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Community-based Approaches for Supporting Positive Development in Youth and Young Adults with Serious Mental Health Conditions

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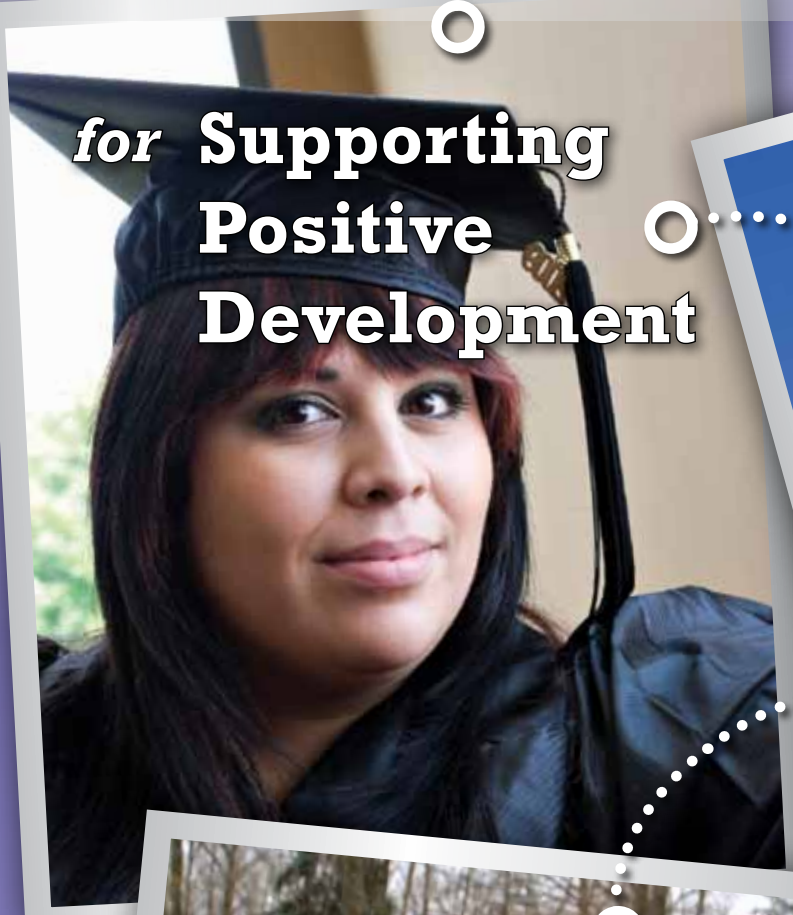

