services, and making youth with SMH conditions ages 14-25 feel welcome. The system received the poorest ratings for characteristics that only applied to the system: using a common triage form for clinical information across agencies (mean± S.D.=4.14±0.99), using a common intake form for basic information across agencies (mean± S.D.=4.09±1.00), and having a single transition plan focusing on goals of young adulthood (mean± S.D.=4.01±0.95).

Program Self-Ratings. Self-rating was highest for preventing "creaming" of higher functioning individuals, making youth with SMH conditions ages 14-25 feel welcome, and providing timely access to client records. Self-ratings were lowest for having mechanisms by which youth with SMH conditions could have input into program policies, providing outreach to youth with SMH conditions who are reticent to engage in services, and engaging individuals of different backgrounds in community-wide planning.

Transition-Related Items Rated Poor. As can be seen from Table 3, nine characteristics specifically tapped transition issues (labeled **T**). These items were selected from the standard procedure for network analysis established by Morrissey and colleagues (1998), with the addition of several items that were created to reflect the unique qualities of services for youth with SMH conditions during the transition to adulthood, using the standards described by Clark and colleagues (2000). Examining these items reveals that respondents felt that the system and their organizations struggle in these areas. One way to examine how well a group of issues is rated is to compare the ratings for those items to the "middle" score for all items (in other parlance – are they higher or lower than the average). Two-thirds of the transition items were rated worse than the median rating (which is the measure that is exactly in the middle of all ratings) for organizations (median=2.31) or the system (medians=3.40). Interestingly, making youth with SMH conditions at ages 14-25 feel welcome (item #13) was one of the highest-rated items for both organizations and the system.

Table 3: Respondents' Ratings of Their Own Organization and the System for Fiscal Year '02-'03.
N = 103; n for individual items varies, due to missing data.

How well do your/does the system's transition services for youth with SED perform according to the following criteria?	Organization		System	
	Mean	S.D.	Mean	S.D.
AVAILABILITY				
1. Avoiding excessive waiting lists or long delays in scheduling transition services…….	1.95	*1.08*	3.52	*0.84*
2. Keeping "red tape" to a minimum in enrolling youth with SED into transition services……	2.20	*.96*	3.59	*0.90*
3. Providing transportation to transition programs and services…….	2.52	*1.26*	3.76	*0.94*
4. Developing individualized transition services or programs for youth with SED……...	2.19	*1.05*	3.20	*0.86*
ACCESSIBILITY				
5. Placing transition services and supports in accessible locations for youth with SED……..	2.35	*1.00*	3.18	*0.96*
6. Providing transition services and supports at reasonable cost to youth with SED……..	2.01	*1.12*	3.21	*1.09*
7. Preventing "creaming" of higher functioning or less challenging youth, leaving lower functioning or more challenging youth at risk…….	1.84	*0.94*	3.10	*1.14*
8. **[T]**Ensuring that youth continue to access appropriate services when their change in age signifies a change in legal or eligibility status……	2.28	*1.18*	3.55	*0.95*
9. Providing "unconditional" services and supports despite authority-testing, experimenting or other concerning behavior…….	2.06	*1.08*	3.33	*1.04*
COORDINATION				
10. Fostering a "big picture" understanding of the service system that provides elements of transition supports for youth with SED in Clark County and the roles and responsibilities of the agencies that constitute that system……	2.78	*1.06*	3.58	*0.95*
11. Ensuring that other agencies have timely access to client records in ways that do not violate client confidentiality or the rights of clients……...	1.94	*0.89*	3.28	*0.88*
12. Ensuring meaningful discharge planning that links youth with appropriate services and supports and completed in sufficient time for those linkages to be successful……	2.35	*0.96*	3.64	*0.86*
QUALITY OF CARE				
13. **[T]** Making youth with SED ages 14-25 feel welcome and at ease in services settings……	1.89	*0.96*	3.04	*0.87*
14. **[T]** Giving priority to transition services for youth with SED……	2.48	*1.07*	3.41	*0.92*
15. Establishing grievance mechanisms for youth with SED ages 14-25…….	2.31	*1.14*	3.12	*1.04*
16. Attracting people of different backgrounds to participate in community-wide planning of transition services……	2.81	*1.19*	3.17	*0.97*
17. **[T]** Emphasizing the strengths of youth with SED during transition ages 14-25……	2.14	*0.98*	2.95	*0.98*
18. **[T]** Ensuring that transition services are developmentally appropriate for this age group……	2.15	*0.94*	3.04	*0.90*
19. **[T]** Developing formal mechanisms for input from youth with SED ages 14-25 into program development, policies, and practices……	2.90	*1.22*	3.53	*0.91*
20. **[T]** Having individual clients aged 14-25 lead his/her own transition planning process……	2.52	*0.97*	3.40	*0.87*
21. **[T]** Developing transition supports and services that are appealing to youth with SED aged 14-25…..……	2.64	*0.99*	3.46	*0.80*
22. **[T]** Offer transition supports and services that address the needs of youth across the complete array of life domains (i.e. housing, vocation, education, MH or SA treatment, social skills etc.)… ……	2.57	*1.18*	3.73	*0.76*
23. **[T]** Providing outreach to youth with SED aged 14-25 who may be reticent to engage in services……	2.86	*1.15*	3.78	*0.76*

