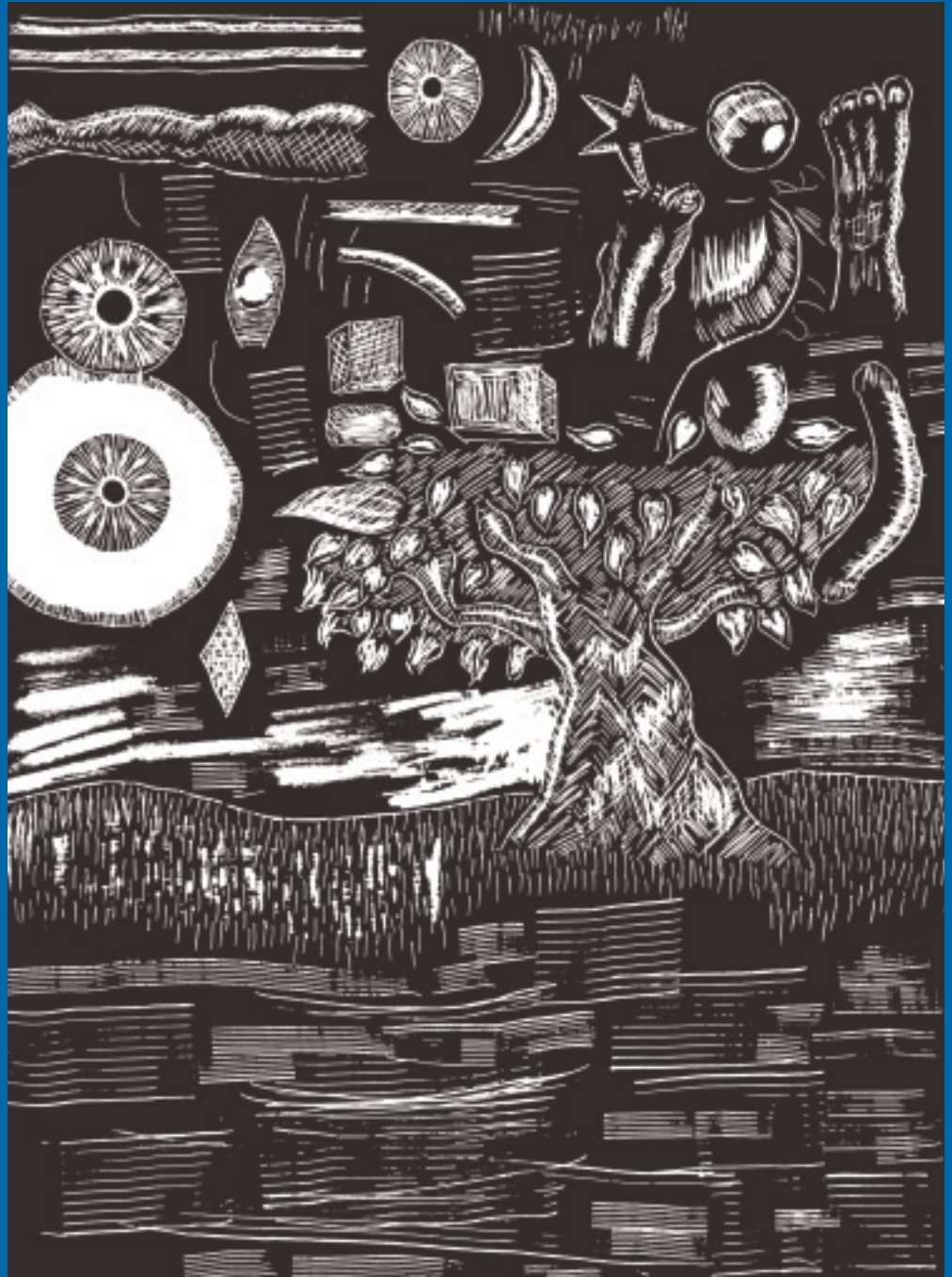


# A Chance for Change:

Supporting Youth in Transition in New York City



A Report on the Findings of the  
2006-2007 Youth Initiative Work Group

The Center's Youth Initiative Project was made possible through funding from the New York State Office of Mental Health and the Francis L. & Edwin L. Cummings Memorial Fund.

The Center for Rehabilitation and Recovery of the Coalition of Behavioral Health Agencies guides and promotes systemic change toward the integration of rehabilitation and recovery-enhancing services within New York City's mental health sector. The Center provides consultation to community mental health providers through expert training, technical assistance, information dissemination, and special projects.

The Coalition of Behavioral Health Agencies, Inc. is the umbrella advocacy organization of New York's behavioral health community, representing over 100 non-profit, community-based, behavioral health agencies that serve more than 350,000 clients in the five boroughs of New York City and its environs. Founded in 1972, the Coalition is supported by membership along with foundation and government funding for special purpose advocacy and assistance projects.

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A Chance for Change: Supporting Youth in Transition in New York City  
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# A Chance for Change:

## Supporting Youth in Transition in New York City

A Report on the Findings  
of the 2006-2007  
Youth Initiative Work Group

Amy Smiley and Alysia Pascaris

Center for Rehabilitation and Recovery  
Coalition of Behavioral Health Agencies

THE  
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OF BEHAVIORAL  
HEALTH  
AGENCIES, INC.



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# Executive Summary

## Introduction

*A Chance for Change: Supporting Youth in Transition in New York City* extensively documents the findings of the 2006-2007 Youth Initiative Work Group, established by the Center for Rehabilitation and Recovery of the Coalition of Behavioral Health Agencies to determine how the mental health system can better support young people, ages 16-25 with Serious Emotional Disturbance (SED), as they face the challenges of adulthood. This paper identifies barriers to optimal transition to adulthood, from both a micro and macro perspective, taking into consideration the individual, program, and systems levels of interaction. It constitutes an attempt to remedy the crippling fragmentation of the mental health system by creating a mechanism—across the board—to locate, for each individual in need, the services that he or she requires, or what we might euphemistically call a system of no wrong doors. Further, it offers insight into the historical, cultural and sociological factors that influence the transition process in an effort to de-pathologize disturbance, which is so often the consequence of the preponderant factors of poverty and racism. Finally, the document lays out a theoretical *framework of transition* to help us make sense of this developmental period from a clinical perspective, orienting us to the distress even the most highly functional individuals might feel as they fashion their own identity and consider ethical and relational factors of great consequence. Most importantly, the paper proposes that the most useful support we can give to young people is to expose them to a broad range of educational, vocational, civic, and social options, and foster key connections beyond the world of the agency so that they will be more confident in their ability to enter the adult world and, whenever possible, leave behind the mental health system.

## The Center's Youth Initiative

The Youth Initiative Work Group was one of many enterprises engendered by the Center's Youth Initiative Project, beginning in 2006 with an extension into 2008, due to recognition, on both the local and national level, that young people on the cusp of adulthood, particularly those with SED or serious and persistent mental illness, are

increasingly at risk of isolation, disconnection from school and/or employment, and violence, either self-inflicted or targeting others in acts of desperation. The imperative of addressing the needs of this population spurred this Project. Consistent with the educational mission of the Center for Rehabilitation and Recovery, seminars and technical assistance related to two nationally recognized models—Transition to Independence Process System (TIP) and WAVE (Work, Achievement, Values & Education) — were made available to providers to enhance services in their programs. TIP founder Hewitt “Rusty” Clark presented a series of seminars on evidence-based practices for working with youth, including core competencies, problem-solving, and decision-making strategies, and provided technical assistance to six sites that had the capacity to implement the TIP model. WAVE specialists focused on job readiness curriculum and motivational strategies to inspire young people entering the work force. We also note the critical importance of international human rights lawyer John Tobin's seminar on a rights-based approach to working with adolescents, which presented new possibilities for framing the problems that preoccupied us. For the drafting of the recommendations contained within this report and the conceptual ideas that substantiate them, we therefore drew on the principles and practices that emanate from the Convention of the Rights of the Child, those that inform TIP and WAVE, our observations of their application in adolescent programs, and our conversations with the young people with whom we spoke at length about the things that boost their self-confidence, inspire their participation, and impede their attainment of a meaningful and sustaining existence.

## The Youth Initiative Work Group

With the support of the New York State Office of Mental Health (OMH) and The Frances L. & Edwin L. Cummings Memorial Fund, the formation of the Work Group proceeded from a dual initiative: 1) to address barriers to optimal transition for young people with SED and 2) to provide a forum and support for mental health and related professionals who work with this population. It is important to note that the Center sought to create as inclusive a group as possible, both in regard to professional

role, i.e. from line staff to managers, and to diversity in discipline: mental health providers convened with representatives from the Department of Education (DOE), the Administration for Children's Services (ACS), OMH, the New York City Department of Health and Mental Hygiene (DOHMH), family members, and academic institutions, such as the New York University School of Social Work. The Group organized its discussions in a thematic fashion, around various essential components that affect young people, such as literacy, employment, aging out of foster care, family involvement, and forensic mental health, and extended invitations to experts whose presentations provided up-to-date information and spurred more in-depth and accurate deliberation. In this way, the Group really seemed to meet the criteria of a multidisciplinary forum and took into account the perspective of different staff in the roles they play in the lives of young people. While the Work Group can pride itself in successfully meeting these expectations, going forward, it will strive to involve young people to a greater extent, as it is clear that such a Group should not speak *for* them, but *with* them, on these matters that so greatly affect their lives.

## The Recommendations

The efforts of the Youth Initiative Work Group resulted in a number of recommendations destined for the Board of Directors of the Coalition to inform future advocacy and educational initiatives. They were also written for dissemination in the mental health community at large, in the hope that they will make a difference in the way we all think about working with young people, so many of whom are nowhere near realizing their potential. Although the paper as a whole contains 17 recommendations, only 11 are presented within the Executive Summary. These eleven recommendations by no means represent the full scope of the Work Group's efforts, either in actual number or in range of application. As we worked through the formulation of the recommendations, it became clear that the Group's ambitious effort to analyze all kinds of considerations, such as housing, employment, education, clinical issues, forensic mental health and foster care, generated an abundance of suggestions. It also became apparent that there are many good ideas about, and effective approaches to, working with young people. In this regard, we have attempted to draw the distinction between these good ideas—which are noteworthy for their inspirational value—and the eleven recommendations that directly follow.

The potential to stimulate change drove the selection process of the recommendations that appear in the Executive Summary. But what do we mean by *change*, exactly? Is it purely structural, as in crucial amendment to policy or in the creation of much needed programs? As we all know, perception and attitude are equally vital to change. By this we mean how we *see* young people with SED and work with them, ideally, as valued and respected participants in the culture of an agency and the community. This paper, especially the section on Disempowered Youth, advocates for this kind of recognition of the creative power of young people and their right to claim it. Surely, it is apparent to all of us in the profession that structure is intimately related to mindset and, furthermore, that change—be it in regulations or in ideology—takes time, which many of our young people at risk simply do not have. Ultimately, we must ask how considerations of *structure* and *ideology* actually play out on the ground in terms of *economic feasibility*. The recommendations which follow seek to instigate change within the realm of what we believe to be most financially possible. These Summary Recommendations should be understood as a starting place where actual implementation might be possible within the context of a specific setting. However, they might be thought of in broader terms, applicable in a number of mental health and related settings.

## The Center for Rehabilitation and Recovery and the Role of Education

Literacy and education figured prominently in most, if not all, Work Group discussions. As we know, the success of a young person in the adult world is exceedingly hard to attain without pre-requisite literacy skills and at least a high school diploma; many adolescents with SED are lacking in these areas and it is imperative that this problem be addressed. While City Hall is now making admirable efforts to reach out to the tens of thousands of students who are seriously behind in their school credits and at risk of dropping out,<sup>1</sup> more needs to be done to analyze the factors of racism, the punitive strategies used by the Department of Education to manage emotional and

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<sup>1</sup> "In an effort that has expanded across Mayor Michael R. Bloomberg's second term, the city has spent nearly \$37 million to identify and cater to students who are at the biggest risk of dropping out and has already contracted for \$31 million more in programs.... The city has established special centers to provide counseling, night classes and an environment designed to avoid the stigma of being college age but in class with 14-year-olds," in Medina, J. (2007, August 21). More students finish school, given the time. *The New York Times*, A1.

behavioral problems in students, the impact of testing, the quality of assessment of learning disabilities, and the relationship between trauma and cognition in order to determine how mental health treatment can better support clients who are at risk of or who have already dropped out of school. Further, it is imperative to bridge the gap between secondary and post-secondary education and open up the world of higher education to young people with a broad range of emotional and cognitive challenges. The Center for Rehabilitation and Recovery plans to convene a special conference on these crucial questions during the 2007-2008 fiscal year.

6 Training and education is not only an area of concern for adolescents and young adults, however. Work Group participants were adamant that mental health staff also have crucial needs that must be addressed so that they might gain insight into the emotional disturbance of their clients and enhance their competency to work effectively with them. This Report ends with a section on Workforce Development, which identifies these areas of competency, their interdisciplinary underpinnings, and the importance of cross-training staff from both the child and adult divisions of mental health. Consistent with its educational mission, the Center will provide seminars and support throughout the fiscal year to address these questions of competency and, within this context, provide a forum for child and adult staff to communicate across the divide of the mental health system.

Finally, the Center for Rehabilitation and Recovery is currently responding to the desperate problem of

disconnection by creating a comprehensive, online resource guide and directory of New York City services and programs designed to address the housing, education, employment, social, and mental health and wellness needs of transition-age youth. While most guides have been designed for practitioners, the Center's interactive web-based resource seeks to emphasize the importance of self-direction and the primary involvement of youth in their own life planning.

## Conclusion

It is essential that it be understood that all of the recommendations and good ideas that came out of the deliberations of the Youth Initiative Work Group speak to a specific purpose and are of equal value. But the work does not stop here. The Center for Rehabilitation and Recovery considers *A Chance for Change: Supporting Youth in Transition in New York City* to be a work in progress, an on-going collaborative effort between the mental health community and the many systems (child welfare, education, substance abuse, juvenile justice, etc.) with which young people interact. Because of its primary focus on mental health, the Center recognizes that the recommendations contained within this report are not necessarily comprehensive, nor do they take into account all of the effective programmatic, advocacy and local, state, and federal government efforts related to improving the chances of success for youth in New York City. It does hope, however, that it will make a contribution to the way we all think about, reach out to and, most importantly, learn from young people.

# Summary Recommendations

## Eligibility Requirements

**Create a work group to study eligibility requirements for child and adult mental health service systems and modify diagnostic and programmatic discrepancies accordingly to facilitate access to the adult mental health system for youth with SED.**

- The work group, initiated by New York State Office of Mental Health (OMH), should include members from the Coalition of Behavioral Health Agencies (CBHA), experts in adolescent psychiatry, parent advocates, and the New York City Department of Health and Mental Hygiene (DOHMH) child and adult divisions to promote access to adult services for those who are aging out of child services.
- Identify priority programmatic areas, such as case management and residential, to address incongruous points of program access impeding transition from child to adult services; include a review of Child Single Point of Access (C-SPOA) and adult SPOA.
- Consider: i) adjusting regulatory definitions of Seriously and Persistently Mentally Ill (SPMI) and Serious Emotional Disturbance (SED) that hinder service continuity; ii) “grandfathering” adolescent clients in need of adult services into the adult system; iii) creating a mechanism for automatic eligibility for specific adult services, such as case management, if the individual meets child system criteria; and v) extending eligibility within child services to, for example, age 25.
- Parallel to this process, state and city planning documents should include a section dedicated to addressing the needs of transition-age youth; a DOHMH advisory forum should be dedicated to transition issues.

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## Adult Mental Health Services

**Modify adult mental health service programming to better address the particular needs of older adolescents/young adults through specialized transition support services that are developmentally appropriate.**

- OMH should endorse changes within Continuing Day Treatment (CDT) programs, resulting in: i) a “specialized track” for young adults which, along with social and clinical support, focuses on the transitional domains of education, employment, housing, and community participation and ii) the transformation of one CDTP per borough into a specialized young adult program for 18-30 year olds.
- OMH should establish guidelines for specialized youth services in new Personalized Recovery Oriented Services (PROS) Programs.
- Children’s and adult case management and Assertive Community Treatment (ACT) teams must be competent to address transition-related issues and service coordination for individuals shifting from child to adult service provision. Mandatory core training should be modified to meet transition competency standards.