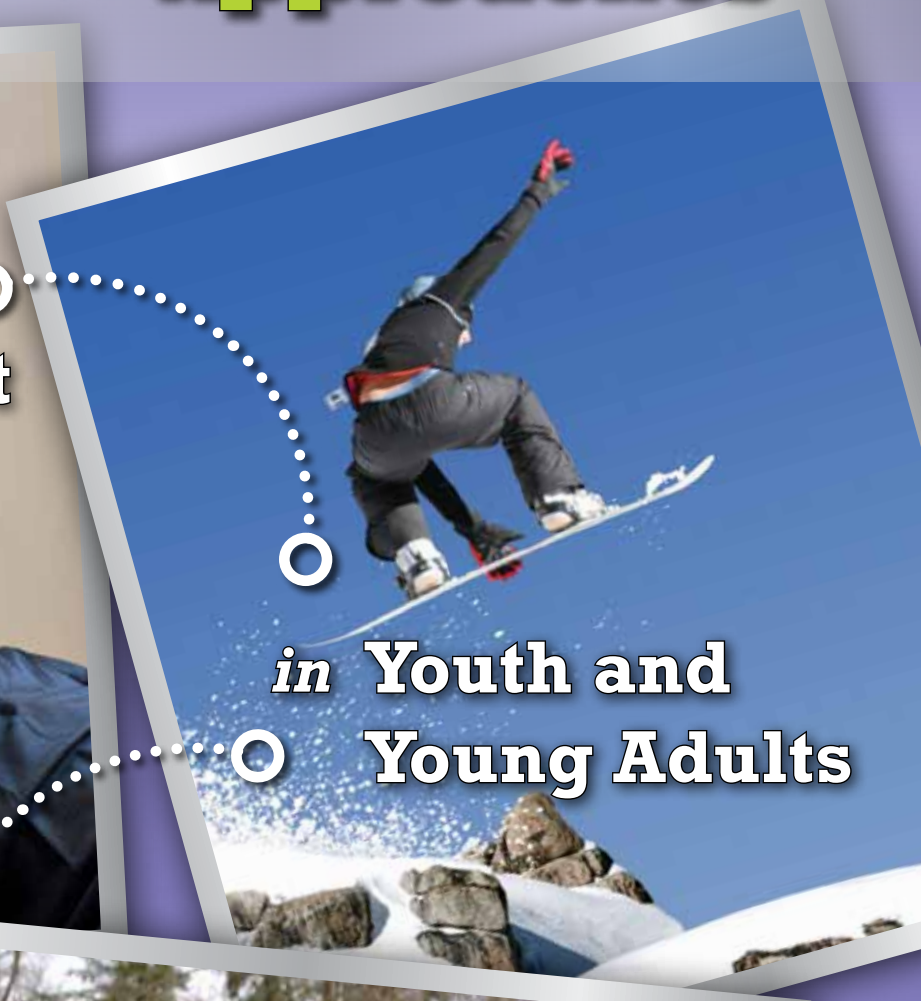

in Youth and Young Adults

with Serious Mental Health Conditions

by Janet S. Walker & L. Kris Gowen

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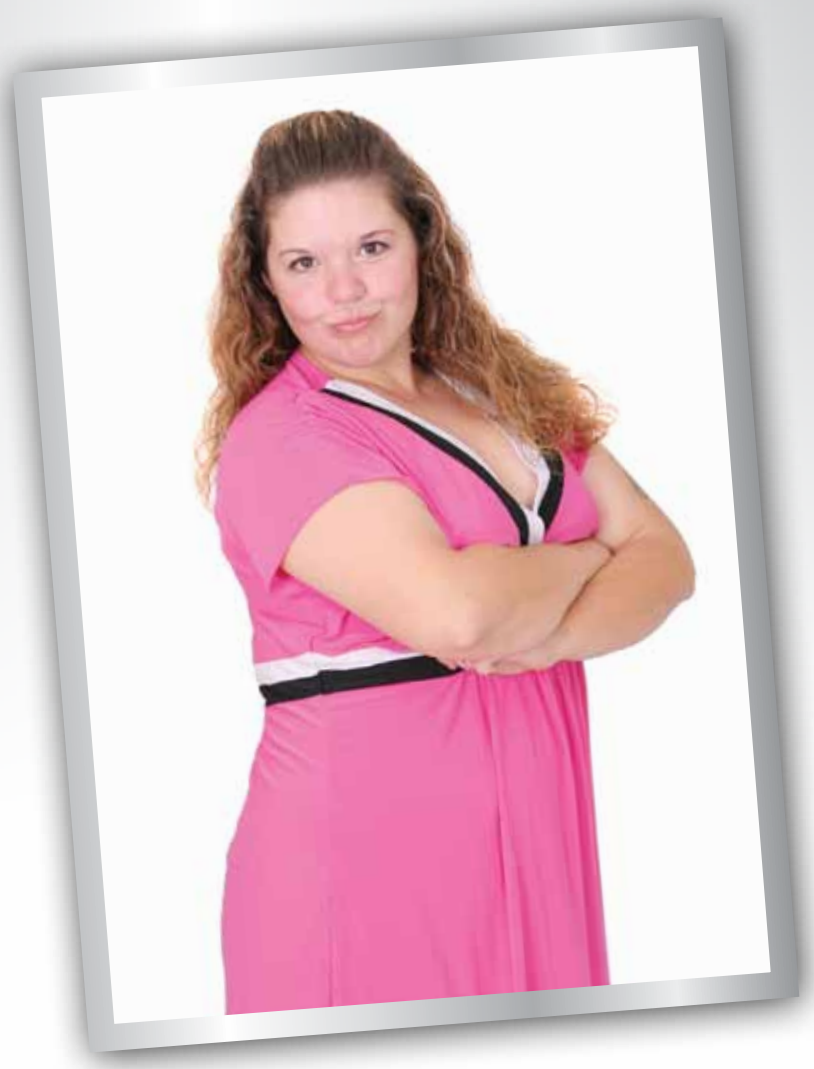

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The period of transition to adulthood is a time of life that typically brings many challenges, as young people are expected to move into roles and relationships that reflect increasing independence and responsibility. These challenges are particularly pronounced for young people who experience serious mental health conditions (SMHC) during transition. Compared to their peers, young people with SMHC tend to fare worse educationally and economically, and they are more likely to have legal troubles or become parents at a young age. What is more, many of the young people who experience SMHC are vulnerable and/or at risk in other ways. For example, rates of SMHC are elevated among young people who are homeless or who have had experience in the child welfare or juvenile justice systems.

In recent years, attention has been drawn to the fact that existing mental health and related services are not effectively meeting the needs of young people with SMHC. This is due in part to the lack of services that are attractive to, and developmentally appropriate for, older adolescents and young adults. Additionally, there are policy and funding barriers that often make it difficult for young people who want to receive services to access and/or continue in care.

Our goal in this chapter is to describe empirically-supported and promising community-based programs or approaches that are designed to promote positive development and to achieve better outcomes for young people with SMHC. We begin by providing more detail regarding the nature of the challenges that these young people face, as well as some of the challenges that systems and providers currently face in trying to serve the population. We then go on to describe recent theory and research on positive development, particularly as it applies to older adolescents and young or "emerging" adults. The next sections of the chapter describe a series of empirically-supported and promising programs, including programs specifically designed to serve highly vulnerable populations of transition-age young people, such as those who are homeless and those who are transitioning out of the juvenile justice system. Throughout these sections, we describe how these various approaches are connected to central themes in the research and theory on positive development during late adolescence and early adulthood. Finally, we review some questions and implications raised by considering programs and interventions from a positive development perspective.

Many challenges. Among transition-age young people aged 14-30 in the United States, it is likely that at least 1 in 15 has a SMHC, and the rate may be much higher. The Government Accountability Office (GAO) recently estimated

that at least 2.4 million young adults aged 18-26—or 6.5% of the total population in that age range—had a serious mental illness (2008). However, the report notes that this is likely an underestimate, since certain subpopulations with high rates of mental illness—such as homeless or incarcerated young people—were not included in the figure. For youth aged 14-18, estimates of the percent with serious emotional or behavioral disorders typically range from 5-10%, though some estimates put the rate even higher (Burns, 2002; Friedman, Katz-Leavy, Manderscheid, & Sondheimer, 1998; Mark & Buck, 2006; National Institute of Mental Health, 2006).

Though exact figures are hard to come by, there is no doubt that many of these young people face multiple challenges. For example, according to the 2008 GAO report, among young adults with serious mental illness, 89% had two or more diagnoses, 56% had four or more, and 32% had a co-occurring diagnosis of substance abuse or dependence. For the younger cohort, studies have estimated that upwards of 40% have had a substance use disorder at some point, and that about 20% have a current co-occurring disorder (Aarons, Brown, Hough, Garland, & Wood, 2001; Manteuffel, Stephens, Sondheimer, & Fisher, 2008; Turner, Muck, Muck, Stephens, & Sukumar, 2004). Rates of SMHC are particularly high among youth from low-income households and those who receive public services in any sector, and many of these young people receive services from multiple systems (Garland et al., 2001; Manteuffel, Stephens, Sondheimer, & Fisher, 2008; Mark & Buck, 2006).

Youth and young adults in vulnerable populations are particularly likely to have a significant mental health condition, including 45-65% of homeless youth and young adults (Unger & Kipkke, 1997; Vander Stoep et al., 2000); at least 50% of foster youth and young adult former foster youth (Courtney & Dworsky, 2005; Garland et al., 2001); and at least 50% of youth and upwards of 60% of young adults involved in juvenile justice or corrections, respectively (James & Glaze, 2006; Shufelt & Cocozza, 2006). Significant proportions of these youth have multiple challenges. For example, one study of young adults who had been foster youth found that 20% had symptoms of three or more mental disorders (Courtney & Dworsky, 2005), while other studies have found that, among youth in juvenile justice who have mental health disorders, half or more also have co-occurring substance use disorders (Garland et al., 2001; Skowyra & Cocozza, 2006; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002).