DISCUSSION

These findings describe a network of services that youth with SMH conditions could potentially access during the critical period of life when they transition from adolescence to adulthood, in a locale that is typical of many across the country. Overall, there were slightly over 100 organizations that provided services that these young people might access, and the array of services available was quite broad. Efforts to bring these services together in a systematic fashion for the purpose of supporting youth throughout the transition stage will likely benefit from the number and array of services already available.

However, these findings demonstrate some of the complexity encountered in trying to discern the service system challenges, and then improve on them, for this age group. While there is a comprehensive array of services offered generally to those between 14 and 25 years old, this preliminary analysis highlights that only a small proportion of agencies offer *continuity* of services across the age thresholds of 18 or 21, within the service. In addition, within the county-wide service system, the youth and adult systems appear to be either minimally connected or completely disconnected.

Within-Service Discontinuity

What's wrong with almost all of the services typically serving only youth or adults? Whole systems, supported by laws and regulations, and concomitant funding streams, have been organized to treat and serve children and adolescents separately from adults. On the positive side, it allows for the services to develop expertise in working with the particular age group served, which promotes appropriate care. It also ensures that unrelated minors and adults are not housed together (e.g. group homes or inpatient units). Having services that end or begin at a standard age also produces "graduation points", which could be positive markers of progress and form the basis of important rituals that celebrate rites of passage (e.g. high school graduation). However, the absence of within-service continuity both reflects and promotes the system's lack of response to the unique needs of this stage of life, which spans both systems. The expertise that is developed for the age groups served, including service design, policies, and practices comes at the expense of expertise in other age groups, such as age groups that are younger or older than, or span the two systems. In separate youth and adult systems, the gray areas are tricky. One big gray area is the demarcation between adolescence and adulthood. These age categories are not dichotomous phenomenon; the two "stages" of life blend during the transition stage. There clearly is no magic birthday denoting a sudden shift into adult functioning. Psychosocial developmental changes accumulate gradually, and functional capacity is based in part on developmental progress. Thus, there is a significant period during which most individuals are developmentally truly neither adolescents (as

adolescence is currently defined) nor adults. Service systems should be organized to accommodate the gray area better.

At the level of individual youth, the within-service discontinuity imposes changes in treatment or services that are not based on need, but rather on the configuration of services. For example, a young woman, upon turning 18, will have to move from the adolescent to the adult inpatient psychiatric unit, which terminates the important therapeutic relationships she has formed there, and likely surrounds her with a much older group of individuals. For many youth with significant mental health conditions, forming trust with a therapist or other helper comes slowly and painfully. Causing, for all intents and purposes, the end of that relationship because there is no way to administratively allow it to continue, which is far from being in the best interest of that young person. The absence of opportunities to continue receiving a service between age 18 to 21 represents an inflexibility that is antithetical to the concept and practice of individualizing services.