# Summary Recommendations

## Child Mental Health Services

### Extend services in child mental health programs.

- Establish flexible financial mechanisms to assist providers to offer formal post-discharge support services to young people leaving residential and outpatient programs.
- For Family-Based Treatment (FBT), extend financial support to agencies for families to sustain relationships with transitioning youth up to the age of 21.
- For Residential Treatment Facilities (RTFs), incorporate services that better prepare young people for living more independently in their communities.
- Re-formulate Family Support Service Programs through pending DOHMH scope of service and RFP process to include the allocation of resources for transition specialist positions.

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## Transition-Age Services

### Enhance existing Adolescent Skills Centers in the five boroughs.

- DOHMH should utilize adult division funds to expand the capacity of Adolescent Skills Centers. Ensure that increased capacity preserves small class or group size and that the Centers continue to be funded by non-Medicaid dollars.
- Extend program age limit to 25 years.
- Integrate principles and approaches reflecting the Transition to Independence Process (TIP) System, and emphasize youth participation, education, employment, and housing outcomes. Ensure collaborative mechanisms for addressing mental health needs.

## Youth Participation

### Promote youth participation as a best practice in agency and community life.

- Providers should establish mechanisms for formal input in the areas of treatment, education and advocacy: e.g. case-based reviews, youth leadership councils, youth speaker bureaus, advisory, and other committees.
- OMH and DOHMH should develop and integrate Youth Peer positions into Home and Community Based Services Waiver Program, Adolescent Skills Centers and other settings. Responsibilities include outreach, civic engagement, social support, gang prevention, smoking prevention, and mentoring.

# Summary Recommendations

## Employment

### **Increase financial and other resources to enhance youth access to early employment opportunities.**

- Integrate effective job readiness skills training, such as WAVE curriculum, into children’s Day Treatment and adult CDTP activities.
- DOHMH and OMH should accept “transitional” and time-limited employment among young adults (18-25 years) as a viable outcome in supported employment programs including ACE (Assisted Competitive Employment).
- Utilizing flexible funding mechanisms, OMH, DOHMH, and the Department of Youth and Community Development (DYCD) should support youth internships and temporary stipend-reimbursed employment, which build basic employment and career readiness skills.
- With additional contractual funds, providers should introduce proven cognitive remediation techniques into outpatient programs and Adolescent Skills Centers to address barriers to education and employment.
- Vocational and Educational Services for Individuals with Disabilities (VESID) should i) address career exploration needs of youth disconnected from school through incorporation of situational assessments (exploring functional and motivational readiness) and protocols that support informed choices in employment pursuits and ii) enhance transition services and increase the number of counselors within the transition units of NYC district offices.

## Education

### **Improve the educational level of young people with SED.**

- Educational programs of study in Residential Treatment Facilities (RTFs), Day Treatment Programs and State Children’s Psychiatric Centers should be reviewed and enhanced to include pre-GED curriculum to effectively address remedial literacy needs.
- Provide resources to integrate supported education and literacy services into clubhouses, adult supported employment, and pending PROS programs.
- Establish links between higher education, mental health agencies, VESID, and high schools so that students with SED or disabilities can be better prepared for the world of higher education and college-level expectations.

# Summary Recommendations

## Housing

**Make beds! State and City Offices of Mental Health should continue to partner with the Department of Housing and Urban Development, the New York City Departments of Homeless Services (DHS), Housing Preservation and Development, ACS, and Youth and Community Development (DYCD) to create additional supportive housing options with on-site clinical and transitional support services.**

- Supportive transitional and permanent housing must offer comprehensive and individualized services for youth with SED transitioning out of foster, family or residential care, and for homeless youth.
- Implement on-site vocational and education services in supportive housing units. Include benefits counseling as a best practice.
- In partnership with the State Offices of Mental Retardation and Developmental Disabilities (OMRDD) and Alcohol and Substance Abuse Services (OASAS), OMH should allocate beds for individuals who are dually diagnosed with mental retardation and developmental disabilities as well as substance abuse.
- OMH wrap-around funds should be made more accessible to providers needing expertise and consultation related to individual resident needs.
- Formulate a collaboration between ACS, DOHMH, OMH, Department of Juvenile Justice (DJJ), and DYCD to establish respite beds throughout the five boroughs.

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## Drop-In Centers

**The City of New York should invest in drop-in centers with comprehensive services for disconnected youth.**

- DHS and DOHMH should establish drop-in centers, which provide meals, social activities, educational programs, on-site crisis intervention and counseling, psychosocial support for young people aging out of foster care, legal services, skill development, and active outreach.
- Drop-in programs should partner with primary health care clinics with family planning services and provide extensive referral services addressing behavioral health needs.
- Youth Peer staff/leaders and professional staff should partner in operating programs.

# Summary Recommendations

## Forensic Mental Health

### Respond to the needs of youth at risk of or involved with the criminal justice system.

- ❑ Eligibility criteria in mental health residential programs should be modified so that youth who are court-involved are not excluded from services.
- ❑ A city-wide, forensic ACT team should be established to meet the needs of severely mentally ill adolescents and young adults in alternative to incarceration programs.
- ❑ Coalitions and mental health providers should urgently commit to an advocacy effort to ban trying 16 and 17 year olds in the adult court system. In conjunction with this effort, Family Court must secure the necessary resources to effectively accommodate these adolescents, i.e. appoint additional family court judges; reduce caseload of law guardians to ensure adequate representation of adolescents; increase links to alternative to incarceration programs; and increase opportunities to screen for mental health conditions in pre-trial detention centers.

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## Child Welfare and Mental Health

### Strengthen the connection between ACS and mental health services.

- ❑ The ACS Family Assessment Program should ensure that assessment and referral services are provided by licensed mental health practitioners with the competencies required to accurately assess family needs and address emotional components of a young person's behavior.
- ❑ ACS should make clinical assessments a priority for adolescents with SED by ensuring that ACS workers and foster care agency staff i) fully understand diagnoses and socio-emotional needs and ii) integrate this information to a greater extent into service planning and placement planning.
- ❑ ACS should increase opportunities for mental health treatment of adolescents in foster care by providing clinical services in both foster care agencies and residential facilities.

# A Chance for Change: Supporting Youth in Transition in New York City

## Overview

The aim of this paper is to present recommendations regarding transition-age youth with serious emotional disturbance (SED),<sup>2</sup> ages 16-25 approximately, in order to promote their best possible chances of success in a world where the challenges of employment, housing, education, and healthy relationships are rife. We write from a behavioral health and holistic perspective, and ask how we can best support young people with mental and emotional difficulties in their attempts to enter into adulthood as responsible and capable citizens. We do not intend to propose in-depth analyses of all of the multiple systems with which young people interact but rather, seek to contribute to the debate that has arrested national, state and local city attention regarding the crisis facing young people today.

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To this end, the recommendations in this report stem from two complementary initiatives emanating from the Coalition's Center for Rehabilitation and Recovery, with the support of the New York State Office of Mental Health (OMH) and the Cummings Foundation. In September 2006, the Center created a Youth Initiative Work Group to provide a multidisciplinary forum for New York City providers and other professionals from the New York City Department of Education (DOE), the Administration for Children's Services (ACS), OMH, the New York City Department of Health and Mental Hygiene (DOHMH), and New York University School of Social Work. The mission of the Work Group was fourfold: to identify key issues facing this population regarding the transition to adulthood; to further educate participants in selected areas of concern; to promote interagency collaboration; and to contribute to the substance of these recommendations based on the Work Group's expertise. The Work Group convened on a monthly basis, from September 2006 to June 2007, and focused its attention on a number of relevant themes in order to identify best practices, gaps in services, systems-related

barriers, educational needs for providers, and possible areas of advocacy that the Coalition might consider incorporating into its agenda in the near future. The Work Group discussions were greatly enhanced by the knowledge base of Work Group participants themselves as well as by the insights of reputable experts in the community who were invited to present their findings on a given subject.

Second, consistent with the educational mission of the Center for Rehabilitation and Recovery, seminars and technical assistance related to two nationally recognized models—Transition to Independence Process System (TIP) and WAVE (Work, Achievement, Values & Education)—were made available to providers to enhance services in their programs. TIP founder Hewitt “Rusty” Clark presented a three-part seminar series, comprising an in-depth Overview, Core Competencies, and Problem Solving and Decision Making components. In conjunction with this training series, the Center was able to support—with Dr. Clark's integral participation—technical assistance to six provider sites that had the capacity to implement the TIP model. Application of the TIP model proved to be a crucial learning and networking experience for providers, enabling them to enhance youth voice through a shift of focus to the four transition domains that define their existence in the adult world (i.e. Employment and Career, Educational Opportunities, Living Situation, and Community Life Functioning). On their end, WAVE specialists J. Tyler, Jackie Hayden, and Donald Summons presented a six-part seminar series to enhance vocational services within provider agencies, emphasizing the use of a crucial job readiness curriculum (replete with 109 lessons in 11 competency areas), motivational strategies to inspire young people entering the work force, and the importance of a leadership association within agency life. We also note the critical importance of international human rights lawyer John Tobin's one-day seminar on a rights-based approach to working with adolescents, which presented new possibilities for framing the problems we were preoccupied with. We drew on the principles and practices that emanate from the Convention of the Rights of the Child and those that inform TIP and WAVE, as well as on our observations of their application in adolescent programs to further inform these recommendations.

<sup>2</sup> For the definition of SED, see The Mental Health Work Group of the Child Welfare Subcommittee of the New York City Family Court Advisory Council. (2005, Spring). *Mental health services available to children and their families: A resource guide for family court practitioners*, New York, pp. 16-17. <http://www.lawyersforchildren.org/siteFiles/OMH.pdf>.

Finally, because these recommendations stem from a behavioral health perspective, we hope to make the link throughout this paper between best practices and adolescent development. This unusually complex period is discussed at length in Levy-Warren's study (1996),<sup>3</sup> inclusive of three developmental phases, covering the period between ages 14-26, i.e. early, middle, and late adolescence, presenting specific biological, psychological and social challenges. The work of Arnett (2000)<sup>4</sup> helps us conceptualize the later period as one of "emerging adulthood," extending from ages 18-30, and the implications of the rapid and central changes that occur prior to entering full-fledged adulthood. In light of these challenges, it is not surprising that reputable experts in this field, such as Rusty Clark and Maryann Davis, call for a third service system that would serve this transition population, i.e. ages 16-30.<sup>5</sup> The ways in which the specific challenges and conflicts inherent in adolescence play themselves out are no doubt related to the socio-economic realities of growing up in New York City, where one in three children live below the poverty level, compared to the national average of one in six.<sup>6</sup> Cailin McGreevy, Director of Mental Health at Covenant House, is convinced that much of the disturbance we are seeing in young adults is directly linked to these stressors: "It has been my experience that socio-economic demands increase the amount of stress placed on adolescents entering early adulthood. This stress often leads to the onset of serious psychiatric disorders."<sup>7</sup> It therefore became important in the drafting of these recommendations to consider the parameters and ramifications of the terms "functioning" and "behavior" to ensure the local relevance of this analysis to this population and to all of the key players with whom they work or come into contact. We want to highlight the devastating incidence of mental illness in New York State (one million children under 18 years of age, or one in five

<sup>3</sup> Levy-Warren, M. (1996). *The adolescent journey: Development, identity, formation & psychotherapy*. Northvale, NJ: Jason Aronson.

<sup>4</sup> Arnett, J. J. (2000). Emerging adulthood: A theory of development from the late teens through the twenties. *American Psychologist*, 55(5): 469-480.

<sup>5</sup> See Davis, M. & Hunt, B. (2005). *State efforts to expand transition supports for young adults receiving adult public mental health services*. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. Rockville, MD.

<sup>6</sup> A Community Service Society Annual Report. (2004). *Poverty in New York City, 2003: Where is the recovery? Where was the recession?*, p. 8. <http://www.cssny.org>.

<sup>7</sup> Presentation to the Youth Initiative Work Group, June 20th, 2007.

children and youth).<sup>8</sup> According to the August 6, 2001 NAMI (National Alliance for the Mentally Ill) report: *Children's Mental Health State Legislative Trends in 2001 Session*, in the USA, one in ten children and adolescents suffer from mental illness severe enough to cause impairment. However, in any given year, fewer than one in five of these children receive needed treatment. The prevalence rates for the year 2005 in the New York City region for Severe Emotional Disturbance and Severe Mental Illness break down as follows: 50,695 for ages 14-17 and 39,319 for ages 18-24.<sup>9</sup> Finally, it is important that we weigh the findings of Kessler et al.,<sup>10</sup> which situate onset of mental illness at an earlier age than what was previously established, i.e. now at age 11 for impulse control and anxiety disorders and age 14 for half of lifetime mental illness. The recent study by senior author Mark Olfson of the New York State Psychiatric Institute at Columbia University indicates that bipolar disorder diagnosis in adolescents has increased 40-fold.<sup>11</sup> While we are aware that the increase in this and other disorders represents a recent application of disorders within the spectrum of adolescent diagnosis (as in the case of bipolar disorder), we also need to ponder the ways in which oppressive conditions in our society either exacerbate or instigate disturbance, as well as the ways in which such diagnoses fuel drug companies specializing in psychotropic medication.

As indicated above, we want to be careful not to pathologize behavior in light of certain economic realities (related to housing, employment, neighborhood safety, education) that induce tremendous stress and decrease coping ability. Many studies, such as Masten et al., 1999,<sup>12</sup> make the correlation

<sup>8</sup> Victorson, K., Walsh, B., Robinson, D., Hilliard, T., Schimke, K., & Mastin, D. (2006). *Growing up in New York. Charting the next generation of workers, citizens and leaders*. Schuyler Center for Analysis and Advocacy. Albany, NY.

<sup>9</sup> Many thanks to Kevin Conley at the NYS Office of Mental Health who provided these estimates, which are based on the published rate indicated in the report, *Mental health: A report of the surgeon general*, Rockville, MD. The data is based on the US census 2005 estimates.

<sup>10</sup> Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, J.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62(6), 593-602.

<sup>11</sup> Carey, B. (September 3, 2007). More children being treated for bipolar disorder. *The New York Times*, A1.

<sup>12</sup> Masten, A.S., Hubbard, J.J., Gest, S.D., Tellegen, A., Garmezy, N., & Ramirez, M. (1999). Competence in the context of adversity: Pathways to resilience and maladaptation from childhood to late adolescence. *Development and Psychopathology*, 11: 143-169.

between poor adaptation ability in youth and life in poverty. As Leontopoulou (2006) asserts, “the more resources young people have to draw on at times of stress, the better their chances of dealing with difficulties more effectively.”<sup>13</sup> It was therefore incumbent upon us to pose the following general questions that would guide our reflections:

- How does the current two-pronged mental health system, with child/adolescent services on the one end and adult services on the other, promote or inhibit the transition to adulthood? Might we consider introducing a transition-age, third prong that would specialize in the particular needs of this age group (16-25)?
- How do we create a provider environment that supports treatment of mental illness (especially related to the effects of trauma, abuse, depression, and conduct disorder) and dual diagnoses at the same time that it constructs bridges to the real world of independent living, artistic expression, employment, community life, and housing? Is the present mental health system too fragmented to ensure a holistic approach?
- What can be done to raise the level of resiliency and self-efficacy in this population, as these factors determine ability to function under stress and potential to overcome emotional disturbance, crisis and disconnection?
- What exactly constitutes success in terms of academic and vocational achievement and daily living skills?
- How does racism impact on vocational, social and educational opportunities and, conversely, what correlation is there between race and risk of violence, school expulsion, and incarceration?
- What is the relationship between gender and emotional disturbance, given the fact that female teenagers are more likely to be victims of abuse and male teenagers are more likely to be labeled as emotionally disturbed?
- In what ways is mental illness overly correlated with crime, homelessness and unemployment? Such a correlation infers that mental illness *results in* socioeconomic distress. As Draine, Salzer, & Hadley (2002)<sup>14</sup> propose, it is more useful to understand

<sup>13</sup> Leontopoulou, S. (2006). Resilience of Greek youth at an educational transition point: The role of locus of control and coping strategies as resources. *Social Indicators Research*, 76, 95-126.