Finally, the transition years are the time of greatest vulnerability for young people with SMHC, when they are likely to have their highest levels of risk and challenge, including risk of arrest and criminal involvement and peaking substance use (Davis, Banks, Fisher, & Grudzinskas, 2004; Davis & Vander Stoep, 1997; Garland et al., 2001; Vander Stoep et al., 2000). Furthermore, the typical age of onset for psychotic disorders

comes during these transition years, and overall, adult mental health disorders have their highest rates of incidence in early adulthood (Pottick, Bilder, Stoep, Warner, & Alvarez, 2008).

There is ample and growing evidence of the many ways that young people with SMHC fare worse than their peers in terms of educational attainment, career success, and community integration (Davis, Banks, Fisher, & Grudzinskas, 2004; Davis & Vander Stoep, 1997; Vander Stoep et al., 2000). These young people have high school completion rates even lower than other students with disabilities (56% vs. 72%), and only 36% are employed two years after high school. Approximately one-third (34%) attend postsecondary programs, compared to 60% of youth overall; this is in spite of the fact that 70-80% aspire to participate in education after high school (Wagner, et. al, 2007). Youth with mental health conditions are also more likely than their peers to become young parents. More than half have been arrested at least once, and 43% have been on probation or parole (NLTS-2, 2006-2008).

There is also growing evidence that existing services and systems do not serve these young people adequately. There is a steady decrease in service utilization across the transition-age groups (Pottick, Bilder, Stoep, Warner, & Alvarez, 2008), and among adults, those in the youngest cohort are least likely to get treatment (Kessler et al., 2005). Discontinuities between child- and adult-serving systems are significant contributors to this drop-off in utilization, which is most pronounced precisely when young people lose eligibility for child systems at age 18-22, depending on state of residence (Davis & Koroloff, 2007; Pottick, Bilder, Stoep, Warner, & Alvarez, 2008). As they cross the divide between child and adult services, young people face different and usually more restrictive requirements for adult programs. Even where young people are eligible, transition to adult services often means the end of established relationships with providers from children's systems (Davis & Koroloff, 2007; U.S. Government Accountability Office, 2008; Vander Stoep et al., 2000). Separate child and adult finance streams—and competition between child and adult systems for the same funds—discourage shared planning and restrict options for creating specialized programs and strategies to serve young people across the transition-age (Clark, Koroloff, Geller, & Sondheimer, 2008; Davis & Sondheimer, 2005; Pottick, Bilder, Stoep, Warner, & Alvarez, 2008).

The unattractiveness of typical adult services to the younger population likely also contributes to the decrease in service utilization. For example, the GAO report quoted a state official who said that more than half of the eligible young adults who had received mental health services as children chose not to receive them as adults, and SAMHSA has reported that young adults have the lowest help-seeking behavior of any age group (U.S. Department of Human Services Substance Abuse and Mental Health Services Administration, 2007). Young people do not necessarily feel comfortable in settings dominated by older adults, and this discomfort may be exacerbated by changes in treatment approach between child and adult services. Additionally, young people often experience typical adult services as not well adapted to their needs or culture, and providers report having difficulty finding adequate age-appropriate mental health services for their clients (Davis, 2007; Jivanjee, Kruzich, & Gordon, 2008; Sieler, Orso, & Unruh, in press; U.S. Government Accountability Office, 2008). Other factors may inhibit young people from even approaching adult services. The stigmatization and self-stigmatization associated with seeking treatment is particularly pronounced among young people of transition-

age, and acts as a significant deterrent to help-seeking (Biddle, Donovan, Sharp, & Gunnell, 2007; Vogel, Wade, & Haake, 2006). Young people who have "graduated" from child services often have had unpleasant experiences that lead them to avoid services once they are able to make their own decisions. Adolescents often find mental health and related services stigmatizing, blaming and coercive: Planning is often undertaken without input from the young person, and youth often do not agree with the goals of treatment (Amodeo & Collins, 2007; Center for Mental Health Services, 2006; Federation of Families for Children's Mental Health & Keys for Networking Inc., 2001; Garland, Lewczyk-Boxmeyer, Gabayan, & Hawley, 2004). Finally, there are few programs and intervention approaches that specifically respond to the developmental needs and challenges of the transition-age population as outlined above. Adult providers are not usually trained in adolescent and emerging adult development, and so they are unprepared to work with young adults with SMHC, who tend to be less developmentally mature than their age alone would suggest (Pottick, Bilder, Stoep, Warner, & Alvarez, 2008; U.S. Government Accountability Office, 2008). More generally, interventions designed or adapted for this age range are relatively unstudied, and the evidence base is underdeveloped (Clark, Koroloff, Geller, & Sondheimer, 2008; Kurtines et al., 2008). It thus remains the unfortunate truth that the combination of high risk and inadequate response jeopardizes the life chances of this highly vulnerable segment of the population.

Given the evidence outlined above, it is clear that more research is needed in order to identify, develop, and evaluate interventions that are *developmentally appropriate, attractive to young people, and effective in achieving positive outcomes*. In the next few pages, we use a review of research, theory and related literature to develop a description of key features of interventions that are consistent with all of these criteria.

Development during transition. Though the legal age of adulthood in Western societies is typically 18, the transition to full biological, cognitive, and social maturity is not typically achieved until at least the mid-20s. During the transition period, there is significant brain development that is qualitatively different from the development in childhood and early adolescence. The most notable change is the maturation of the frontal lobe, the seat of "higher" functions such as self-control, emotional regulation, organization and planning (Giedd, Blumenthal, & Jeffries, 1999; Sowell, 2001). Alongside brain development comes cognitive development, particularly in capacities to think abstractly, make reasoned judgments, process information efficiently, and self-reflect (Zarrett & Eccles, 2006). These are precisely the capacities that young people need to successfully navigate the challenges of transition.