Across System Chasm

Not only are specific services age-segregated, but the majority of youth services in Clark County have little exchange with the majority of adult services. On the whole, the transition services network relied on two small groups of organizations (members of which served both children and adults) to knit together what would otherwise be characterized as quite distinct and separate youth and adult service delivery systems. The absence of these relationships is problematic. Either few youth continue on in adult services, and thus no meeting for planning purposes is necessary, or youth continue in adult services but there is little coordination between the new and old services. The block model for referrals indicates that at least some of the lack of meetings mirrors the lack of making referrals. For those who do move from youth to adult services, it is hard to achieve any coordination of services without client planning efforts. Thus, the lack of relationship across most youth and adult organizations in this county likely makes care continuity, coordination, and integration difficult.

Not only did the network analysis indicate a disconnection in communication between the youth and adult systems, but it also suggests that there may be very different system attitudes and practices regarding interagency coordination and collaboration. While the organizations in the blocks of child service systems seemed to be well-connected, the connections within the adult system were weaker or non-existent. This suggests that the comprehensive array of services needed to support young adults (see Clark et al., 2000), (e.g. housing, work, education, parenting, substance abuse, mental health etc.) either are not accessed by most young adults once they are in the adult system or the adult system may not coordinate well with the other systems.

IMPLICATIONS

These findings underscore the importance of examining and addressing structural impediments (both within and between organizations) that stand in the way of providing continuous and appropriate services for adolescents with serious emotional disturbances throughout the transition to adulthood. Clearly one of the tasks for the grant-funded project in Clark County, and for any site that is working towards improving transition supports for this population, is to identify and correct mechanisms that prevent changes in this kind of system, and implement mechanisms that would motivate change. These findings suggest the following changes would be advantageous:

- **Remove Age Barriers**.
  - When continuity of services are therapeutically important, services should have the flexibility to continue beyond typical adult/child defining age limits, rather than beginning or ending based on age.
  - Adult services would benefit from the capacity to serve those who are underage, as part of a strategy to engage young people in services which they might continue in as they mature into adulthood.
- **Intersystem Coordination**.
  - Staff members of organizations should meet for client planning purposes when a young person exits the services of one organization and enters the services of another. Policies towards this end would be helpful.
  - Youth and adult organizations should interact more to exchange the expertise of each system, and to build knowledge about how to serve this age group that spans both systems.
  - Care coordinators who are transition specialists that bridge the adult and youth systems would also facilitate intersystem coordination when youths' service must shift from an age restricted youth agency to an age restricted adult agency.
- **Increased Relationships Within the Adult System**. Increased interactions among organizations within adult systems, to learn about and engage each other in addressing transition support needs, and exchanging expertise, would enhance the development of appropriate transition supports.
- **Increased Referrals from Youth to Adult Systems**. It is likely that the absence of referrals from youth to adult systems stem from a variety of causes (see above), but a measure of improved services will certainly include an increase in the number of these referrals.

After viewing preliminary analyses of these data, one step that the County DCS administrator took was to investigate what lead to such separate systems. In the process of that inquiry, it became clear that old licensing practices had helped support age separateness, and that current licensing was neutral to age issues. This resulted in a change of contract language between DCS and providers that encouraged age continuity in services.

Other sites looking to improve their capacity to serve the transitioning population are likely to find some of the catalysis and impediments to system change that state child and adult MH administrators across the country identified (Davis, 2001; in press). For most issues described as hindering system development, the opposite could be stated as supporting development. Issues generally fell into one of the following four categories: fundamental change factors, system fragmentation issues, beneficial practices, and professional and staffing issues. *Fundamental change factors* are factors that impact any system change, not just transition system change. *System fragmentation* issues particularly impact the transitioning population, because they span the youth and adult system and across the subsystems within those systems. *Beneficial practices*, are those practices that facilitate a service culture that would benefit the transitioning population. *Professional and staffing issues* contain some general problems, such as resistance to change, but also some specific issues that arise with providing good transition services. These issues are presented below.

Fundamental Change Factors

- *Leadership*. Numerous models of organizational change list leadership as one key component (Burke & Litwin, 1992). Leadership is needed to develop a vision, to raise the issue to a high priority, to keep the issue in the forefront among many competing agendas, to constantly look for opportunities to make changes, to inspire those who need to change their ways of working, to inspire creative approaches, and to seek out and procure the resources and funding necessary to make the change. If there is leadership, prioritization and funding will follow. Leadership was viewed as necessary at the state and federal levels, and as needing to be complemented by persistent and intense advocacy from consumers, family members, and from providers (all of whom can serve as 'squeaky wheels').