<sup>14</sup> Draine, J., Salzer, M.S., & Hadley, T.R. (2002). Role of social disadvantage in crime, joblessness, and homelessness among persons with serious mental illness. *Psychiatric Services*, 53, 565-573.

poverty as a *mediating factor* in psychological distress, due to poor quality and quantity of resources, since there are many people who live in poverty who are not mentally ill. We should contemplate the dynamic that arises, for example, between psychological distress, the use of alcohol, and low-income neighborhoods characterized by drug trafficking, insufficient police protection, and neglected living conditions. By understanding the links between these factors, we might better treat depression and anxiety.<sup>15</sup> Further, we should think about the extent to which suicidal ideation is associated with unemployment.<sup>16</sup> We emphasize the importance of framing emotional disturbance within a socioeconomic context.

- In considering the category of SED, it is important to take into account the multiple factors contributing to disturbance with equal attention paid to the organic/biological factors and those that are stress-induced. What are the implications for diagnoses if we address more directly the sources of stress, e.g. creating greater opportunities for housing, high quality education, employment, addressing gang activity, and bullying and adequately assessing learning disabilities in every child? While our reflections emanate from the problems facing youth with SED, it should be understood that we include the many adolescents who do not receive services, who are suffering in a variety of ways, and have no DSM diagnosis.
- How might a rights-based approach inform services for youth and indirectly address the stigma associated with mental illness?
- What do we do about the simple lack of services for youth with dual diagnoses (i.e. Axis I with mental retardation or substance abuse) who are discharged from high levels of care, or who are mandated to treatment by the criminal justice system due to conduct disorder or sexual perversion, and have no program to go to?

### ***Why are we focusing on transition-age youth with SED?***

Adolescence constitutes a developmental period of its own, during which one progressively grows out of childhood and becomes an adult, and is fraught with conflict related to this

<sup>15</sup> Hill, T. & Angel, R.J. (2005). Neighborhood disorder, psychological distress, and heavy drinking. *Social Sciences and Medicine*, 61(5), 965-975.

<sup>16</sup> Fergusson, D.M., Horwood, L.J., & Woodward, L.J. (2001). Unemployment and psychosocial adjustment in young adults: Causation or selection? *Social Science Medicine*, 53(3), 305-320.

momentous change. These young people are arguably underserved due to mental health and other approaches (related to school, vocation, criminal justice, etc.) that do not necessarily match their particular needs and aspirations. Underserved, one in six adolescents in New York City (approximately 170,000) are currently disconnected from school or employment. *Out of school, out of work...out of luck?* (2005)<sup>17</sup> goes on to state that the New York City rate of disconnection is twice as high for males (16.2%) than the national average (7.7%). It directly associates this disconnection with emotional disturbance, asserting that 75% of students with this disturbance are likely to drop out of high school. The report cites disturbingly high rates of incarceration, with 73% of this population facing arrest 3-5 years after they leave school. According to the Citizens' Committee for Children's *Keeping Track of New York City's Children*, "3,742 young people 16 years and older were placed in Juvenile Justice detention in 2003. Youth in that age group made up 24% of admissions to detention that year."<sup>18</sup> Currently, over 40,000 students in the New York City public schools are classified as emotionally disturbed and are at high risk of not being able to meet academic expectations and dropping out of school.<sup>19</sup> We need to urgently ponder these statistics and face their profound ramifications for adolescents and society at large, especially in terms of the increased likelihood of violence, either self-inflicted or directed at others. *Growing Up in New York* states that teens aged 15-19 in New York State are more than twice as likely as other age groups to inflict injury on themselves.<sup>20</sup> Of course, these trends need to be brought into the context of major changes in New York City over the past decade regarding welfare reform, the restructuring of the economy, and the rise in immigration. The question of immigration has particular relevance to young people, many of whom are either first generation American or immigrants themselves and experience tensions related to dual cultural practices, linguistic challenges, and legal status. Finally, as we ponder ways to ameliorate the lives of young people, poverty remains the over-arching concern, as

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<sup>17</sup> Levitan, M. (2005). *Out of school, out of work... out of luck?* New York City's Disconnected Youth. Community Service Society. <http://www.cssny.org>.

<sup>18</sup> See Facts, Sheets, Charts and Graphs for teenagers. The report (*Keeping Track of New York City's Children*) can be viewed on line at <http://www.cccnewyork.org/Web%20Graphics/teens.pdf>.

<sup>19</sup> Victorson, K. et al. (2006). *Growing up in New York. Charting the next generation of workers, citizens and leaders*. Schuyler Center for Analysis and Advocacy. Albany, NY, p. 36. *Growing up in New York*.

<sup>20</sup> *Ibid.*, p. 38.

disconnection in young people increases the chances of poverty when they reach adulthood.

To place this in a national context, *The President's New Freedom Commission on Mental Health 2003 Report* clearly identifies ways in which the mental health system can better serve this population. Transition-age youth with SED represent between 1 and 3 million, and those who are being served, either in state mental health or special education systems, have difficulty achieving the crucial tasks of young adulthood that would ensure optimal functioning.<sup>21</sup> Further, in most states, there appears to be little coordination between child and adult mental health services, exacerbating the disconnection that transition-age youth so often experience.

Our attention to young adults with SED embraces a preventive approach. The World Health Organization indicates that "one fifth of teenagers under the age of 18 years suffer from developmental, emotional or behavioral problems, one in eight has a mental disorder," and estimates that "by the year 2020, neuropsychiatric disorders will account for 15% of disability worldwide."<sup>22</sup> The Work Group applauds the recent focus on prevention in child welfare and, in cases where safety to a child is not at risk, supports the increase of work with the family unit to link them to needed services so that they may improve their chances of remaining together. Further, in view of the fact that many adult mental disorders are diagnosed in young adults between the ages of 18-21,<sup>23</sup> it is imperative to reach this population, identify and treat their conditions so that they might, as successfully as possible, meet the challenges of adulthood and live meaningful lives in terms of their intimate relationships, their participation in community life and their work. As we know, the consequences of leaving a mental illness untreated are three-fold: impairment in ability to learn and perform in an academic or employment setting;

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<sup>21</sup> Davis, M. & Sondheimer, D.L. (2005). State child mental health efforts to support youth in transition to adulthood. *Journal of Behavioral Health Services & Research*, 32(1), 27-42.

<sup>22</sup> A Report of the World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Prevention Research Centre of the Universities of Nijmegen and Maastricht. (2004). *Prevention of mental disorders. Effective interventions and policy options*. Geneva, Switzerland. [http://www.who.int/mental\\_health/evidence/en/prevention\\_of\\_mental\\_disorders\\_sr.pdf](http://www.who.int/mental_health/evidence/en/prevention_of_mental_disorders_sr.pdf).

<sup>23</sup> Davis, M. and Hunt, B. (2005). *State efforts to expand transition supports for young adults receiving adult public mental health services*. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. Rockville, MD.

increased risk for more severe forms of illness, especially depression, bipolar and eating disorders, increased anxiety, suicidality, and aggression and social dysfunction. The focus on the most tragic of these conditions in the New York City CDC 2001 report indicates that 21,000 high school age young people (9th-12th grade) in New York City attempted suicide at least once.<sup>24</sup> Their cry is clearly desperate.

### ***A Third System?***

When most young adults in treatment reach their 18th or 21st birthday, they face discharge from their program. Youth Initiative Work Group providers characterize this moment as equivalent to falling off a cliff. Indeed, disruption in services and the severing from a secure base—the agency—induces intense anxiety in young people facing discharge, causing exacerbation of symptoms and increased absence from program activities. This practice of discharge is hitting young people where they are most vulnerable. Disturbance related to attachment is at the heart of dysfunction for many adolescents. In fact, it is this very disturbance that brought many of them into the child system in the first place. How can it possibly make sense to reintroduce painful severance, i.e. discharge, based on what feels like an arbitrary age limitation that is divorced from what the young person is actually going through, either developmentally or in terms of her ability to function in the world? Moreover, treatment staff involved in discharge experience similar anxiety as they sense the degree of helplessness in their clients who must somehow recreate this base. TIP model site participants urgently sense the need to rethink transition into the adult world as a major goal of treatment, and are adjusting their programs to more adequately address discharge and transition. But it is a struggle. When links to the adult world are not easily come by, from the standpoint of clinical connection as well as concrete aid such as Medicaid or supportive housing, the sense of disruption is acute. It is a well-known fact that continuity of care is essential for recovery from mental illness: “Qualitative data show that strong, positive, trusting relationships with clinicians, developed over time, can aid recovery.”<sup>25</sup> Winnicott and

<sup>24</sup> New York City Department of Health and Mental Hygiene. (2003). *Prevalence and cost estimates of psychiatric and substance use disorders and mental retardation and developmental disabilities in New York City*. New York, NY.

<sup>25</sup> Society for Social Work and Research. (2006). *The importance of continuity of care and relationships with providers on the recovery of persons with SPMI: Implications for policy and practice*. <http://www.sswr.confex.com/sswr/2006/technprogram/P3992.htm>.

Erikson argued decades ago that continuity is the element on which trust in others depends, without which the ability to discover and exist in the world is severely hampered.

The major disruption occurring within the child and adult systems is clearly a problem that we need to address, and in so doing, refer to the Partnerships for Youth Transition Initiative to frame this problem through the three questions they pose: “Are we imposing artificial barriers to continuity of care for young people with mental health needs as they turn 18? Are we providing services that are developmentally appropriate? Are we offering a rich and diverse set of transition supports and services?”<sup>26</sup>

We present our thoughts on systems change in this overview, rather than within the recommendations themselves, due to some hesitation we have in choosing to advocate for either the creation of a third, transition-age system or for enhancing both existing adult and child divisions through services that target this transitional population. As Rusty Clark concedes, “we don’t have a research base indicative of which configuration of service systems might work best.” Both options have their merits which we will foreground here, as they are essential in both systems models, for improving services for transition-age youth.

### ***Argument for a third, transition-age system***

Introducing a transition-age system has the clear benefit of providing clinical services that feel relevant to adolescents and young adults *as they make their way to adulthood*, as well as focusing, from a holistic perspective, on the needs that seem to unite all individuals of this group, be they 16 or 25 years of age, in terms of their priorities, i.e. education, employment, identity formation (in the Eriksonian developmental perspective of establishing one’s own sense of self), dealing with family issues, relationships with peers, independent living. While the language of adulthood is often described in terms of “independence” and “autonomy,” we prefer “supportive independence.” This concept is rooted in the recognition of the crucial factors of interpersonal relationships and supportive services that make the attainment of adulthood possible, especially for a young person with SED. In this regard, transition-age youth and young adults will similarly be inspired by peer

<sup>26</sup> Partnerships for Youth Transition Initiative (PYT). (2007, June). *On the move: Helping young adults with serious mental health needs transition into adulthood*. Seeking effective solutions. <http://nycy.fmhi.usf.edu/index2.cfm>.

educators and mentors with whom they can identify and who instill much needed hope. From a programmatic perspective, the more young people take on responsibility to create positive and vibrant agency culture and the more youth voice is integral to activities and services, the greater the chance that self-control, positive self-expression and social responsibility will be replicated in the outside world. A third system would incrementally ensure youth participation and leadership in a developmentally-informed manner, so that transition to adulthood would be a more natural outcome of specific transition services. The transition system would also have the crucially important benefit of continuum of clinical services, as access to the adult mental health division requires the individual to present with symptoms common to Axis I disorders, which is not necessarily the case in the child system. Finally, a third system would better address concerns regarding the continuum of Medicaid and other entitlements which, in the current system, are by no means guaranteed, as eligibility criteria change at ages 18 or 21, but which are crucial to a young person's support system.

### ***Argument for transforming the current child and adult mental health system***

This option is probably the more realistic of the two in that implementing a third system, particularly on the state and federal levels, would meet with tremendous resistance to change—necessitating an extensive reconfiguration of the mental health system and its programs—and would require intensive research and advocacy efforts to support such an endeavor. *This does not mean that we should not engage in this*

*worthy cause*, but rather, that it is very daunting, and it is crucial to begin implementing change *now*. It is clear that both the child and adult systems do not adequately meet the needs of transition-age youth. By implementing services that better address these needs, within both systems, we would have a better chance of engaging young people in leading healthier lives. It is essential that funding mechanisms support an initiative of continuity of care and the enhancement and creation of transition services across the board.

To this end, we propose that adolescent programs engage in transition-focused services as early as the initial assessment with the goal of exposing individuals to a variety of options so that they can make informed and confident decisions regarding education, employment, and mental health treatment (if need be) as they move toward the adult world. These programs would benefit from aftercare services, which currently exist in some agencies on an informal basis, providing the opportunity for discharged clients to return to their secure base and the staff with whom they made strong connections to talk through whatever challenges they are facing. At the same time, we feel that it is incumbent on adult programs to rethink their services for young adults to make sure that their activities are developmentally informed and meaningful for this population. It is obvious that the emotional and concrete needs of a 21 year old are going to differ dramatically from a 40 year old, but most adult programs do not seem to address this major developmental discrepancy. It is critical that adult programs enhance strategies to engage young people and encourage them to become a vital asset to agency culture.

# Towards a Framework of Transition

The Youth Initiative Work Group structured its discussions around thematic concerns of importance, i.e. foster care, housing, literacy, vocation and employment, engagement strategies, psychiatric issues, family involvement, forensic mental health, and young adult programs in the adult system. However, in order for these recommendations to have the greatest possible relevance in terms of both the population we are advocating for and the mental health and other staff in the local context of New York City, we chose to frame our reflections around the concept of *transition*, the governing principle of this paper.

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By *transition*, we are thinking of the concept first formulated by Winnicott half a century ago of an “intermediate area of experience.”<sup>27</sup> Originally designating the creative attempts of the infant to facilitate his entry into daunting reality, we can readily apply this concept to the similar challenge of the adolescent at the threshold of daunting adulthood, making ready his entry into the world. For even the highest functioning young adult, the major tasks and developmental challenges of this period invariably induce distress. And yet, the rewards for successfully emerging from this “intermediate area of experience” will determine the quality of life for years to come. As the adolescent embarks on her search for self-definition, fraught with conflicting anticipation and terror of independence, she creates a bridge between childhood and adulthood on an emotional, pragmatic, and ethical level. With trust, support and encouragement, Winnicott’s infant overcomes his anxiety and embarks on a journey of discovery. So, too, the adolescent has the potential to make this journey a creative and fruitful one.

For the young person who has experienced considerable loss, abuse, neglect, or exposure to violence, leaving home and making her home (on a real and symbolic level) requires abilities that have been seriously compromised by tragedy, insufficient resources, or mental or emotional difficulties. How can a young person meet the developmental task of self-regulation and feel a confident

degree of mastery when the world often seems to be spinning out of control and he has met with inordinate degrees of failure and rejection? Indeed, resiliency—or how one responds to life’s challenges—is predicated on an internal locus of control, i.e. the feeling that one is in control of one’s life.<sup>28</sup> It takes self-esteem and a strong sense of identity to establish positive peer connections, engage in healthy intimate relationships, continually educate one’s self, pursue a meaningful vocation or profession, and be a responsible citizen in one’s community. For the young person who has not been encouraged to dream, to set goals, to create, who, in short, has not learned that his existence is one of value, these challenges are daunting at best.

The framework of transition thus demands of us to consider how we can best support our young people who find themselves in this “intermediate area of experience” and guides our reflections in terms of the following fundamental questions: How might we promote self-efficacy and build on the capacity to meet life’s challenges? How can we encourage healthy attachments so that young people can trust in themselves and in their ability to find a valued place in the world? How can we create opportunities for exposure to a range of motivating options for our youth? And most importantly of all, *how can we best listen to them* so that they can tell us of their struggles, needs and desires and consequently assert themselves in agency and community life? In keeping with this framework of transition, Benjamin Kirshner (2004) poignantly notes: “Organizations can provide a valuable “intermediary space” for urban youth, in which there are opportunities for initiative, relationships, voice, as well as more traditional academic skill-building.”<sup>29</sup>

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<sup>28</sup> “Locus of control emerged as an important resource which affected adaptation in the face of difficulties,” in Leontopoulou, S. (2006). Resilience of Greek youth at an educational transition point: The role of locus of control and coping strategies as resources, *Social Indicators Research*, 76, 95-126.