This transition period brings a unique set of challenges as young people move away from subordinate and dependent relationships with parents and other adults, toward relationships that reflect increasing maturity and responsibility in the family and community. The earlier part of this period, ages 14 to 18 or so, is often described as "youth," while the later part, ages from the late teens to the mid-or even late 20's, is increasingly known as "emerging adulthood" (Arnett, 2004; Obradovic, Burt, & Masten, 2006). While emerging adults in Western cultures clearly differ from youth-—particularly in terms of their level of independence, freedom and mobility—the fundamental developmental tasks are similar. These developmental tasks of transition have been enumerated and listed in a variety of ways over the years (Masten & Coatsworth, 1998), as have the lists of assets or competencies that support accomplishing developmental tasks (Eccles

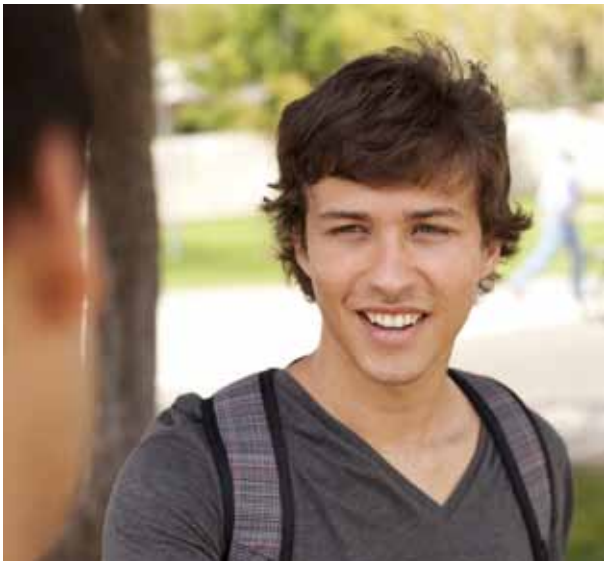
& Gootman, 2002; Hawkins, Letcher, Sanson, Smart, & Toumbourou, 2009; Lerner & Benson, 2003; Schwartz, Cote, & Arnett, 2009). Across these various lists, however, there is a fairly high degree of recent consensus about several interrelated types of assets or capacities that are crucial for successful development during this time period (Catalano, Berglund, Ryan, Lonczak, & Hawkins, 2004; Guerra & Bradshaw, 2008; Larson, 2000; Riediger, Freund, & Baltes, 2005; Schwartz, Cote, & Arnett, 2009; Zarrett & Eccles, 2006). This level of agreement across the lists is explained by the fact that the authors rely on scientifically-derived evidence as a basis for enumerating assets and capacities. These four key types of developmental assets are:

1. developing a positive identity and a sense of purpose, including self-determination, efficacy and empowerment;
2. acquiring the capacity, motivation, and self-control to make decisions and carry out plans consistent with personally meaningful goals;
3. acquiring skills that provide a sense of mastery, aid in leveraging resources, and contribute to the ability to take on adult roles; and
4. developing supportive relationships and prosocial connectedness.

Positive development, resilience and recovery. While a focus on developmental tasks of different life stages is longstanding, a relatively recent trend in the field has been the coalescing of a "positive development" (PD) approach that focuses on actively promoting thriving and well-being across the life span (Bronstein, Davidson, Keyes, & Moore, 2003; Seligman & Csikszentmihalyi, 2000). A major thrust of PD theory and research has been to identify characteristics of thriving and well-being that are invariant across widely diverse world cultures. The PD approach has been characterized as nothing less than a paradigm shift, because of its explicit turn away from a focus on correcting deficits and preventing negative outcomes and toward a focus on strengths and enhancing healthy development (Barton, Watkins, & Jarjoura, 1997; Bronstein, Davidson, Keyes, & Moore, 2003; Kurtines et al., 2008). Positive development has been most

clearly described as it applies to youth. This approach, called positive youth development (PYD), has a growing theory and research base; however, recent years have seen the beginnings of an approach to the study of positive development in "emerging adulthood" as well. (Arnett, 2004; Obradovic, Burt, & Masten, 2006; Schwartz, Cote, & Arnett, 2009). These PD approaches for youth in transition focus on how to prepare young people for adulthood by actively promoting the four types of assets and capacities described above.

A key element of the PD approach is the idea that development is heavily influenced by envi-



ronment, and that positive development is promoted through the interplay between individual capacities and supportive relationships, settings and institutions. There is emerging consensus and research support regarding the key features of settings that support development of the capacities needed during the transition period (Catalano, Berglund, Ryan, Lonczak, & Hawkins, 2004; Guerra & Bradshaw, 2008; Larson, 2000). Such environments are psychologically and physically safe; they provide connection to prosocial adults and peers; they allow for opportunities to build skills; and they provide a balance between structure and flexibility, so that while there are clear expectations, there are also opportunities for young people to set goals and make decisions and plans about how to reach those goals. In short, what facilitates successful development during transition is when young people and their environments interact in ways that build the capacities, motivation, and skills that young people need in order to become constructive agents of their own development.

Young people with SMHC may well lag behind their peers in terms of their developmental "age." A key feature of emotional or behavioral disorders is difficulty in developing self-control and self-regulation. Furthermore, many of these young people have personal histories characterized by inadequate exposure to settings that support positive development. As noted above, child and adolescent services and systems—including mental health, special education, child welfare and juvenile justice—are frequently experienced as deficit-based, paternalistic, compliance-driven and/or coercive, and offer little opportunity for young people to set goals or make decisions. Furthermore, many of these young people have been traumatized, abused and/or exploited. This implies not only that they have been significantly connected to *anti*social adults and/or peers, but also that their emotional and cognitive development has been put at risk. Traumatic experience, and the resulting stress, has a cumulative, detrimental impact on the developing brain (Shonkoff & Phillips, 2000), particularly in the areas of executive function and emotional and self-regulation that are so essential for successful development during the transition years.

Interventions rooted in positive development thus appear to be an ideal way to approach the challenges experienced by young people with SMHC. Indeed, PD is becoming increasingly popular—and research supported—in youth development programs and prevention efforts aimed at young people from various cultural backgrounds and with different risk profiles. Among professionals who focus on youth and young adults, there is a growing awareness of the literature on assets and PYD, and of the large body of resilience research. These studies show that, across cultural subpopulations, young people with higher levels of assets are far more likely to thrive—both as adolescents and as adults—despite multiple challenges and significant adversity (e.g., Condly, 2006; Iwaniec, Larkin, & Higgins, 2006).