- *Insufficient Funding*. While it is clear that some changes can be implemented in the absence of new funds, states that had made significant progress in improving transition supports had done so with an influx of new funding.

- *Prioritization*. Fundamental change factors are interrelated, with several administrators pointing out that leadership keeps the issue prioritized and finds the funding. Furthermore, as an issue becomes a priority, funding is often attached to it.

System Fragmentation

- *Ownership.* When *both* child and adult mental health systems feel a sense of ownership for the transitioning population, action and funding are likely to follow. To date, child mental health systems have shouldered most of the advocacy for this population. If a joint sense of ownership does not materialize, access to developmentally appropriate services in the adult system is unlikely to develop.

- *Separateness begets separateness.* Fragmentation between child and adult mental health, and with other systems are common as evidenced by separate funding streams, separate administrations with separate regulations and policies, and separate practices. Lack of knowledge about each other's systems, lack of knowledge about each other's populations, and territoriality (chiefly in protecting funding or resources), reduce system capacity to provide good transition support services. Development of stronger ties between child and adult system members may begin a virtuous cycle (Putnam), which might take on a life of its own.

- *Population Policies.* Eligibility or target population policies generally differ between child and adult MH (Davis & Hunt, 2005), as they do across other service systems. This produces groups of young people who are unable to access adult services upon reaching that age threshold, and is likely a major underpinning of separate systems.

- *Different Developmental Perspectives.* The absence of a developmental perspective within adult services (Davis & Hunt, 2005) underlies the general reduced awareness of the need for transition supports in that system, and has led some to reject the notion that specialized services are even needed for the younger adult age group. In contrast, the child system is generally grounded in a developmental perspective.

Beneficial Practices

- *Youth voice*. Ensure that young people's opinions are heard and considered. This is essential to developing appropriate and appealing transition services. Many states have found that having a youth advisory group or enabling youth to participate in existing mental health advisory groups had a positive impact on service provision. The Clark County site included youth in the strategic planning process (Gordon, et al., 2003), and has an active youth advisory group that provides ongoing input into program activities and practices.

- *Progressive practices*. A long list of practices fell into this area, including practices that were recovery oriented, flexible, individualized, offered in normalizing environments, and focused on functioning. Most of the practices that were viewed as helpful are part of the system of care values for children (Stroul & Friedman, 1984), with the addition of some of the more current adult models or values, including recovery, psychosocial rehabilitation, and Assertive Community Treatment. In Clark County, the grant

program has drawn heavily on the Transition to Independence Process (TIP) system practice model (Clark, et al., 2000), developed specifically for youth and young adults with SMH conditions.

Professional/Staffing Issues

- *Lack of expertise*. One of the issues specific to the young adult population is the view that professional training reflects the same weakness as is evidenced in the system in general, i.e., individuals are trained *either* as child *or* adult MH professionals. This produces individuals who are not comfortable or trained to work with individuals whose developmental stage crosses this arbitrary child/adult distinction. Separate training can also foster some of the other issues implicit in the child/adult system fragmentation, including philosophical, cultural, and practice differences. In addition, training in transition practices for young people with SMH conditions is hard to find, because it is a relatively new field, and it is an additional expense.

- *Resistance to change*. Change is generally uncomfortable, and must be implemented in a firm but understanding approach. There may be particular resistance to working with this age group given that they can be resistant to any perceived authoritarianism, and that their experimentation and boundary pushing, which is typical of this age group, can be unsafe.

Future Research

It is always desirable to replicate findings to bolster their strength, or find exceptions. Thus, it is important to determine how generalizable the configuration of organizations in Clark County is to other locales. Specifically, is the interrelatedness within the youth system common and the limited connection between the youth and adult system common? It is important to know factors that lead to variability in this configuration. Finding locations where this configuration is different, particularly as it pertains to increased and decreased connections across the youth/adult systems, might reveal conditions that support improved transition supports. This presupposes a relationship between system configuration and the quality of transition supports, a relationship that has not yet been demonstrated in a systematic fashion.

Perhaps most important at this point is to track the changes that occur in Clark County as a result of the grant-funded efforts and determine which of those efforts lead to the greatest change, and to eventually be able to understand the relationship between those changes and the quality of transition supports.

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