<sup>29</sup> Kirshner, B. (2004). Democracy now: Activism and learning in urban youth organizations. Dissertation. School of Education and the Committee on Graduate Studies, Stanford University, CA, p. 16.

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<sup>27</sup> Winnicott, D.W. (1971). Transitional objects and transitional phenomena, in *Playing and Reality*. Philadelphia, PA: Rutledge.

Using this framework of transition as our guide, we have incorporated the concerns raised by the Youth Initiative Work Group, the principles of the TIP and WAVE models, the experience of youth, staff and managers at the TIP model sites, and the principles of the rights-based approach. We pertinently identify problem areas in relation to systems, clients, services, programs, and staff competency

levels. To this end, the recommendations that follow are organized around the following four problem areas: Disconnection between the Child and Adult Mental Health Service Systems; Disempowered Youth; Absence of Effective Programs and Services; and Workforce Development: Training and Technical Assistance.

# Disconnection between the Child and Adult Mental Health Service Systems

As we made clear in the overview, regardless of whether it is preferable to advocate for the creation of a third transition-age system or modification of the present child and adult systems, it is urgent that this disconnection be repaired as soon as possible so that a young adult does not feel that she is falling off a cliff, or that there is an insurmountable gulf between the two worlds. To place this in a larger context, New York is just one of most states that do not have mechanisms in place that support transition. We might look to the exceptions to help us reformulate our approach to transition on a systems level. As Davis and Hunt (2005) point out, Maryland is a prime example in which the eligibility requirements for the vast majority of services are the same. In Vermont, transition coordinators are responsible for identifying young people who do not meet eligibility criteria in order for them to receive special services funded by the adult system.<sup>30</sup> By establishing a connection between these service systems, a young person might feel a necessary sense of continuity of care, which is consistent with a recovery-facilitating approach. In this vein, he will sense that there is an ongoing, secure base that will shore up his resiliency and encourage him to soar so that he can eventually emancipate himself from the system, and thereby avoid the destructive fate of isolation, self harm, substance abuse, deficient literacy levels, unemployment, gang life, or incarceration that arise, in part, from this disconnection.

<sup>30</sup> Davis, M. & Hunt, B. (2005). *State efforts to expand transition supports for young adults receiving adult public mental health services*. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. Rockville, MD. See in particular pages 10-12, which focus on “Comprehensive System-Building.”

## Recommendation #1

### Eligibility Requirements

**Create a work group to study eligibility requirements for child and adult mental health service systems and modify diagnostic and programmatic discrepancies accordingly to facilitate access to the adult mental health system for youth with SED.**

- The work group, initiated by New York State Office of Mental Health (OMH), should include members from the Coalition of Behavioral Health Agencies (CBHA), experts in adolescent psychiatry, parent advocates, and the New York City Department of Health and Mental Hygiene (DOHMH) child and adult divisions to promote access to adult services for those who are aging out of child services.
- Identify priority programmatic areas, such as case management and residential, to address incongruous points of program access impeding on transition from child to adult services; include a review of Child Single Point of Access (C-SPOA) and adult SPOA.
- Consider: i) adjusting regulatory definitions of Seriously and Persistently Mentally Ill (SPMI) and Serious Emotional Disturbance (SED) that hinder service continuity; ii) “grandfathering” adolescent clients in need of adult services into the adult system; iii) creating a mechanism for automatic eligibility for specific adult services, such as case management, if the individual meets child system criteria; and v) extending eligibility within child services to, for example, age 25.
- Parallel to this process, state and city planning documents should include a section dedicated to addressing the needs of transition-age youth; a DOHMH advisory forum should be dedicated to transition issues.

Presently, providers struggle with making referrals to the adult system because criteria are not as broad as in the child system, which better addresses the needs of emotional disturbance. This becomes a real issue of concern when adolescents are aging out of services and is particularly the case in terms of eligibility requirements. While an Axis I diagnosis is needed in either system to access services, childhood disorders related to behavioral problems (conduct disorder, oppositional defiant disorder, ADD/ADHD) do not easily translate into an adult Axis I diagnosis. For an adult diagnosis, these behavioral disorders are more in line with the Axis II personality disorders, which do not meet eligibility requirements. Beyond the question of diagnosis per se, Work Group participants note that the adult system does not approach the young adult with adequate understanding of the developmental tasks and challenges of the transition-age period, which makes it difficult to identify services for young people in need. For example, ACS staff note the discrepancy in accessing services in an ER for hospital care for a 17 year old in comparison to an 18.5 year old. The older youth will meet with more rigid criteria for inpatient services, i.e. needing to present with acute psychosis or stating the presence of suicidal intent at that very moment, whereas child/adolescent access is more flexible. Older youth presenting with serious borderline, anti-social disorders, or trauma related disorders will not meet hospital criteria, even if it is recommended by an agency clinician. The discrepancies regarding eligibility criteria are arguably at issue *both* for youth transitioning between systems *and* for those attempting to access services for the first time because diagnostic criteria as well as clinical approach do not reflect the needs of the transition-age individual with SED.

## Recommendation #2

### Adult Mental Health Services

#### **Modify adult mental health service programming to better address the particular needs of older adolescents/young adults through specialized transition support services that are developmentally appropriate.**

- OMH should endorse changes within Continuing Day Treatment (CDT) programs, resulting in: i) a “specialized track” for young adults which, along with social and clinical support, focuses on the transitional domains of education, employment, housing, and community participation and ii) the transformation of one CDTP per borough into a specialized young adult program for 18-30 year olds.
- OMH should establish guidelines for specialized youth services in new Personalized Recovery Oriented Services (PROS) Programs.
- Children’s and adult case management and Assertive Community Treatment (ACT) teams must be competent to address transition-related issues and service coordination for individuals shifting from child to adult service provision. Mandatory core training should be modified to meet transition competency standards.

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At the present time, precious few adult programs can meet the needs of transition-age young adults, due to lack of understanding of the specific needs of transition-age young individuals and/or lack of resources in terms of budgetary limitations or in staff availability and/or competency. This absence imposes a lack of continuity of care between service systems that inhibits connection to the adult system and subsequent recovery.

**Recommendation #3**

**Child Mental Health Services**

**Extend services in child mental health programs.**

- Establish flexible financial mechanisms to assist providers to offer formal post-discharge support services to young people leaving residential and outpatient programs.
- For Family-Based Treatment (FBT), extend financial support to agencies for families to sustain relationships with transitioning youth up to the age of 21.
- For Residential Treatment Facilities (RTFs), incorporate services that better prepare young people for living more independently in their communities.
- Re-formulate Family Support Service Programs through pending DOHMH scope of service and RFP process to include the allocation of resources for transition specialist positions.

Typically, when an adolescent is discharged from a program due to age limitations, there are no formal mechanisms that facilitate his return to that place of attachment. Work Group participants report that they welcome back clients on an informal basis or that they make follow-up calls to discharged clients to track their progress, but that this is insufficient to meet the needs of this particular population, for whom attachment is a core, vulnerable issue.

There are 10 OMH licensed Family-Based Treatment (FBT) programs in New York City, serving up to a total of 240 young people at any given time. In these programs, which train and support professional parents through home-based treatment, the discharge process inhibits on-going connection to the family of attachment, be it a foster or a professional family. This lack of connection, as well as the disconnection between systems, retriggers the very trauma of separation that the young person has endured and hopes to surmount. Although ACS can work with youth up until the age of 21, OMH formally requires FBT to discharge at age 18. There is a need to address this difference to ensure the successful transition into adulthood by implementing aftercare transition services within FBT. At the same time that a discharge plan is being developed, additional services that could be provided by a transition coordinator could support both professional parents and the needs of young people.

**Recommendation #4**

**Transition-Age Services**

**Enhance existing Adolescent Skills Centers in the five boroughs.**

- DOHMH should utilize adult division funds to expand the capacity of Adolescent Skills Centers. Ensure that increased capacity preserves small class or group size and that the Centers continue to be funded by non-Medicaid dollars.
- Extend program age limit to 25 years.
- Integrate principles and approaches reflecting the Transition to Independence Process (TIP) System, and emphasizing youth participation, education, employment, and housing outcomes. Ensure collaborative mechanisms for addressing mental health needs.

The Adolescent Skills Centers reflect the developmental needs of young people and facilitate the transitional process in substantial ways: i) currently, discharge occurs between 21 and 23 years at these Centers, rather than at 18 years; ii) they implement mechanisms for connections to the community in terms of employment, education, and civic engagement; and iii) they promote youth participation on programmatic and administrative levels. Enhancing their ability to work with young adults up to age 25 will strengthen their ability to ensure stable connections to the community and optimal functioning.

**Recommendation #5**

**Medicaid Coverage**

**Extend Medicaid coverage to transitioning youth, at least until age 21.**

- Create services and supports to help young adults successfully navigate the Medicaid system to ensure coverage.

Under the present system, at age 18, a young adult must reapply for Medicaid, unless he or she remains in foster care due to an Exception to Policy (i.e. if a Permanency Plan has not been completed); in this case, Medicaid will remain active. Without coverage, Medicaid-funded mental health and health services are severely compromised.

Although states can opt to cover youth up to the age of 22, not all states have chosen to do so.

For young adults, meeting eligibility criteria is daunting at best, as they must be aware of regulations regarding income, enrollment in full-time educational programs, parental income if the young adult is still living at home, or immigrant/citizenship status, as well as the review process for eligibility every 12 months. Indeed, there are at least 25 eligibility categories for Medicaid, depending on which options a state will choose. As O'Connell et al. point out,

“Medicaid covers more Americans than Medicare or any other health insurer, yet many people living in poverty are not eligible for this program. This is because Medicaid covers only those people who fit within special categories of eligibility and who meet the program’s stringent income and resource eligibility requirements.”<sup>31</sup> Young people need specialists to help them best utilize Medicaid coverage.

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<sup>31</sup> O'Connell, M., Watson, S., Butler, B., & Straube, D. (2004). *Introduction to Medicaid: Eligibility, federal mandates, hearings and litigation*. Southern Disability Law Center. <http://www.nls.org/conf2004/medicaid-intro.htm>.

# Disempowered Youth

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To speak, and to be heard, confirms and validates our existence. The expression of hope, of pain, of dreams, of unbearable anguish finds relief when it is received, contained for us, responded to with respect, by others. For children and adolescents, whose views, ideas, and feelings are all too often discounted, to provide them with the opportunity to speak and be heard is to give them value, from which will grow self-esteem, self-determination, in short, a core sense of dignity. As stated in the opening lines of the preamble of the United Nations Convention on the Rights of the Child (CRC): “recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world.” Indeed, providing children with the right to speak is not merely an opportunity that we may choose to give, but rather, an obligation, one that recognizes their inalienable rights that we must uphold and advocate for.

Ratified universally on November 20, 1989, with two exceptions, the CRC represents an incalculable stride in the history of human rights with its emphasis on children, who, all too often, have been stripped of their “inherent dignity” and whose voices have been silenced. The fact that the United States (and Somalia) did not ratify the Convention, and are therefore not bound by its provisions, is, according to John Tobin, “in many ways irrelevant... the underlying values and policies that inform the CRC and its rights-based approach are more significant than its legal status. As such they provide an alternative model for informing the design, delivery and implementation of policies regarding children, irrespective of the CRC’s legal status.”<sup>32</sup>

We can therefore look to the CRC as both a normative standard, as it has been almost universally accepted, and an inspiring alternative model that can help transform both practice and approach to working with transition-age youth. It is important to note that the CRC does not pit children against parents in its advancement of children’s rights, but rather, “involves a tripartite relationship of accountability between parents, the State and the international community... [with] parents or other legal

guardians hav[ing] primary responsibility for the upbringing and development of their children.”<sup>33</sup> The CRC sets the standard for state accountability regarding care and protection, which parents can advocate for in the name of their child.

The Right to Participation is one of the four general principles of the rights-based approach and is stipulated in article 12 in the Convention; it relates to other fundamental rights regarding self-expression throughout the document (freedom of expression, freedom of thought, conscience and religion). As John Tobin states most eloquently: “The obligation to respect the views of children in all matters affecting them demands a radical shift in the treatment of children from benign objects to active participants in all decision making at all levels of society.”<sup>34</sup> Being recognized as a partner in treatment should be considered a first step in this decision-making process. In this regard, the Youth Initiative Work Group and TIP experts recommend the use of person-centered, goal-oriented treatment, especially concerning vocation, education, and living situation.

Recognition of one’s inherent dignity and the right to participation are consistent with the foundational tenets of the recovery movement, predicated on the necessity of empowering individuals with mental illness to reclaim control over their lives. Patricia Deegan, who has been instrumental in articulating the vision of the recovery movement, describes her interaction with her psychiatrist during her third hospitalization at age 18: “The psychiatrist was telling me that my life, by virtue of being labeled with schizophrenia, was already a closed book. He was saying that my future had already been written. The goals and dreams that I aspired to were mere fantasies. . . he did not see me. He saw an illness.”<sup>35</sup> In stark opposition to this experience, the process of recovery is specifically driven by the very goals and dreams of the individual. The narrative of a person’s life is written by the individual in her own

<sup>32</sup> J. Tobin (personal communication, June 25, 2007).

<sup>33</sup> Tobin, J. (2006). Beyond the supermarket shelf: Using a rights based approach to address children’s health needs. *International Journal of Children’s Rights*, 14(3), 275-306.

<sup>34</sup> *Ibid.*

<sup>35</sup> Deegan, P. (1996). Recovery as a journey of the heart. *Psychiatric Rehabilitation Journal*, 19(3), 92.

unique voice. To this end, and in keeping with a recovery facilitating approach, the provider community and all related systems and personnel need to shift their perspective from the young person as *client* to the young person as *partner* in treatment.<sup>36</sup>

Recovery can thus be understood as a reconfiguration of one's identity to incorporate (rather than be defined by) one's experience with mental illness. As J. Tyler (WAVE expert) explained it in his training seminars at the Coalition, if an adolescent is always on the receiving end of services, his identity will be constructed around being an object of treatment: "Those who seek necessary assistance from human service providers can ironically deepen their feelings of helplessness, hopelessness and worthlessness as they become dependent upon helping professionals."<sup>37</sup> If the young person is encouraged to take on a role of responsibility in the community, he will learn not only civic responsibility, but will experience a deep sense of self-worth by giving to others in need. Both the WAVE and TIP models strongly advocate for youth participation by creating leadership associations at agencies to promote decision-making, imparting the understanding of democratic processes, and providing the opportunity for pride in whatever activities the young people wish to engage in. Rusty Clark sees youth voice as playing an integral role in agency and community culture, with the success of treatment actually hinging on the participation of young people and their families. The recent Annapolis Coalition report emphasizes this shift in the role that families play in treatment: "Families have moved from being seen as the cause of problems and recipients of care to key partners at all stages of the service system, from policy planning and development of services to treatment planning and delivery of care for their children."<sup>38</sup>

By encouraging young people to actively participate in the social and political life of their communities, agencies are promoting the critical value of *having a say* in the decisions

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<sup>36</sup> "Young people and families need to be viewed as partners rather than clients of the system. They need to be involved in creating and implementing programs and services," in Matarese, M., McGinnis, L., & Mora, M. (2005). *Youth involvement in systems of care: A guide to empowerment. Reflections from the field*. Technical Assistance Partnership. Washington, DC, p. 3.

<sup>37</sup> J. Tyler (personal communication, June 11, 2007).

<sup>38</sup> Annapolis Coalition on the Behavioral Health Workforce. (2007). *An action plan for behavioral health workforce development*. Ohio: Cincinnati, p. 176.

that affect them and their families. Without such participation, there is little chance that young people can revise their perception of helplessness when it comes to shaping social policy.<sup>39</sup> As stressed by Benjamin Kirshner (2004), a vibrant democracy depends on the civic engagement of its young people. Not only do young people assert their vision in their communities through such engagement, but they learn the valuable skill of "critically assess[ing] their surroundings while seeking solutions to the problems they identify."<sup>40</sup> What greater sense of self-efficacy can one have than to be engaged in such a process of advocacy? In terms of adolescent development, in the *Eight Ages of Man*, Erikson identifies this period as *Identity vs. Role Confusion*, a pivotal moment in a young person's life as he unbinds himself from parental authority in the quest to create meaning for himself on his own terms. "In searching for the social values that guide identity,"<sup>41</sup> the adolescent is forming an all-important ethics for existence. How society reflects back this identity to a young person is of the utmost importance in that policies, which have become increasingly punitive, restrictive, and oppressive, can only contribute to a self-image of uncontrollable, dangerous, and degenerate youth. If, on the contrary, agencies can revise this culture by reflecting back the value and importance of youth voice, then their self-image will likewise be fashioned in this positive vein and, ultimately, social policy will be informed by this positive image of youth.