In recent years, there has been an emergence

of more focused efforts to use PD approaches in targeted interventions with young people who experience serious disabilities or who have "problem behavior" (e.g., Amodeo & Collins, 2007; Bradshaw, Brown & Hamilton, 2008; Kurtines et al., 2008). Yet incorporation of PD elements into interventions with struggling youth of transition-age—including those with SMHC—is still relatively rare and under-researched. On the other hand, for this age group generally the intervention literature is very underdeveloped (Clark & Unruh, 2010; Kurtines et al., 2008). The only evidence-supported practice specifically targeted at transition-age young people with SMHC is the Transition to Independence (TIP) model, which is entirely consistent with a PYD approach and has an explicit focus on enhancing protective factors (assets), youth-driven planning, and positive, supportive relationships (Haber, Karpur, Deschenes, & Clark, 2009). More generally, the appropriateness of a PD approach for this population—particularly the emphasis on strengths and assets combined with individualized, youth-driven planning—is increasingly recognized in consensus statements (e.g., Altschuler, Stangler, Berkley, & Burton, 2009; Gagnon & Richards, 2008; e.g., Institute of Medicine, 2006), definitions of promising practices (Clark & Unruh, 2010; Davis, 2007) and federal initiatives aimed at this population (Frakera & Rangarajan, 2009; U.S. Department of Health and Human Services, 2007, 2009).

Crucially, a focus on positive development resonates with what youth and young adults with SMHC want for themselves: to take charge of their own lives; to develop positive connections to others; to have a sense of optimism, empowerment and efficacy; and to have the opportunity to pursue personally meaningful goals (Anthony, 1993; Jivanjee, Kruzich, & Gordon, 2008; Sieler, Orso, & Unruh, 2010). Indeed, positive development elements are at the very core of definitions of recovery in mental health, with their emphasis on strengths, hope, empowerment, well-being, community integration, and support from positive peers and family (Gagne, White, & Anthony, 2007; Ralph & Corrigan, 2005). It is not hard to see recovery as essentially a positive development approach for people with SMHC, and thus it is perhaps not surprising that the types of programs, environments and settings that are seen as helpful in supporting recovery are quite similar to those that support positive development more generally (O'Connell, Tondora, Croog, Evans, & Davidson, 2005; Ridgeway & Press, 2004).

In sum, research, theory and expert consensus suggest that there is a need to develop and test programs and interventions that are rooted in a positive development approach. In addition, these programs should be attractive to young people, and designed to promote positive outcomes in areas that include education, career, social support, mental health and quality of life. Such programs and interventions would act to build assets in each of the four key areas.

1. **Positive identity, sense of purpose, efficacy, empowerment, self-determination.** The PD approach outlined above suggests that effective programs to support transition-aged youth with SMHC would include an individualized approach that focuses on supporting young people to identify and move toward personally meaningful goals. This begins with envisioning a positive future identity (Who do I want to become?). Pursuing goals promotes a sense of purpose, and making progress towards those goals contributes to building feelings of efficacy, empowerment and self-determination. These three are related concepts that reference the individual's ability to act as the primary causal agent in pursuing personally meaningful goals (Powers et al., 1996; Wehmeyer, 1996),

though empowerment also includes the additional dimension of acting as an agent for change in the broader community (Walker, Thorne, Powers, & Gaonkar, 2010). Self-determination has been identified as one of the key predictors of post-secondary success for youth with disabilities. Randomized controlled studies, as well as other research (see the review in Test, Fowler, & Brewer, 2005) have demonstrated the benefit of self-determination enhancing interventions for these youth and young adults.

2. **Capacity, motivation, self-control and confidence to make decisions and carry out plans**. In order to experience success in reaching personally meaningful goals, young people need to develop persistence and self control, as well as specific skills related to decision-making and follow-through. Having these capacities and skills increases the likelihood that they will gain confidence in their decision making and planning capabilities, and that they will persevere, even in the face of inevitable setbacks.
3. **Skills for adult roles and leveraging resources**. In order to reach their goals and to assume adult roles, young people with SMHC need opportunities to learn a wide range of specific skills. For example, many young people need to develop skills related to finding and maintaining housing and employment. Other needed skills can range from seeking and evaluating information, to enlisting help from others, to presenting ideas to a group, to requesting accommodations and supports.
4. **Supportive relationships and prosocial connectedness.** A PD perspective further suggests that young people with SMHC will benefit from learning specific strategies for increasing and maintaining interpersonal support from positive peers, family, providers and people in the community. Young people can learn specific steps and skills that can help them increase the quality and the extent of their interpersonal networks, as well as the amount of emotional, instrumental and informational support available to them.

Using a PD perspective suggests that the development of these four types of assets are important recovery-oriented outcomes in and of themselves, as well as mediators of longer-term outcomes related to education, employment, mental health and general quality of life. Indeed, a review of the available research on community-based programs and interventions for transition-aged young people with SMHC reveals a common focus on asset building as described above. Also consistent with the PD perspective is that many of the programs and interventions include a focus on changing the settings around the youth so that the settings are more likely to encourage young people to develop or express strengths and assets. Below, we describe a series of empirically-supported and promising approaches, and highlight the ways in which these approaches reflect a PD perspective.

Promising programs. To date, there are very few programs designed specifically to support the lives of transition-aged youth with SMHC, and even fewer programs that have been evaluated for effectiveness. However, there are some programs for which there is enough empirical evidence that they can be considered as either "supported" or "promising" practices for improving the outcomes in this population. These programs (listed alphabetically), along with their outcomes, are briefly described in this section.[1]

1. Please note that community- rather than school-based programs are highlighted where possible.

Achieve My Plan! Achieve my Plan! (AMP) is an intervention designed for use in any context in which a young person with a mental health condition is involved in a team planning process. Human service and educational agencies and systems often convene teams to work collaboratively on plans for serving young people—typically those who have high levels of need and/or who are involved in multiple systems—as they approach the transition into adulthood. These kinds of planning teams include IEP teams, wraparound teams, youth/family decision teams, and so on. AMP aims to increase the extent to which youth are involved and engaged in planning, the extent to which the plans that are produced reflect participating youths' own goals and perspectives, and the extent to which the young people are actively involved in carrying out action steps for their plans. In turn, this greater engagement with the planning process is expected to impact therapeutic alliance, treatment engagement, and mental health outcomes. One of the unique features of AMP is that the intervention was developed in collaboration with an advisory board that included youth, caregivers and service providers.