It is the feeling of Youth Initiative Work Group participants, John Tobin, and TIP and WAVE experts that we need to do more to protect the dignity of adolescents and their right to participation. Too many decisions are made *for* them in the culture of agency life, which deprive them of the control that they desperately need to exert over their lives. By advocating for youth voice, we are essentially advocating for them to take ownership of and responsibility for their existence as active members of their communities. The Youth Involvement in Systems of Care

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<sup>39</sup> "Young Americans in the past two years have lost some of their trust in government, other people and their own ability to make a difference in their community." Results from a *USA Today* survey. (2004, January, 16). [http://www.usatoday.com/news/politicsselections/nation/2004-01-16-youngvoters-gns\\_x.htm](http://www.usatoday.com/news/politicsselections/nation/2004-01-16-youngvoters-gns_x.htm).

<sup>40</sup> Kirshner, B. (2004). *Democracy now: Activism and learning in urban youth organizations*. Dissertation. School of Education and the Committee on Graduate Studies, Stanford University, CA, p. 3.

<sup>41</sup> Erikson, E. (1963). *Eight ages of man*. (Chapter 7, p. 263). *Childhood and Society*. NY: W.W. Norton & Company.

manual makes this relationship tangible: “Young people should grow up in communities, not programs. . . . All young people need to feel a connection and a sense of belonging and will seek out ways in which they can meet their basic physical and social needs, as well as build competencies that they feel are necessary to participate in society.”<sup>42</sup> An agency can act as a microcosm of this community, in which young people can be given the opportunity to make a difference in the world they live in. Moreover, the agency should act as a bridge to the community beyond its doors, and promote youth voice in the neighborhood, the city, the state, and beyond so that incrementally, a young person in transition can understand the role he can play and what he can do to shape his future. And when he is ready for “discharge,” he will already be a valued member of society. The recommendations that follow address specific ways that mental health agencies and external services can give back the voice to young people.

**Recommendation #6**

**Youth Participation**

**Promote youth participation as a best practice in agency and community life.**

- Providers should establish mechanisms for formal input in the areas of treatment, education and advocacy, e.g. case-based reviews, youth leadership councils, youth speaker bureaus, advisory, and other committees.
- OMH and DOHMH should develop and integrate Youth Peer positions into Home and Community Based Services Waiver Program, Adolescent Skills Centers and other settings. Responsibilities include outreach, civic engagement, social support, gang prevention, smoking prevention, and mentoring.

In assessing the contributions to The Youth Initiative Project at the Center, program approaches and activities that integrate youth voice figure at the top of the list. Such activities can include a range of options, such as providing young people with the opportunity to identify community resources and plan community outreach, social, and artistic

<sup>42</sup> Matarese, M., McGinnis, L., & Mora, M. (2005). *Youth involvement in systems of care: A guide to empowerment. Reflections from the field*. Technical Assistance Partnership. Washington, DC, p. 4.

initiatives through their own efforts, with the consulting guidance of an agency staff member; youth participation in agency steering committees and program planning; avenues for civic activism and participation in advocacy efforts at the local, state, and federal level; and peer mentoring and outreach as a viable form of youth support. We also draw attention to the fact that young people and families can access support from youth and family advocates through the Coordinated Children’s Services Initiative (CCSI), established to improve the system of care in New York City and serving teens with major psychiatric illness.

**Recommendation #7**

**Employment**

**Increase financial and other resources to enhance youth access to early employment opportunities.**

- Integrate effective job readiness skills training, such as WAVE curriculum, into children’s Day Treatment and adult CDTP activities.
- DOHMH and OMH should accept “transitional” and time-limited employment among young adults (18-25 years) as a viable outcome in supported employment programs including ACE (Assisted Competitive Employment).
- Utilizing flexible funding mechanisms, OMH, DOHMH, and the Department of Youth and Community Development (DYCD) should support youth internships and temporary stipend-reimbursed employment, which build basic employment and career readiness skills.
- With additional contractual funds, providers should introduce proven cognitive remediation techniques into outpatient programs and Adolescent Skills Centers to address barriers to education and employment.
- Vocational and Educational Services for Individuals with Disabilities (VESID) should i) address career exploration needs of youth disconnected from school through incorporation of situational assessments (exploring functional and motivational readiness) and protocols that support informed choices in employment pursuits and ii) enhance transition services and increase the number of counselors within the transition units of NYC district offices.

Radin (1997) clearly establishes for us the relationship between participation and employment: “Having a job is critical to a feeling of being seen as a contributing member of our society.”<sup>43</sup> Securing that job, especially for young people with emotional difficulties, is often the culmination of a process—with profound implications—, beginning with their hopes and dreams, which many no longer dare to articulate. Consistent with a strengths-based and person-centered approach to treatment, it is imperative that young people participate to the fullest extent possible in the process of choosing a career path and selection of internship and employment possibilities. Second, preparing young people for the world of work arguably enhances their chances of success.<sup>44</sup> The WAVE Job Readiness Curriculum (taught at the Center of Rehabilitation and Recovery) integrates into its program 11 competency areas that seek to prepare a young person for life (e.g. effective interpersonal skills, demonstrating positive attitudes and behaviors), as well as teaching the hard skills necessary to meet the demands of employment (preparing resumes, maintaining regular attendance). By affording young people this opportunity for preparation, agencies directly build self-confidence and optimal self-expression. It is not enough, however, to dream and prepare, as Marrone and Golowka (1999) assert. Assisting people in getting a job is crucial to any employment trajectory. From a prevention point of view, “the longer people delay their vocational aspirations, the more danger they face of insufficient work experience for career advancement.”<sup>45</sup> It is therefore incumbent upon practitioners to create the bridge between the agency and the world of work by, for example, partnering with schools and VESID to support a system that will provide training and give credit for an employment practicum;<sup>46</sup> accessing summer youth employment; partnering with employers for internships and other transitional work options; or implementing supported employment, an evidence-based

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<sup>43</sup> Radin, C.A. (1997, February 9). Ready, willing, and disabled. *Boston Globe Magazine*, p. 17.

<sup>44</sup> “The more vocational services participants received, the better the employment outcomes they achieved, especially among those receiving job development services,” in Cook, J.A. & O’Day, B. (2006). *Supported employment: A best practice for people with psychiatric disabilities*. Cornell University Institute for Policy Research. Washington, DC, p. 2.

<sup>45</sup> Marrone, J. & Golowka, E. (1999). If work makes people with mental illness sick, what do unemployment, poverty, and social isolation cause? *Psychiatric Rehabilitation Journal*, 23(2), p. 190.

<sup>46</sup> At the time of the writing of this report plans are underway to implement the Model Transition Program demonstration project, spearheaded by VESID in partnership with high schools and community-based organizations.

practice that upholds the values of integrated competitive work and rapid job search, as defined by Bond et al. (2001).<sup>47</sup>

Programs can provide further support to young people by effectively assessing and addressing cognitive deficits which so often present as barriers to job performance and tenure. The Work Group recommends the use of proven cognitive remediation techniques that, through engaging and fun computer games, foster executive functioning, i.e. problem-solving, attention and concentration, memory, recall and decision-making. It is necessary to apply these skills to the specific work context; cognitive remediation specialists can translate skill-building into the workplace with the assistance of employment staff who have an in-depth understanding of job expectations and employer needs. Susan McGurk and colleagues have written on the effectiveness of cognitive training in improving employment outcomes among adults with mental illness.<sup>48</sup> More extensive information on cognitive remediation can be found at the Center’s website at <http://www.coalitionny.org/ccrr/projects/>.

In her presentation to the TIP Community of Learning at the third Cross-Site Forum at the Coalition, Robin Sklarin, Program Director of Staten Island Mental Health’s SafeTY.net, who has over twenty years of expertise in the area of vocation/employment for young people with SED, makes a very convincing argument for an employment approach that links job preparation with actual job experience: “Without this bridge into the real world, young people cannot understand the expectations of employers.” SafeTY.net, an Adolescent Skills Center that serves the transition-age population to age 23, receives funds to offer stipends to clients participating in the workforce. This stipend approach has proved to be an important incentive for creating relationships with employers who otherwise would not be receptive to working with this population. Young people gain from the monetary incentive to work and, crucially, obtain real skills in the employment setting. Finally, according to Robin Sklarin, stipend employment opportunities turned into real job offers fifty percent of the time, which is an astounding rate, considering the emotional and mental challenges of the clients she works with and the difficulties young people face in general in procuring jobs.

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<sup>47</sup> Bond, G.R., Becker, D.R., Drake, R.E., Rapp, C.A., Meisler, N., Lehman, A.F., Bell, M.D., & Blyler, C.R. (2001). Implementing supported employment as an evidence-based practice. *Psychiatric Services*, 50(3), 313-322.

<sup>48</sup> McGurk, S.R., Mueser, K.T., Pascaris, A. (2005). Cognitive training and supported employment for adults with severe mental illness: One-year results from a randomized controlled trial. *Schizophrenia Bulletin*, 31(4): 899-909.

VESID is the Federal-State vocational rehabilitation agency mandated to assist individuals with disabilities, including psychiatric, in returning to work. Mental health providers working with VESID note that VESID counselors do not seem to be able to help young adults choose a career path and that they cannot provide employment aid unless the person already knows what career path he/she would like to take. This may be due to a number of factors including VESID's mandate and responsibilities as compared with other agencies, such as the DOE, and counselors' caseloads and their training. It is important, however, that VESID counselors expand their abilities to support young adults by assertively outreaching to those disconnected from school and helping youth to identify a career that matches both interests and abilities. Moreover, young adults would better benefit from VESID if the criteria for success were modified to match the realities of finding and maintaining employment, which change as the young person hones his or her readiness for the world of work. Losing employment should therefore not be associated with failure, but rather be understood as part of the learning process. Mature adults sponsored by VESID have different vocational needs, whereas young adults often change jobs and increase their social and technical skills with each experience. Changing jobs is part of the continuum of entering the working world, and should be factored into criteria for success by all entities charged with assisting individuals with mental health disabilities in attaining work.

## Recommendation #8

### Education

#### Improve the educational level of young people with SED.

- Educational programs of study in Residential Treatment Facilities (RTFs), Day Treatment Programs and State Children's Psychiatric Centers should be reviewed and enhanced to include pre-GED curriculum to effectively address remedial literacy needs.
- Provide resources to integrate supported education and literacy services into clubhouses, adult supported employment and pending PROS programs.
- Establish links between higher education, mental health agencies, VESID and high schools so that students with SED or disabilities can be better prepared for the world of higher education and college-level expectations.

Many young people with SED have been victim of physical or sexual abuse, neglect, or object of or witness to violence, which have severely traumatized them. The relationship between trauma and learning ability—complicated, moreover, by subsequent difficulties in affect regulation—has long been established, as the seminal work of Van der Kolk and others has made clear.<sup>49</sup> We see how this plays out locally in the New York State Commission on Quality of Care and Advocacy for Persons with Disabilities recent report on Residential Treatment Facilities, which indicates that the majority of the residents have “significant trauma histories,” and specifically establishes the relationship between trauma and cognitive impairment.<sup>50</sup> Analyses pertaining to the National Adult Literacy Survey (NALS) point to a clear association between “mental illness [and] low literacy skills and limited literary practice.”<sup>51</sup>

How does the problem of emotional disturbance and literacy play out on the ground? According to Advocates for Children of New York, “96% of children classified as having an ‘emotional disturbance’ leave school without a diploma.”<sup>52</sup> In this same population, 38% drop out of school, which represents a higher rate than those who are classified as learning disabled.<sup>53</sup> As their report indicates, the percentage of students in special education graduating with diplomas in New York City falls far behind the state and national averages (at half the state-wide rate and one third of the national rate).<sup>54</sup> Clearly this problem has taken on significant local proportions, due to the lack of transition

<sup>49</sup> See, for example, Van der Kolk, B.A. (1989). The compulsion to repeat the trauma: Re-enactment, revictimization, and masochism. *Psychiatric Clinics of North America*, 12(2), 389-411.

<sup>50</sup> New York State Commission on Quality of Care and Advocacy for Persons with Disabilities (2006, June). *Residential treatment facilities: The experiences of 60 youths*, pp. 14-15. Of the 60 young people under study, “over two-thirds [had] a documented history of neglect and 70 percent [had] a documented history of either physical or sexual abuse,” p. 14.

<sup>51</sup> Sentell, T.L. & Shumway, M.A. (2003). Low literacy and mental illness in a nationally representative sample. *Journal of Nervous and Mental Disease*, 191(8), p. 550.

<sup>52</sup> Advocates for Children of New York (2005). *Leaving school empty handed: A report on graduation and dropout rates for students who receive special education services in New York City*. New York, NY: p. 2. <http://www.advocatesforchildren.org/pubs/2005/spedgradrates.pdf>.

<sup>53</sup> *Ibid.*, p. 31.

<sup>54</sup> *Ibid.*, p. 24.

services within the DOE.<sup>55</sup> Addressing literacy needs would no doubt serve a preventive purpose, as it is important that adult development not be hampered by problems related to verbal ability and reading skills.

Programs in New York City, within the purview of both the mental health community and the Department of Education, have begun to address the problem of literacy. City Hall is actively addressing this problem: “In an effort that has expanded across Mayor Michael R. Bloomberg’s second term, the city has spent nearly \$37 million to identify and cater to students who are at the biggest risk of dropping out and has already contracted for \$31 million more in programs. . . . The city has established special centers to provide counseling, night classes and an environment designed to avoid the stigma of being college age but in class with 14-year-olds”.<sup>56</sup>

The establishment of five Adolescent Skill Centers in New York City by DOHMH represents a vastly important stride in addressing the problems of literacy as well as employment. In his special presentation to the Youth Initiative Work Group, Anthony Diaz, Director of Adolescent Services at the Mental Health Association of New York City, talked about the fact that the vast majority of young people referred to that program are at least four years below grade level in reading and math. He discussed the strategies that he uses to enhance academic study, such as reducing class size; addressing mental health concerns as soon as possible and providing a safe environment for students to express frustrations; attaching a prevention program to curriculum that offers group counseling and workshops that relate to emotional concerns; educating parents regarding mental health; and offering a psychodrama group that encourages students to write scenarios relevant to their lives and the obstacles they face, and which promotes literacy through a creative approach. (See page 22 in relation to Adolescent Skills Centers).

In the context of adult programs, a supported education model<sup>57</sup> could effectively help young adults achieve

<sup>55</sup> See the excellent analysis by Marc Silverman (2007, September). *Transitioning to nowhere: An analysis of the planning and provision of transition services to students with disabilities in New York City*. Advocates for Children of New York, Inc. [http://www.advocatesforchildren.org/pubs/Transitioning\\_to\\_nowhere\\_final\\_report.pdf](http://www.advocatesforchildren.org/pubs/Transitioning_to_nowhere_final_report.pdf).

<sup>56</sup> Medina, J. (2007, August 21). More students finish school, given the time. *The New York Times*, A1.

<sup>57</sup> See, for example, Mowbray, C.T., Brown, K.S., Furlong-Norman, K., & Soydan, A.S. (2002). *Supported education & psychiatric rehabilitation. Models and methods*. Linthicum, MD: International Association of Psychosocial Rehabilitation Services.

educational goals by facilitating the connection to school and providing individualized support as needed. Fountain House is an example of a clubhouse that has over time successfully offered supported education services in its Young Adult Program. The Work Group recommends that similar services be integrated into other community-based settings, with the ultimate goal of procuring a job and building a career.

It is important to note that students with mental illness with a wide range of diagnoses do in fact succeed in college. Students in special education programs should be encouraged to transition to higher education to increase their possibilities for success in employment. According to Matthew Joffe, Director of the Office for Students with Disabilities at LaGuardia Community College, the disconnection between secondary and post-secondary education results from a lack of options for this population that translate into inappropriate academic settings, program priorities that do not promote higher education, and lack of understanding of college requirements. In mental health and educational settings, it is therefore important to inform young people about college and create opportunities for workshops, financial aid and the application process. VESID’s new CUNY Project, which strives to identify students on campus and provide services that help youth complete school and then connect with employment through placement services, has promise in bridging the gap between higher education and employment. Education needs to be discussed by all as a viable option. It would be extremely helpful if mental health workers could maintain dialogue with the individual as well as with the college after discharge.

### Recommendation #9

#### Racism in Public Schools

**DOE should make addressing the problem of racism a priority in staff development.**

- DOE should educate support staff and teachers in the public school system about racism and the way it impacts on the treatment of minorities, resulting in an over-representation of this population, especially African-American students, being labeled emotionally disturbed.

Who are these emotionally disturbed teenagers? Dan Losen of the Harvard Civil Rights Project indicates that there is a “racial gap in achievement, in New York. . . . [There is an] overrepresentation of minority students in areas of special

education, especially with regard to the category of emotional disturbance. . . . [They] are being pushed into special ed[ucation] as a form of discipline.”<sup>58</sup> African-American students with disabilities have a far greater chance of being suspended in New York City than do Caucasian students with disabilities. Losen also points out that “about a third of all kids in the juvenile justice system are kids with disabilities [with] some estimates going as high as 75%.”<sup>59</sup> So while we are studying the correlation between mental health and literacy, it is imperative that we take into account the overwhelming factor of racism, which appears to be, in and of itself, a determining factor in the classification of Emotional Disturbance. In this regard, it is

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<sup>58</sup> Center for New York City Affairs. (2006). *Working toward a common goal: Safe, supportive schools for every New York teen*. Milano School of Management and Urban Policy, The New School, p. 4. [http://www.newschool.edu/milano/nyc affairs/trans/Working\\_Common\\_Goal.pdf](http://www.newschool.edu/milano/nyc affairs/trans/Working_Common_Goal.pdf).

<sup>59</sup> *Ibid.*, p. 6.

crucial to accurately diagnose cognitive problems, which can be misdiagnosed as behavioral problems.

The Board of Education has signaled a commitment to disconnected youth under the Bloomberg administration with the creation of the Office of Multiple Pathways to Graduation and other programs, such as the Young Adult Borough Centers and Learning to Work. Each One Teach One, a program of the Juvenile Justice Project at the Correctional Association, is exemplary in its devotion to helping young people learn to advocate for themselves. Clearly, there are multiple efforts underway around the city and the funding of some innovative programs. However, much more needs to be done in terms of creating a cross-systems, collaborative effort so that the link between literacy, mental health, racism, and delinquency is undone. We need to teach our children well, so that their voices will become powerful instruments of social inquiry and change.

# Absence of Effective Programs and Services

How can agencies working with youth with SED provide the most effective kinds of services to facilitate a successful transition to adulthood? Through its multiple seminars, experiences, site visits, and discussions, the Youth Initiative Project at the Coalition has determined that, regardless of the setting, young people will most benefit from services organized around two inter-related principles: connection and transition. It is especially important for young people who do not have a home base to return to after discharge or who suffer from isolation that service providers create viable connections beyond the doors of the agency so that they have a home in the world. In this regard, one of the TIP model sites—Bonding Links program at The Coalition of Hispanic Family Services—came to the conclusion that prevention services in Family-Based Treatment must begin in the earlier years of adolescence to foster a network of connections as early as possible for those young people who will not have a family base following discharge.

Services that best reflect these principles will engage in a partnership with young people, so that they may experience:

- a secure base and trusting relationships with peers and staff;
- an active role in agency and community life;
- a basic, working knowledge of fundamental life skills;
- the ability to emotionally self-regulate and other treatment modalities that specifically address mental health and emotional issues;
- positive social connections;
- family involvement in the treatment process, where appropriate;
- a solid grounding in the world of employment;
- the ability to acquire necessary educational diplomas, depending on each person's goal in this area;
- relationships in the outside world, both personal and professional, that will anchor the young person after discharge.

The recommendations which follow seek to identify best practices in existing programs in New York City in an effort

to see them implemented more broadly. Further, it outlines strategies that agencies can consider in a collaborative effort to repair the existing sense of fragmentation of mental health and other related systems.

## Recommendation #10

### Interagency Collaboration

**Government agencies—municipal, state, and federal—should take the initiative and create incentives, through technical support and funding, to facilitate the building of formal collaborations to address programmatic needs for young people with SED.**

- Collaborations should exist between mental health service providers, i.e. on an interagency level, and between systems, including mental health, criminal justice, substance abuse, child welfare and education.

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While the Youth Initiative Project supports programmatic models that are as holistic as possible, it recognizes how daunting a task it could be for any one agency to help a young person attain fulfillment in all of the areas indicated above. Indeed, fragmentation at both the service and systems level in New York City contributes to the deep frustration consumers experience as they try to navigate this disconnected landscape. To address this challenge, the Work Group strongly advocates for interagency collaboration, which must go beyond informal networking strategies to enter into real partnerships between providers and across service systems with those who can share and establish a common vision and likewise benefit from pooling resources to meet goals that will most benefit consumers. By collaboration, we are thinking of “a long-term, well-defined relationship entered into by two or more organizations to achieve common goals. It involves genuine sharing of authority, accountability, resources and rewards.”<sup>60</sup> Successful examples of such an undertaking can be seen in the TIP Community of Learning, conceived of by Rusty Clark and supported by the Center for

<sup>60</sup> Mattessich, P. (2003). Can this collaboration be saved? Twenty factors that can make or break any group effort. *Shelterforce Online*, 129, p. 1.

Rehabilitation, as a way to frame a crucial aspect of the technical support that he provided to the six TIP model sites in New York City. The model sites participated in three separate Cross-Site Forums at the Coalition between November 2006 and June 2007. They were encouraged to bring staff, youth, family members, and community partners to assess common strengths and barriers to the implementation process and inspire each other through strategies and activities that have been successful at their agencies. A second noteworthy example of collaboration in New York City is the CCSI (Coordinated Children's Services Initiative [see p. 26]) which is designed to promote cooperative inter-agency planning and service delivery within multiple systems and includes families as integral partners in the Initiative.

While there are tangible barriers to interagency and cross-systems collaboration, including role definition, discrepancies in terminology, and fiscal and reporting inconsistencies, real solutions can be found to surmount such barriers, involving deep commitment, strong leadership, cross-training, inclusion of families and consumers, on-going communication between key stakeholders, shared data bases, merging of funding streams, and inclusion of staff from all levels in process meetings.

In this regard, SAMHSA's Federal Comprehensive Community Mental Health Services for Children and Their Families Program actually "requires that system-of-care communities take an interagency approach to building their systems of care."<sup>61</sup> A collaborative approach is beneficial to a community as "broad interagency participation can help paint a comprehensive picture of community needs and thus benefit a wider array of children."<sup>62</sup> Devoted to one of the most underserved, at-risk populations, Wraparound Milwaukee represents an exemplary collaborative effort to provide real support to youth with SED in the juvenile justice system as well as to their families.<sup>63</sup> The model

promotes the use of a strengths-based, person-centered approach, drawing on the integrated resources of the mental health, juvenile justice, child welfare, and education systems. The philosophy grounding this program is committed to desegregation (placing delinquent and non-delinquent youth together in a residency), with the goal of reuniting young people with their families or caregivers as soon as possible. The program supports this endeavor both prior to and post-unification, employing a team approach to identify and address specific issues, e.g. the Child and Family Team and the Mobile Crisis Team. The outcomes—on both a clinical and financial level—are more than promising, with a huge reduction in recidivism, a 60% decrease in residential treatment, 80% decrease in in-patient psychiatric hospitalization, and a decrease from \$5,000 to \$3,000 per month in cost per child.<sup>64</sup> Similarly, in a collaborative project in Maine involving coordinated mental health and substance abuse providers, outcomes indicate "a cost-effective approach to maximizing current resources and improving the local delivery of services."<sup>65</sup> These outcomes are all the more inspiring in light of the historical breach between mental illness and substance abuse service providers that has arguably failed the adolescent and adult dually-diagnosed population. In this regard, it is promising indeed that a New York state-wide collaborative effort between the Office of Mental Health and the Office of Alcoholism and Substance Abuse Services was recently announced (in June 2007) to better address the needs of those who are dually-diagnosed (i.e. Task Force on Co-Occurring Disorders).

Community collaboration creates a process through which there is the greatest opportunity for representation of consumers and key stakeholders who participate in decision-making processes and, in this regard, reflects to the greatest possible advantage the values of a democratic society.<sup>66</sup> Embedded in community collaboration, therefore, are the very same values that we advocate for in terms of youth voice and the right to participation.

<sup>61</sup> Center for Mental Health Services. Substance Abuse and Mental Health Services Administration. (2002, January). *System-of-care evaluation brief. Interagency collaboration in systems of care*, 3(4), 1. U.S. Department of Health and Human Services.

<sup>62</sup> *Ibid.*

<sup>63</sup> It is important to note that the vast majority of these young people were diagnosed with conduct disorder (97%), in Kamradt, B. (2000). *Wraparound Milwaukee: Aiding youth with mental health needs. Juvenile Justice Journal*, 7(1), p. 1

<sup>64</sup> *Ibid.*, p. 9.

<sup>65</sup> Ridgely, M.S., Lambert, D., Goodman, A., Chichester, C.S. & Ralph, R. (1998). Interagency collaboration in services for people with co-occurring mental illness and substance use disorder. *Psychiatric Services*, 49, p. 237.

<sup>66</sup> See The Chandler Center for Community Leadership. *Community based collaboration. Community wellness multiplied*. <http://crs.uvm.edu/nmco/collab/wellness.html>. See also Sussman, T. (2000). Interagency collaboration and welfare reform. *Welfare Information Network Issue Notes*, 4(1). <http://www.financeproject.org/Publications/crosscuttingtara.htm>.

## Recommendation #11

### Housing

**Make beds! State and City Offices of Mental Health should continue to partner with the Department of Housing and Urban Development, the New York City Departments of Homeless Services (DHS), Housing Preservation and Development, ACS, and Youth and Community Development (DYCD) to create additional supportive housing options with on-site clinical and transitional support services.**

- ❑ Supportive transitional and permanent housing must offer comprehensive and individualized services for youth with SED transitioning out of foster, family or residential care, and for homeless youth.
- ❑ Implement on-site vocational and education services in supportive housing units. Include benefits counseling as a best practice.
- ❑ In partnership with the State Offices of Mental Retardation and Developmental Disabilities (OMRDD) and Alcohol and Substance Abuse Services (OASAS), OMH should allocate beds for individuals who are dually diagnosed with mental retardation and developmental disabilities as well as substance abuse.
- ❑ OMH wrap-around funds should be made more accessible to providers needing expertise and consultation related to individual resident needs.
- ❑ Formulate a collaboration between ACS, DOHMH, OMH, Department of Juvenile Justice (DJJ), and DYCD to establish respite beds throughout the five boroughs.

Sustaining emotional ties and a physical space together constitute the place one calls *home*. What is the best way to create housing for young adults with mental health needs? The New York State Campaign for Mental Health Housing's position paper indicates that "when community-based case management services and mainstream medical and psychiatric care are provided to people in supportive housing, quality of life improves, as do chances for long-term recovery."<sup>67</sup> Unique programs like Covenant House,

<sup>67</sup> <http://www.campaign4housing.org/position.html>.

whose doors are open to homeless and runaway young people every hour and every day of the year, report that 19% percent of the mentally ill young adults that they treat found placements in supportive housing. "The other 79% remain homeless and often return to the street because there is no place for them... there is nowhere to send these young people and there does not appear to be any thorough, state-developed programs to address this particular population's needs."<sup>68</sup>

Indeed, at every Youth Initiative Work Group session that took place during 2006-2007, participants were unanimous in their appraisal that there are not enough beds in New York City for transition-age youth. This absence is related to a broader problem, i.e. the fact that housing and related programming for young adults is rarely conceived of from a developmental perspective, and which is crucial to ensure adjustment to the challenges of adulthood.<sup>69</sup> The Ali Forney Center in Manhattan does exemplary work with lesbian, gay, bisexual, and transgender (LGBT) young people, who face inordinate discrimination in our society. The Center reports a high incidence of mental illness (approximately one third of its clients), homelessness, trauma, HIV/AIDS and substance abuse. They conceive of their services in terms of a true transition-age population, i.e. ages 16-24, with such a development perspective in mind. Safe, transitional housing is a priority, with groups of approximately six young people living together in a two or three bedroom apartment, under adult supervision. The existence of the Ali Forney Center in large part stems from the tireless efforts of its Executive Director, Carl Siciliano, who, over a two-year period, approached countless staff and elected members of City Council in a successful advocacy effort that secured funds for housing which, together with grants from private foundations, enables the Center to provide 70 beds for homeless LGBT youth.<sup>70</sup>

The findings of the Youth Initiative Work Group indicate that young adults with SED or SMI are in need of housing

<sup>68</sup> Cailin McGreevy. Presentation to the Youth Initiative Work Group. June 20th, 2007.

<sup>69</sup> See Giugliano, R.J. (2004). The systemic neglect of New York's young adults with mental illness. *Psychiatric Services*, 55(4), 451-453.

<sup>70</sup> Carl Siciliano emphasizes the importance of young people living in small groups, rather than in large numbers, as they procure a sense of family from this kind of housing arrangement. It also stands to reason that the small apartment model gives them privacy as well as a real sense of what it is like to live in an apartment on a daily basis. Carl Siciliano (personal communication, July 17, 2007).

units that provide mental health, daily living skills and other services to ensure successful transition to adulthood. The NY/NYIII effort is an excellent start, ensuring 100 congregate and 100 scattered site beds to young adults leaving foster care or who are homeless, as well as development of 200 congregate care beds for young adults in mental health settings. However, the number of teens and young adults who are homeless or who will soon find themselves with no home base far outweighs these initial efforts.

It is also the case that young adults being discharged from inpatient facilities or state psychiatric hospitals have precious few choices as they step down to less restrictive levels of care. Residential treatment-oriented facilities, both for teens (in Child/Adolescent Services) and young adults (age 18 and over), are seriously lacking in beds.<sup>71</sup> First, there are a dearth of programs for youth with severe opposition defiant, anti-social and borderline disorders; those at risk of or who are involved with the criminal justice system; and individuals with dual diagnosis with MRDD (Mental Retardation and Developmental Disabilities) or substance abuse. The Saint Christopher Otilie (SCO) campus is one of the rare residential programs that serve dually diagnosed teenagers with MRDD; in fact their referrals come from all over New York State. The SCO facility can accommodate 62 children. The vast majority of the residents present with mild retardation, with approximately 50% in foster care. The greatest difficulty the agency is facing is finding therapeutic placements (not hospital-based) for their transition-age young adults, 19 and 20 years of age, who are aging out of the program as well as out of foster care and do not have a home to go to.

In New York City, there are only 125 RTF beds, out of a total of 539 in New York State.<sup>72</sup> It should be noted that a total of 220 beds in the State are set aside for New York City residents. The RTFs are at capacity, with females facing longer waits than males. Further, as Donald Leichter, Director of Mental Health Assessment at ACS notes, the sanctuary model, while it provides necessary supervision, is not optimally designed to serve the transitional needs of teens

<sup>71</sup> Criticism of the RTF model is threefold: "Some said the problem was simply an insufficient number of RTF beds. Others said it was the limited number of specialty beds; still others said the RTF was an anachronistic model and should be replaced with smaller, community-based services (both treatment and residential)," in New York State Commission on Quality of Care and Advocacy for Persons with Disabilities. (2007, June). *Residential treatment facilities: The experiences of 60 youths*, p. ii.

<sup>72</sup> *Ibid.*, p. 3.

who must adapt to real world expectations and challenges. In the adult mental health system as well, existing residential facilities rarely integrate services designed for the young adult population, resulting in further disconnection and alienation of young adults. Overall, the options in adult services are not as creative or holistic as they are in child services.

So, while we are advocating for the procurement of additional beds, it is imperative to examine this endeavor in the context of a broad transition initiative, one that thoroughly integrates services that address both mental health and concrete rehabilitation needs (employment, education, daily living skills, etc.). We can look to the Chelsea Foyer as a particularly successful model for procuring needed support to homeless youth, especially in terms of its focus on the integration of skill-building in its services.