An AMP coach works one-on-one with a young person to prepare him/her to participate actively and constructively in the team meetings. The coaching is more intensive prior to the first meeting, and becomes less intensive over time. Other team members, particularly the person who is in charge of facilitating the team meeting, also receive AMP training and ongoing coaching, so that they can become skilled in creating a team atmosphere that is conducive to and supportive of meaningful youth participation.

AMP was pilot tested with youth in two wraparound programs and youth in a high school/day treatment program (Walker, Geenen, Thorne & Powers, 2009). Despite the relatively small sample size, the data show positive results. For example, analyses of pre- post- data from video recordings of team meetings show improvements in the quality of youth participation, the supportiveness of adults toward youth, and overall team task focus. Pre- post- data from assessments with youth showed significant improvement in perceptions of participation in planning. As assessed by the Youth Empowerment Scale (Walker, et al., 2010), youth also indicated they were more confident both in managing their own mental health and in working with service providers to optimize their services and supports. Overall empowerment also increased. A randomized controlled trial of AMP is currently underway to test AMP's effect on more distal outcomes, including therapeutic alliance, quality of life, recovery and mental health.

The Community Reinforcement Approach at Homeless Youth Drop-In Centers. Slesnick and colleagues (2007) provided counseling to homeless youth in a drop-in center, rather than a counseling or mental health clinic. Drop-in centers traditionally offer homeless youth access to food, clothing, recreation, health care, and

other services. The Community Reinforcement Approach (CRA), a comprehensive behavioral program that utilizes social, recreational, familial, and vocational resources to support the young adult (Meyers & Smith 1995), was used to treat the young adults over the course of six months. CRA programs also stress the importance of the client taking a leadership role in his or her treatment.

Findings indicate that youth participating in CRA (N=172) had lower rates of substance use and internalizing problems, compared to youth receiving treatment as usual. They also had increased social stability and housing at the twelve-month follow-up when compared to baseline. This study provided initial evidence that mental health services and substance use treatment can be integrated successfully and effectively into drop-in services for homeless youth.

Early Assessment and Support Alliance (EASA). EASA is a program designed to help youth and young adults maintain normal life trajectories when psychotic symptoms first occur. EASA focuses its interventions on mobilizing family and community resources in order to assist young people in achieving their goals. To accomplish this, services are strengths-focused and oriented toward goals the young people find relevant and personally meaningful, such as getting through school, resolving conflicts, paying off debts, or regaining proficiency in areas where they once excelled but in which they are now struggling. In addition, a supported employment specialist meets with each EASA participant, and occupational therapists are also on staff to offer support as needed.

An evaluation of EASA has shown dramatic decreases in hospitalization rates for its participants; for the one-year period following EASA's inception at the beginning of 2008, EASA served 340 young people and their families. Of those young people served, 42% needed hospitalization in the three months prior to intake; after participating in EASA, only 7% percent required hospitalization in the following three months and 3% were hospitalized after two years (Sale, 2008). Evaluation of EASA also indicates that the longer youth have been involved in EASA, the more likely they are to be either working or in school (Sale, & Melton, 2010).

My Life. The My Life intervention uses a self-determination enhancement approach to improve the outcomes of transition-aged youth in both special education and foster care. The primary focus of this model is to facilitate youths' self determination through recognizing their accomplishments; encouraging them to learn from mentors, and promoting their acquisition of self-regulation strategies (Geenen, Powers, Hogansen, & Pittman, 2007). My Life provides youth with about 50 hours of coaching in self-determination skills for achieving their personal transition goals. They also participate in three or four mentoring workshops with young adults who have foster care experience and who are working or in college. Additionally, each youth develops an individualized transition plan that he or she presents in an inter-agency transition planning meeting. The goals of My Life are to increase quality of life, engagement in transition planning, educational attainment, employment, and stability of living situation among its participants.

In a pilot study of My Life, 60 youth (age 17) who were both receiving special education services and under the guardianship of child welfare were recruited. Of those participants, 29 completed the program, and 31 were randomized into a control group, where they received usual care. After a 12-month follow up, young people participating in the intervention had better educational and employment outcomes than those in the control group. My Life participants

also reported significantly greater levels of competence, empowerment, and social belonging in a quality of life measure.

Rehabilitation, Empowerment, Natural Supports, Education, and Work (RENEW). RENEW is designed to support youth with emotional or behavioral disorders to achieve the following outcomes: high-school completion, employment, postsecondary education and training, and community inclusion. Five principles guide its practice: (1) promote self-determination; (2) increase community inclusion; (3) provide unconditional care; (4) provide strengths-based services, and; (5) provide flexible resources. RENEW employs a "toolbox" approach to working with young people, providing access to an array of services, such as personal futures planning, alternative education options, and mentoring. Young people receive specific services that fit with their particular goals and needs.

In its demonstration project, RENEW served 72 young people, ages 16 through 21, each of whom had an EBD diagnosed by a mental health professional. In comparing pre- and post-intervention data, young people showed improvement in education and employment outcomes. At the beginning of RENEW, 7% of participants had completed high school; after three years, 63% had completed high school or its equivalent (compared to a national rate of 56%), and another 17% were on track to finish. Of the 42 youth who completed high school, 18 (43%) enrolled in postsecondary education; overall, postsecondary education enrollment in youth with EBD is 34% (Wagner, et. al, 2007). Regarding employment, 71 of the 72 RENEW participants obtained jobs in competitive settings with "typical" wages (Malloy, Drake, Abate, & Cormier, 2010).

Strategies Teaching Adolescent Young Offenders to Use Transition Skills (Project STAY OUT). STAY OUT is an Oregon-based

program designed to support incarcerated youth with EBD by offering system-wide service delivery in order to decrease recidivism and increase rates of employment and education outcomes for these youth. STAY OUT begins while the youth still resides in the correctional facility and continues after his or her release. Services are managed by a transition specialist who coordinates with different agency staff such as vocational rehabilitation counselors, parole officers, mental health professionals, and education staff. Four characteristics form the foundation for service delivery: (1) Facilitated, self-directed planning and decision making for youth; (2) System collaboration to provide access to community resources; (3) Dedication to increasing positive family and peer support, and; (4) Continued development of youths' employment, educational, and independent living skills. Developing a positive relationship between the transition specialist and the youth is critical to program success (Unruh, Waintrup, & Canter, 2010).

An evaluation of STAY OUT was conducted based on the outcomes of the 508 youth served between 1999 and 2007. Six-month post-release, 63% of STAY OUT participants were engaged (defined as being either employed and/or in school and not recidivated), as compared to only 35% in the general juvenile justice population.

The Transition to Independence Process (TIP) Model. The TIP model involves youth and young adults (ages 14-29), their families, and other friends or allies in a process that facilitates the young people's movement toward greater self-sufficiency and successful achievement of their goals. Young people are encouraged to explore their interests and futures as related to a series of transition domains: employment and career, education, living situation, personal effectiveness/wellbeing, and community-life functioning. The seven guidelines that operationalize the TIP model are (1) engage young people through relationship development, person-centered planning, and a focus on their future; (2) tailor services and supports to meet the needs of young participants by building on their strengths; (3) prioritize personal choice and social responsibility in young people; (4) ensure a safety net of support by involving a young person's loved ones and wider community; (5) enhance a young person's competencies so that they can achieve greater self sufficiency; (6) maintain an outcome focus; and (7) involve young people and their social supports in the TIP system at the practice, program, and community levels (Clark, 2004).

The TIP model was evaluated in a year-long school-based program (Karpur, Clark, Caproni, & Sterner, 2005). Those who graduated from the program were less likely to be incarcerated or on probation, and more likely to be enrolled in post-secondary education than a matched sample of youth with EBD who did not participate in the program (3% vs. 12%, and 9% vs. 28%, respectively). In a multi-state project in which the TIP model was implemented across sites, participants showed significant increases in employment and educational advancement, and significant decreases in mental health interference and criminal justice involvement (Haber, Karpur, Deschenes, & Clark, 2008).

Connecticut's Young Adult Services Program (YAS). In 1997, Connecticut's Department of Mental Health and Addiction Services established the YAS Program, designed to help those over 18 with moderate to severe symptoms of mental illness transition smoothly from children's mental health care and into adult services. YAS includes clinical, residential, case management, vocational, and social rehabilitation supports that are guided by three major principles: (1) services must be comprehensive and integrated, because focusing on one issue without supporting other aspects of a young adult's life is ineffective; (2) facilitating young adults' transitions from highly supervised and structured programs into community settings in which they experience higher degrees of autonomy is essential, and; (3) participants should not be removed from YAS, as it is important to provide young adults with opportunities to form secure attachments given the traumas many of them have previously experienced. In addition, services to young adults incorporate both strengths-focused treatment planning (SFTP—defined as assessing a client's social and cognitive strengths, and incorporating them into the treatment plan) and community-focused treatment planning (CFTP—defined as setting a goal of increasing client residential and community supports).

In an evaluation of YAS, 60 clients (average age of 20 years) who had aged out of institutional settings such as foster care or residential treatment were assessed. Most (95%) had known histories of severe and sustained abuse, 95% had been in foster and/or residential care, half had diagnosed learning disabilities, and many had been incarcerated. Three treatment variables were related to improved outcomes. Longer tenure in YAS was significantly associated with a higher quality of life, greater satisfaction with services, client reports of higher functioning, and lower reported loneliness. After controlling for both

demographic variables and time in YAS, two additional treatment characteristics predicted positive outcomes. Based on chart reviews, higher rates of SFTP were significantly associated with higher quality of life, and higher rates of CFTP were significantly associated with fewer arrests and fewer symptoms (Styron, et al., 2006).

Promising programs and a PD perspective

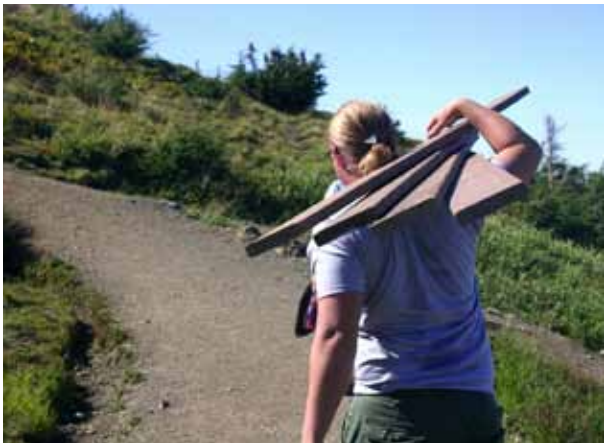
A positive development perspective is clearly evident in a number of the principles and components that are central elements of the programs and interventions described above. As can be seen in Table 1,[2] all of the promising programs explicitly focus on enhancing at least two of the four types of assets. In terms of the range of asset types promoted, TIP and AMP appear to be the most comprehensive of the eight outlined, in that they both address all four positive development assets for transition-aged youth and young adults. Regarding which assets are most likely to be addressed by programs, all eight of the promising programs focus on the development of supportive relationships and prosocial connectedness. This indicates a shared recognition that young adults need to know how to leverage natural supports and work with others in order to achieve successful outcomes. The next most common asset area addressed across programs was

TABLE 1: Developmental Assets Represented in Promising Programs for Transition-aged Youth with Serious Mental Health Conditions

		ASSET			
		Positive identity, sense of purpose, efficacy, empowerment, self-determination	Capacity, motivation, self-control and confidence to make decisions and carry out plans.	Skills for adult roles and leveraging resources.	Supportive relationships and prosocial connectedness.
PROGRAM	AMP	■	■	■	■
	CRA		■		■
	EASA			■	■
	My Life	■	■		■
	RENEW	■	■		■
	STAY OUT		■	■	■
	TIP	■	■	■	■
	YAS		■		■

2. The process of identifying the types of assets promoted by each of these programs or interventions relied primarily on publicly available written descriptions of programs. In some cases, the developers of the programs responded to requests for further information. Therefore, this table reflects a conservative estimate of the extent to which these promising approaches focus on building the various asset types.

teaching young people to develop the capacity to make decisions and move toward goals. This combination of emphasis on two asset areas—building supportive relationships and learning to make decisions—highlights the balancing act that is at the center of the transition age: the need to increase independence and take on aspects of a new identity while also maintaining social connectedness and community ties.



In contrast, the asset least likely to be addressed across promising programs was "skills for adult roles." While all programs addressed at least one adult-related skill, few were explicit in addressing skills across a variety of domains. Instead, many programs (e.g., RENEW, YAS), appeared to focus on narrow goals and outcomes rather than a breadth of skills.