The Youth Initiative Work Group is in agreement with the recommendation made by Lerner and Solow in a recent study at the Center for New York City Affairs<sup>73</sup> that City Hall should revive programs that offer a temporary safe space for teens in family crisis and calls for the creation of respite centers that are used upstate but not in New York City.<sup>74</sup> The Work Group also notes Suffolk County's Crisis-Respite Bed Program, a joint effort among public and private agencies providing temporary out of home placements through the utilization of existing resources. Respite Care is far less expensive than foster care or detention and operates through host families or small independent facilities. While the teenager is in the respite center, families would receive community-based services. Respite would divert teenagers from hospitalization, which is often used when parents find themselves at the breaking point. It is a little known fact that ACS provides short-term respite services (30 days maximum) for children up to 17 years of age, in the settings of trained, certified foster parents. ACS offers more than 100 beds of respite care citywide.

<sup>73</sup> Lerner, S. with Solow, B. (2007, January). "There's no such place": *The Family Assessment Program, PINS and the limits of support services for families with teens in NYC*. Center for New York City Affairs, Milano, The New School for Management and Urban Policy. The New School.

<sup>74</sup> For further information, see the VERA Institute of Justice 2002 report: *Respite care: A promising response to status offenders at risk of court-ordered placement*, by F. Quraishi, H. Segal, and J. Trone, which provides an excellent description of respite care and a detailed study of four respite centers in the USA, including Kids Oneida in Oneida County, NY. The report can be downloaded at [www.vera.org/publication\\_pdf/188\\_356.pdf](http://www.vera.org/publication_pdf/188_356.pdf). It is also the case that in June 2006, the NASW-NYC Child Abuse Task Force strongly recommended that ACS "establish therapeutic crisis and respite care centers in every community district in New York City." See [www.naswnyc.org/childabusereport.html](http://www.naswnyc.org/childabusereport.html).

## Recommendation #12

### Drop-In Centers

**The City of New York should invest in drop-in centers with comprehensive services for disconnected youth.**

- ❑ DHS and DOHMH should establish drop-in centers, which provide meals, social activities, educational programs, on-site crisis intervention and counseling, psychosocial support for young people aging out of foster care, legal services, skill development, and active outreach.
- ❑ Drop-in programs should partner with primary health care clinics with family planning services and provide extensive referral services addressing behavioral health needs.
- ❑ Youth Peer staff/leaders and professional staff should partner in operating programs.

The Door, operated by University Settlement, is a prime example of the model of a drop-in center that the Work Group advocates for, as the observation has been that stigma associated with mental illness is a deterrent in young people's accessing services in traditional mental health settings. Clinical services that are embedded in a broad array of options are more palatable to this population. The Door provides services for adolescents/young adults from ages 12-21 in the spirit of the concepts that underpin these recommendations, as can be seen in their program description: "The Door offers a range of programs to serve the diverse young people who come to The Door seeking the services, support and guidance they need to make a successful transition to adulthood," including career development, counseling, education, health and wellness, leadership development, legal services recreation, creative arts, and specialized services for LGBT young people.

## Recommendation #13

### Life Skills

**Programs working with the transition-age population need to systematically teach life skills.**

- ❑ Programs need to fully integrate life skills teaching and facilitate the acquisition of skills and supports that are crucial to survival in the adult world.

Mastery of life skills serves to promote resilience by building coping strategies related to cognitive ability and competence. Such mastery generates higher levels of self-esteem and general well-being, which are correlates of resilience.<sup>75</sup> The importance of teaching life skills is now common knowledge, as can be seen in its incorporation in the foster care Permanency Law, which stipulates that services promoting independent living skills must commence when a child is 14 years of age. The terms of the federal Foster Care Independence Act require that young people, ages 16 and older, have in place an independent living plan, which includes expertise in daily living skills.

Participants of the Youth Initiative Work Group agree that learning about the basics of financial security is a top priority. The Child Center of New York's Job Net program, for example, has set up a Financial Freedom Group to address this need. A representative from Wachovia comes to the agency to teach these basic skills. On its end, Good Shepherd Services partners with Credit Suisse to develop curriculum pertaining to financial security. Providers might implement other daily living experiential activities that impart essential knowledge of the transportation system in New York City, meal preparation and diet, housekeeping, and self-care.

In terms of life skills, the TIP system teaches us that problem-solving and decision-making skills are instrumental to a successful transition to adulthood and, to this end, provides a specific framework to help young people acquire these skills. "Young people need skills that enable them to think clearly and make thoughtful decisions by considering the advantages and disadvantages of different options, which help lead to a feasible solution applicable to the problem at hand. If youth with

<sup>75</sup> See Leontopoulou, S. (2006). Resilience of Greek youth at an educational transition point: The role of locus of control and coping strategies as resources. *Social Indicators Research*, 76, 95-126.

emotional/behavioral difficulties make better decisions and resolve problems, they can feel empowered instead of victimized and are more likely to create the positive outcomes to improve their quality of life.”<sup>76</sup>

## Recommendation #14

### Caregiver Participation

#### **Mental health providers should increase opportunities for caregiver involvement.**

- ❑ Opportunities for participation and contribution can be enhanced through the creation of caregiver forums for information sharing and decision-making, psycho-educational support groups and collateral therapeutic work.

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Family involvement in treatment—when appropriate—is an essential contributor to recovery and securing an optimal transition into adulthood. The transformation of the nuclear family demands reconsideration of the term as we apply it to the social structure of the young people under discussion. June Horowitz discusses the concept of the family unit as a dynamic system, transformed by the socio-cultural changes of the latter portion of the twentieth century. In this regard, she applies the concept of “wider families” to the family unit, defining it as “types of social organizations that do not conform to all of the conditions applied to traditionally-defined families. Wider families emerge from people’s life-styles as voluntary social systems that are unstructured, not rule- or time-bound, independent of required kin or biological connections. Wider families fill needs of their members through support, availability, and bonds of affection and emotion. When defining parenting, diverse meanings of family must be appreciated.”<sup>77</sup>

In work with families, from a clinical perspective, providers need to ask themselves how family treatment, or inclusion of family in the treatment process, helps them rethink the boundaries of an individual. How do emotional/behavioral problems in a young person emerge from the family as a whole? How do they affect family functioning? These very

questions were asked over sixty years ago by Nathan Ackerman who increasingly found that the traditional psychoanalytic model was problematic in that it tended to isolate the young person from his/her parents and treated emotional and behavioral problems from an intrapsychic perspective, rather than conceptualizing them as embedded in a family relational process. Indeed, Ackerman was the first to identify the family as a psychological entity. He insisted that we recognize the interdependence of children and caregivers, and cease, from a treatment perspective, to separate parent and child into individualized compartments. By working with families, the therapist could promote enhanced health and growth.

In terms of transition-age youth, the desire for independence demands caution when involving family in treatment. This being said, from the standpoint of TIP and other adolescent experts, it is also clear that family participation in the treatment process greatly contributes to the building of a much needed support network, to the extent that the young person opts for such participation. “One of the most essential functions of the transition facilitator, and others who work with these young people, is relationship development... Nurturing relationship development between the young person and existing or past supports may contribute greatly to the young person’s future success as this network of supports may continue when formal key players are terminated.”<sup>78</sup> Model site participants enhanced family involvement and witnessed its positive contribution to the treatment process through implementation of parent forums and parent psycho-educational support groups. In this regard, Anthony Diaz, Director of Adolescent Services at the Mental Health Association, addressed the question of decreasing stigma associated with mental illness by offering psycho-education workshops to caregivers, which provide them with the opportunity to increase their understanding of mental health and diagnoses. MHA strives to help the young person and her caregiver(s) develop coping skills and strategies to ease transition into adulthood and inform them about medication and treatment so that they can make informed decisions, allowing for greater self-determination on the part of youth and families. He stressed the importance of providing a safe haven for caregivers through such activities.

<sup>76</sup> Blase, K., Wagner, R. & Clark, H.B. (2005). *Problem-solving and decision-making processes: The SCOCS framework*. [http://www.Mod\\_SCOCS\\_11-25-05.pdf](http://www.Mod_SCOCS_11-25-05.pdf), 142786 kb.

<sup>77</sup> Horowitz, J.A. (1995). A conceptualization of parenting: Examining the single parent family. In S.M.H. Hanson, M.L. Heims, D.J. Julian & M.B. Sussman (Eds.). *Single parent families: Diversity, myths and realities* (pp. 43-70). New York: The Haworth Press, p. 45.

<sup>78</sup> Clark, H.B. (2004). *TIP system development and operations manual*. Department of Child and Family Studies. Louis de la Parte Florida Mental Health Institute. University of South Florida, Tampa, FL. <http://tip.fmhi.usf.edu/files/TIPOperationsManual-October04.pdf>, p. 14.

## Recommendation #15

### Forensic Mental Health

#### Respond to the needs of youth at risk of or involved with the criminal justice system.

- ❑ Eligibility criteria in mental health residential programs should be modified so that youth who are court-involved are not excluded from services.
- ❑ A city-wide, forensic ACT team should be established to meet the needs of severely mentally ill adolescents and young adults in alternative to incarceration programs.
- ❑ Coalitions and mental health providers should urgently commit to an advocacy effort to ban trying 16 and 17 year olds in the adult court system. In conjunction with this effort, Family Court must secure the necessary resources to effectively accommodate these adolescents, i.e. appoint additional family court judges; reduce caseload of law guardians to ensure adequate representation of adolescents; increase links to alternative to incarceration programs; and increase opportunities to screen for mental health conditions in pre-trial detention centers.

While the number of teenagers involved with criminal justice has decreased in New York City, the figures continue to be staggering with, for the year 2003, “42,812 misdemeanor arrests and 23,190 felony arrests of youth ages 15-20”.<sup>79</sup> In his presentation to the Youth Initiative Work Group, Gerald Landsberg made the convincing case that over the past ten years, there has been steadily increasing criminalization of emotionally disturbed young people: “Research indicates that over 100,000 juveniles are held daily in criminal justice-related facilities, and nearly 670,000 youth are processed annually through these systems. The numbers of these youth affected by mental illness is significant. The 2003 report of the National Center for Mental Health and Juvenile Justice (NCMHJJ) suggests that ‘70 to 80 percent are believed to have a diagnosable mental health disorder’ and ‘at least one out of

<sup>79</sup> Citizen’s Committee for Children of New York, Inc. (2005). *Keeping track of New York City’s children*. Facts, sheets, charts, and graphs. Teenagers in New York City. <http://www.cccnewyork.org/facts.html>.

five has a serious mental disorder.”<sup>80</sup> In addition, youth who are locked up in detention centers pending trial suffer acute interruption to social ties and education, as well as the likelihood of recidivism. Furthermore, they face decreased possibilities for employment.<sup>81</sup> The implications for mental health are tremendous, with many young people, especially those who are detained in adult facilities, experiencing exacerbation of their disorders or, more tragically, increased risk of suicide.<sup>82</sup> According to the Coalition for Juvenile Justice, these young people are “five times more likely to be sexually assaulted than those held in a juvenile facility, three times more likely to be beaten by prison staff than youth in a juvenile facility, and 50 percent more likely to be assaulted with a weapon than youth confined to a juveniles-only institution. In addition, the suicide rate for youth incarcerated with adults is five times higher than the rate of the general adult inmate population and eight times the rate for adolescents held in juvenile facilities.”<sup>83</sup> In addition, there are flagrant racial disparities for youth involved with the criminal justice system, with an overwhelming majority either African-American or Latino.<sup>84</sup>

There are also tremendous implications regarding criminality as it affects those in foster care. According to a special issue of *Child Welfare Watch* from the Milano Center for New York City Affairs at the New School, “more than half of the young people taken by the police to the city’s juvenile detention facilities from July 2000 to June 2001 had been the subject of abuse and neglect investigations by the city’s Administration for Children’s Services at some point in their lives. About one-quarter were either in foster care or had an active preventive

<sup>80</sup> Landsberg, G. & Rees, J. (2007). Forensic practices and serving dually diagnosed youth involved with the juvenile justice system. In D.W. Spring and A.R. Roberts (Eds.). *Handbook of forensic mental health with victims and offenders. Assessment, treatment, and research*. Springer: New York, p. 205.

<sup>81</sup> See Faruqee, M. (2002). *Rethinking juvenile detention in New York City*. The Juvenile Justice Project of the Correctional Association of New York, p. 5. [http://www.soros.org/initiatives/justice/articles\\_publications/publications/juvenile\\_detention\\_20020301/JJReport.pdf](http://www.soros.org/initiatives/justice/articles_publications/publications/juvenile_detention_20020301/JJReport.pdf).

<sup>82</sup> Campaign for Youth Justice. (2007, March). *The consequences aren’t minor. The impact of trying youth as adults and strategies for reform*, p. 7. [http://www.campaignforyouthjustice.org/Downloads/NEWS/National\\_Report\\_consequences.pdf](http://www.campaignforyouthjustice.org/Downloads/NEWS/National_Report_consequences.pdf).

<sup>83</sup> Juvenile Defender Project. (2005, March). *Childhood on trial: The failure of trying and sentencing youth in adult criminal court*. Report overview, p.2. [http://www.juvjustice.org/media/resource\\_115.pdf](http://www.juvjustice.org/media/resource_115.pdf).

<sup>84</sup> Faruqee, M. (2002). *Rethinking Juvenile Detention in New York City*. The Juvenile Justice Project of the Correctional Association of New York, p. 5. [http://www.soros.org/initiatives/justice/articles\\_publications/publications/juvenile\\_detention\\_20020301/JJReport.pdf](http://www.soros.org/initiatives/justice/articles_publications/publications/juvenile_detention_20020301/JJReport.pdf).

services case at the time of the detention.”<sup>85</sup> The report points to the tragic paucity of mental health services for teens in group or boarding homes who generally receive no services beyond an intake. The path leading to delinquency seems painfully clear and steers us in the obvious direction of needing to reach out to these young people and giving them the support they need. One of the biggest problems related to providing mental health services for teens in foster care is the fact that it is very rare that a foster care agency will have its own in-house clinicians. Teens must be referred to community mental health services that do not necessarily have the capacity or the training to deal with serious abuse, neglect and post-traumatic stress disorder.

Along with North Carolina, New York is one of only two states that automatically try 16 and 17 year olds in the adult court system. These cases belong in family court which, unlike the adult court system and the Supreme Court, does not have to subscribe to the mandates of the Juvenile Offender Law. We do not want, however, to oversimplify the dichotomy between the two courts. There are judges in the adult court system who, in their understanding of the developmental needs of the adolescent offender, utilize jail diversion in the interest of rehabilitation. This is not always the case in family court, which would benefit from increased understanding of and collaboration with alternative to incarceration programs. The Adolescent Portable Therapy (APT) diversion program of the VERA Institute is particularly noteworthy for its therapeutic approach, its emphasis on work with families in the home, and its commitment to cross-system collaboration. Evan Elkin, the author of this model, conceives of Adolescent Portable Therapy as a way to serve young people at any point of their involvement with the criminal justice system, be it probation, detention, or discharge from jail or prison.<sup>86</sup> In relation to the latter, the Work Group recommends that the New York State Office of Children and Family Services (OCFS) expand the re-entry program model for youth coming out of OCFS Juvenile facilities so that when they return to their families and communities they can tap into an active support network that could be accessed through community-based youth programs with skilled youth workers, such as the Boys and Girls Clubs.

<sup>85</sup> *Uninvited guests. Teens in New York City foster care, Child Welfare Watch*, 2002, Fall, 8, pp. 22-23. [http://www.citylimits.org/images\\_pdfs/pdfs/CWW%20Teens%20Fall%202002.pdf](http://www.citylimits.org/images_pdfs/pdfs/CWW%20Teens%20Fall%202002.pdf).

<sup>86</sup> Evan Elkin (personal communication, August 24, 2007).

We note the crucial efforts of the Juvenile Justice Coalition which is actively investigating the fiscal, legal, and political implications of raising the age of Family Court youth offenders to the 17th year. While there are differences of opinion on the issue of raising the age, there does appear to be a consensus that sending an adolescent to Riker’s Island greatly decreases his or her chances for recovery. Beth Navon, Executive Director of Friends of Island Academy (FOIA), asserts that the young people being discharged from Riker’s are severely depressed and often think that their two options in life are jail or death. During the first thirty days they are the most vulnerable to recidivism, hence the need to reach out to them while they are still inside the prison to “catch them” before they leave, which is what outreach initiatives—provided by the clients themselves in the FOIA program—seek to accomplish.