Other community-based approaches. Besides the promising programs described above, which offer some evidence of their effectiveness, there are other approaches that have the potential to be effective for youth and young adults either because of their success with adults with mental health conditions and/or because of their perceived developmental appropriateness for youth and young adults.

Supported Employment. In Supported Employment, individuals with severe disabilities (including mental health conditions) work to gain competitive employment that they find personally meaningful. Key components of Supported Employment include job coaches, assistance with transportation, assistive technology, specialized job training, and individually tailored supervision. Although no Supported Employment program targeting transition-aged youth has yet been evaluated, Supported Employment has been shown to be effective for adults with serious mental illness across several studies; more specifically, in experimental studies. For example, 58% of those who received supported employment achieved competitive employment, compared to 21% of those in a control group (usually traditional vocational rehabilitation; see Bond, Drake, Mueser, & Becker, 1997, for a review). Given the importance young adults place on being employed, Supported Employment is a good candidate for evaluating—and, if necessary, adapting—for that population.

Clubhouse model. A Clubhouse is a planned community where staff and mental health consumers work together doing daily activities and chores to provide services and basic needs (e.g., meals, companionship) to its members. In this manner, Clubhouses often provide transitional employment opportunities for people with serious mental health conditions. As with Supported Employment programs, the Clubhouse model has not been evaluated specifically for its effectiveness with transition-aged young people. However, Clubhouses seem to be developmentally appropriate for young adults, as they provide opportunities for participants to learn skills such as working in a community, doing daily chores, and following through with responsibilities – all tasks relevant to becoming an adult. Additionally, Clubhouses have been shown to be effective; in a randomized-controlled study, adults (average age = 38 years) who participated in a Clubhouse had significantly higher wages and remained

competitively employed for significantly more weeks per job than adults who received Assertive Community Treatment, a more clinically oriented intervention that includes some vocational focus (Shonebaum, Boyd, & Dudek, 2006).

Peer support services. Peer support is social, emotional, and/or instrumental support that is offered professionally by a person with a mental health condition to others sharing a similar mental health condition (Solomon, 2004). Endorsement for these services is evident in such documents as a 2008 position statement issued by Mental Health America, which calls on states to incorporate peer support services – including adolescent peer services – into community-based mental health and substance abuse treatments (MHA, 2008). Although there is no consistent evidence that peer support services are *more* effective than support delivered by mental health professionals, neither is there any evidence that they are *less* effective (Rogers, Farkas, Anthony, Kash, & Maru, 2010), or that they cause detrimental effects (Simpson & House, 2002); additionally, there is some evidence that peer-delivered services increase engagement and retention of clients (Rogers, et al, 2010). Given that these services are potentially effective, that they may increase client engagement, that they offer employment opportunities for people recovering from mental health conditions, and that consumer advocacy groups see them as an essential element of a comprehensive service system, it seems that peer support services warrant further implementation and evaluation. Peer support approaches may be particularly appropriate for youth and young adults because of their higher reliance on peers over family during this developmental phase. Having peer support may also ameliorate the stigmatization and social isolation often felt by young adults with mental health conditions. Specific peer support services designed for youth and young adults are lacking, however, and warrant further efforts.

Conclusion

This chapter uses Positive Development as a theoretical framework for understanding shared characteristics of promising community-based programs for youth and young adults with serious mental health conditions. Four essential assets for successful transition to adulthood that capture the essence of PD were identified from the literature: (1) developing a positive identity and sense of purpose; (2) acquiring the capacity to make decisions consistent with personally meaningful goals; (3) acquiring skills that contribute to the ability to take on adult roles; and (4) developing supportive relationships and prosocial connectedness. Our review of the small number of promising programs and interventions that are specifically designed for transition-aged youth with serious mental health conditions indicates that these approaches typically include an explicit focus on one or more of these asset areas. The ways that these programs most focus on building assets is through promoting supportive social relationships and helping young people develop the confidence to make decisions.

Viewing these programs in terms of the assets they promote raises some interesting questions. For example, several of the programs focus on one or two specific domains of success in young adults (usually employment and/or education), rather than helping to build the more general skills needed to function in adult roles, or supporting well-being or community among program participants. It has been suggested that programs designed for young adults should prioritize meeting the developmental needs of emerging adults such as identity formation, exploration, and increased responsibility – the process of becoming an adult – over more concrete outcomes such as getting a job (Tanner, 2010).

A PD perspective also draws attention to the idea that asset development for young people is promoted through the interplay between individual capacities and supportive relationships, settings and institutions. A number of the programs described here recognize the need for working with the young person's social, interpersonal and organizational/institutional environments in order to increase environmental support for asset building. These programs demonstrate a shared awareness that, for young people who are struggling, it may not be enough to teach skills or provide an entrée into a new role. A young person may not be able to exercise the skills or take advantage of an open door if the surrounding environments are not supportive. Researchers working in the area of positive development have identified features of supportive environments, and this information may be helpful to ongoing efforts to develop effective programs and interventions for young people with SMHCs. Beyond this, the PD approach's focus on environments provides insight regarding the types of settings that, even though they are not specifically designed as programs or interventions for young people with SMHCs, nonetheless provide conditions that are likely to support their positive development.

From this review, it is apparent that there are few community-based programs specifically designed to support youth and young adults with serious mental health conditions, and even fewer that have any evidence of effectiveness. More rigorous studies need to be conducted in order to consider both what approaches are best for working with this population, and what outcomes should be stressed in order to optimize long-term success. In recognition of this need for further study, recent initiatives focused on transition-aged youth with mental health needs have been funded by major federal entities. For example, in late 2009, two Research and Training Centers on transition-aged youth with serious mental health conditions were funded by the *National Institute on Disability and Rehabilitation Research* and the Substance Abuse and Mental Health Services Administration (SAMHSA); SAMHSA has also funded two series of demonstration projects, first the Partnership for Youth Transition (2002-2006), and currently the Healthy Transitions Initiative (2009-2013). In 2008, the U.S. Government Accountability Office published a report, *Young adults with serious mental illness: Some states and federal agencies are taking steps to address their transition challenges* (2008), which called attention to the challenges these young people face when trying to access services and engage in meaningful life activities. Such efforts point to the fact that the mental health field acknowledges youth and young adults as a separate population, with specific needs and strengths to consider in order to develop appropriate, meaningful, and effective interventions.

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