The Connecticut State Senate recently passed a bill calling for extensive mental health, educational and re-entry services to be implemented in jails and prisons, which should be an inspiration to law makers in New York State. During a Youth Initiative Work Group discussion about this problem, Susanna Karlin, Program Director at the Education and Assistance Corporation’s Adolescent Link Program in Brooklyn, explained how highly challenging it is to find placements for dually diagnosed adolescents who have substance abuse and conduct disorders, and who are involved in the criminal justice system. The Link program works with adolescents who are being discharged from Riker’s Island and in need of a referral for residential mental health and substance abuse treatment when leaving jail. Moreover, due to the excellent relationship that the Link program has with the Criminal and Supreme Court, Link is called upon to work in a preventive approach with adolescents who are mandated to treatment as a jail diversion measure. It is very difficult to find appropriate programs because the adolescents often do not have an Axis I diagnosis (needed to meet eligibility criteria) and programs typically do not treat *both* the mental health component and the substance problem, but rather one or the other.

It is imperative that programs like Friends of Island Academy (and Adolescent Link for mandated services), one of precious few that offer services to exiting young people from Riker’s Island, receive funding to continue their work. FOIA works from a holistic approach, providing specialized counseling, case management, on-site schooling, employment, and leadership. “We grow them up,” explains Beth Navon,

who works with her staff to help build confidence and self-esteem in young people through community work and a desperately needed nurturing environment.

Even when it comes to non-violent crimes, the trend of incarceration for young adults—rather than rehabilitation—, seems to indicate a primitive fear of teenagers, especially those who are black or Latino; it is as if our society projects onto them unremitting and uncontrollable aggression. Policies of criminalization are rooted in large part in the media response and the Bush administration's reaction to the Central Park Jogger case in 1989. The Campaign for Youth Justice reminds us in its 2007 report of this historical precedent, citing John Dilulio, a Bush appointee who described the teenagers involved (who were later found innocent) as “superpredators,” a “generational wolf pack” of “fatherless, Godless and jobless youth”.<sup>87</sup> Nowhere does this attitude continue to pervade more intensely than toward gangs. It is imperative that New York City officials and those involved in work with teens in all of the service systems transform this trend and address their desperate humanity.

For young people who have experienced severe family trauma and grow up in poverty-stricken neighborhoods—where, typically, police protection is minimal and the quality of education is low—, there is a high risk of gang involvement.<sup>88</sup> In fact, the foremost reason cited by females explaining their gang involvement is the need to flee oppressive family conditions. Boys and girls involved in gang-related activities have low self-esteem and are seeking a sense of belonging.<sup>89</sup> We need to be particularly sensitive to the problems facing young women today, as the rate of victimization for crimes of violence among 16-19 year old females is 72.6 % per 100,000; this age range of females

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<sup>87</sup> The Campaign for Youth Justice (2007, March). *The consequences aren't minor. The impact of trying youth as adults and strategies for reform*, p. 3. Although John Dilulio disavowed his statement some years later, the impact has never been erased from the American consciousness.

<sup>88</sup> “Gang members are less likely than non-gang members to come from intact homes,” in Esbesen, F., Deschenes, E.P., & Winfree, L.T. (1999). Differences between gang girls and gang boys. *Youth & Society*, 31(1), p. 40.

<sup>89</sup>*Ibid.*

also suffers from the highest rate of rape.<sup>90</sup> These rates are considerably higher when compared to those of adult females. Further, female-inflicted violence is on the rise, accounting for 22% of all arrests.<sup>91</sup> Minority women in particular are at risk of gang involvement. Many of these young people, both male and female, suffer from mental disorders that may be stress-induced or organic. Low self-esteem makes it possible to tolerate further abuse and violence inside of gang life. Trauma is prevalent. Delinquent girls and boys often suffer from post-traumatic stress disorder, dissociation disorders, unrelenting grief, loneliness, and isolation.

In his presentation to the Youth Initiative Work Group in May 2007, Felix Castro shared his life story and the circumstances that spurred his gang involvement: “I didn't want to live anymore. I felt like nobody loved me, so why should I care about life?” He now works as Peer Educator and Outreach Specialist at the International Center for the Disabled, Youth Employment Services (YES) Program, and runs his own organization: Changing Thoughts: Gang Prevention for Our Youth. He has been actively involved in the TIP implementation process at the YES program. Young people engaged in destructive and self-destructive behavior gravitate toward him for support; he clearly makes a special connection to them. This kind of peer specialist is a rare inspiration to young people who can really identify with the problems he faced and surmounted. Felix Castro explained the importance of actively listening to youth at risk and of encouraging them to express their dreams, set goals, and help them feel a sense of hope about their lives. Dawn Kiron, Director of the YES program, points out that it is essential that these young people learn to better cope with the violence that surrounds them, and that they learn alternative and healthier mechanisms for dealing with these stressors. At the YES program, young people who have learned these coping skills are now engaged in outreach initiatives to educate and support other young people facing the same challenges. Programs should investigate possibilities of extending outreach efforts to young people in gangs and think about ways in which services could better meet their needs.

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<sup>90</sup> Hunt, G. & Joe-Laidler, K. (2001). Situations of violence in the lives of girl gang members. *Health Care for Women International*, 22, p. 364.

<sup>91</sup>*Ibid.*, p. 365.

## Recommendation #16

### Child Welfare and Mental Health

#### Strengthen the connection between ACS and mental health services.

- The ACS Family Assessment Program should ensure that assessment and referral services are provided by licensed mental health practitioners with the competencies required to accurately assess family needs and address emotional components of a young person's behavior.
- ACS should make clinical assessments a priority for adolescents with SED by ensuring that ACS workers and foster care agency staff i) fully understand diagnoses and socio-emotional needs and ii) integrate this information to a greater extent into service planning and placement planning.
- ACS should increase opportunities for mental health treatment of adolescents in foster care by providing clinical services in both foster care agencies and residential facilities.

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According to the Sharon Lerner and Barbara Solow's 2007 report: *"There's No Such Place": The Family Assessment Program, PINS and the Limits of Support Services for Families with Teens in NYC*,<sup>92</sup> there has been a steep increase in arrests of young people under the age of 16 over the past five years, and cases involving teens in the family and criminal courts. The study points out that, due to juvenile delinquency, foster care placements of teens rose by more than a third, from 400 in 2000 to 610 in 2006.

To address this problem, in 2002, ACS and the Department of Probation created the Family Assessment Program (FAP) as a preventive measure to keep teens out of foster care and the juvenile justice system. To this end, it was deemed that parole, which is a punishment model, is not as effective as a

<sup>92</sup> January 2006. Center for New York City Affairs, Milano. The New School for Management and Urban Policy.

clinical approach which would address the emotional components of behavior as well as family dysfunction. The theory behind FAP is that it would constitute a therapeutic approach to services and would speed up the referral process for clinical intervention. Teenagers who are referred to FAP commonly have experienced a traumatic loss of some kind; are from immigrant families struggling to adjust to American culture; present with mental health and substance abuse problems; and have been victims of sexual, physical and emotional abuse and neglect. Unfortunately, according to ACS specialists at the Youth Initiative Work Group, while the design of FAP is excellent, in practice it does not meet the clinical standards that it laid out for itself, i.e. assessments are not routinely conducted by licensed mental health workers and further evaluation is often brokered out to other mental health agencies.

As the Work Group pondered the ACS system and ways that mental health treatment could be more effective for adolescents in foster care, participants indicated that fragmentation of services for this population created additional stressors for adolescents, foster care families, and biological parents. Ideally, ACS should ensure provision of its own clinical services, which would benefit all involved with the system. First, ACS itself would better integrate mental health assessments and therapeutic work into its planning for the young person if the clinical work was provided by an ACS clinician. Second, the young person would benefit from continuity of care if services were accessible on-site, either in residences or at the foster care agency. And third, foster care and biological parents would not experience the added pressure of going to an additional agency for family treatment. Such fragmentation of services arguably infuses the foster care experience with stressors related to attachment and/or separation from multiple counselors, and the potential—on the part of staff and clients alike—for splitting between systems. While the feasibility of integrating ACS clinical staff on-site in residential settings is not clear to Work Group members, we advance the idea here as an area that ACS might pursue as it continues to ponder its role in the lives of adolescents and their families and caregivers.

## Recommendation #17

### Aging Out of Foster Care

#### Create connections for the young person aging out of foster care.

- ❑ Connections for individuals aging out of foster care can be promoted either by extending the role of foster families or by implementing other options of support, such as linking with a mentor prior to discharge, to avoid the experience of severance at age 18.

Young people facing discharge from foster care are at a particular disadvantage because they will no longer have access to the fundamental unit of family as a base. As a

recent ACS report indicates, “each year, approximately 1,200 of New York’s foster youth over the age of 18 leave the foster care system, but only 20% of them are leaving to be reunified with their families or to be adopted.”<sup>93</sup> It is for this reason that Exceptions to Policy in the ACS system exist, allowing for extension for services until age 21 if a permanency plan has not been completed. While it is the case that ACS certainly acknowledges this crucial problem by its efforts to implement support for the transition-age population by promoting permanency with foster care families and connecting youth to a caring adult prior to Trial Discharge, there is more that can be done to support them.

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<sup>93</sup> New York City Administration for Children’s Services. (2006, June). *Preparing youth for adulthood*. New York, NY. [http://www.nyc.gov/html/acs/downloads/pdf/youth\\_for\\_adulthood.pdf](http://www.nyc.gov/html/acs/downloads/pdf/youth_for_adulthood.pdf).

# Workforce Development: Training and Technical Assistance

Much time has been devoted in these recommendations to rethinking services and systems to better address the needs of young people. However, it is of the utmost importance that we likewise address the needs of the staff working with them, as they are the crucial facilitators of the transition process. In this regard, the World Health Organization identifies the need to address burnout and low morale, particularly rife in the mental health community: “The need for good staff motivation has a financial, clinical and humanitarian basis. . . the stress of mental health work can be challenging, and can provide an opportunity for rewards as clinicians see improvements in their clients and in service effectiveness.”<sup>94</sup> Education, training, and technical assistance are essential to staff motivation and competency. Indeed, this has long been the philosophy and mission of the Center for Rehabilitation and Recovery.

Without the theoretical knowledge base that informs a best practice approach to working with young people, along with the application of these theories in service provision, it will be difficult for mental health and other systems staff that work with this population to enhance their ability to reach these youth. The Annapolis Coalition’s 2007 *Action Plan for Behavioral Health Workforce Development* identifies the debilitating separation between systems and the crucial need to rethink education and training in terms of a cross-systems endeavor: “Frontline human service workers in child welfare, child care, education, or juvenile justice systems often are not recognized as part of the behavioral health workforce. Furthermore, there are large separations among these agencies. . . which must be overcome because these agencies often are critical to identifying the behavioral health needs of children and youth and linking them with or providing behavioral health care.”<sup>95</sup> Likewise, as the Center for Mental Health Services (CMHS) indicates in its study, *Promising Practices*, it is important to conceptualize training from an interdisciplinary approach, otherwise

known as interprofessional training, which entails a cross-systems, cross-disciplinary collaboration in the delivery of knowledge. The position of CMHS is that “care for children with, or at risk for, serious emotional problems and their families is best delivered within an interdisciplinary model in which the perspectives of various professionals are integrated.”<sup>96</sup> The Center for Rehabilitation and Recovery is dedicated to a multidisciplinary approach on the participant level (inclusive of staff from varying divisions of mental health and other related systems) and in the development of training seminars which is informed by an interdisciplinary approach. The Work Group recommends this kind of delivery to all service systems working with young people with SED as they reflect on their own training programs. Just as it is important to actively listen to the voices of young people and their families within agency and community life as a whole, so too should providers in the mental health field actively seek out and take heed of the voices of all of those who have expertise in the challenges facing young people today.

Furthermore, in order for education and training to be truly meaningful and to positively influence actual practice, the Center for Rehabilitation and Recovery recognizes the importance of engaging all levels of staff, from the executive director to the frontline person, in attending training seminars. It is clearly not enough for one isolated staff person to be trained in a targeted model or practice if the agency as a whole is not willing to incorporate the values of that model or practice into the culture of treatment and rehabilitation on a broad basis. For the Center’s activities to be as effective as possible, educational, training and technical assistance initiatives need to reflect both their conceptual and practical content in relation to youth voice, family involvement, services, and systems.

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<sup>94</sup> World Health Organization. (2005). *Human resources and training in mental health*. Geneva, Switzerland. [http://www.who.int/mental\\_health/policy/Training\\_in\\_Mental\\_Health.pdf](http://www.who.int/mental_health/policy/Training_in_Mental_Health.pdf), p. 7.

<sup>95</sup> The Annapolis Coalition on the Behavioral Health Workforce. (2007). *An action plan for behavioral health workforce development*. Cincinnati, OH, p. 172.

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<sup>96</sup> Meyers, J., Kaufman, M., & Goldman, S. (1999). Promising practices: Training strategies for serving children with serious emotional disturbance and their families in a system of care, in *Systems of care Promising practices in children’s mental health*. Volume V. Center for Children’s Mental Health. SAMHSA. Georgetown University, p. 37.

The Center is fully invested in the Youth Initiative Project and will continue to offer training and technical assistance to providers supporting transition-age youth with SED in its desire to build upon the successes of last year. The Center has witnessed the positive influence that TIP, as an evidence-based practice, has had on programs serving young people. Training and consultation has enhanced service providers' abilities to re-conceptualize their services according to TIP principles and their application in a framework of transition. The Center is positioned to offer the TIP Overview and Core Competencies training as it did in 2006 and continue work with the six TIP model sites by extending the Cross-Site Forums and on-site assistance. The Center will target and actively outreach to child and adult system providers who did not participate in previous training opportunities as well as youth leadership and family members. It hopes to expand the opportunity for new agencies to learn how to implement the TIP model and continue to support our already established Community of Learning. The model sites constitute a formal collaborative that extends its function beyond learning to focus on common goals and resources.

In addition, Work Group participants helped to identify a range of topic areas that could be addressed through a seminar series designed to increase the knowledge base of mental health and other providers working with young people with SED. Such a series could include a discussion of hetero-, bi-, trans-, and homo- sexuality and the ways in which bodily and emotional intimacy affect development and self-image; trauma, including physical and sexual abuse, separation with family, and loss; engagement skills and enhanced understanding of the therapeutic relationship as it pertains to adolescents; sensory integration and its application to treatment of adolescents/young adults with SED; and self-harm, including eating disorders; and suicidality. Work Group participants are interested in training in forensic mental health, including an understanding of the pathways through the criminal justice system and how to best support youth who are court involved and, moreover, to provide a recovery orientation when they are at risk of entering the system, when they are part of the system, and when they are discharged from detention. Training could also address benefits counseling competencies, especially SSI and Medicaid concerns among transitional youth. Other topical issues are specific to foster care and the particular crises and predicaments that young people face. There is a need to differentiate between the impact of foster

care on teenagers in general and its effects on development, on the one hand, and pathology on the other, although the two may well be enmeshed.

Consistent with the emphasis on youth participation in agency and community life, the Center for Rehabilitation and Recovery aims to provide the opportunity for mental health staff to expand their understanding of the importance of endeavors like the creation of a Leadership Association. Some of the WAVE seminars offered at the Center focused on this important facet of agency life, and the Center plans to expand the WAVE seminar series to do more in-depth work in this area. Agencies that are interested in and committed to integrating youth voice in program design, delivery and evaluation will be invited to participate in this opportunity.

The Center for Rehabilitation and Recovery is currently creating a resource 'guide' for disconnected youth, ages 16 to 25, containing available services and supports in all five boroughs of New York City. The domains of this resource will include employment, education, health and wellness, recreation, housing, criminal justice, and others. Focus groups have been conducted to identify the areas of interest for young people and the most effective ways to present information. Because adolescents commonly turn to the Internet and their peers (and are unlikely to seek preventive care) for information and support, and spend significant amounts of time on computers, utilizing MySpace and instant messaging, this resource will mainly be accessed electronically. It should be noted that it will be designed first and foremost for a youth audience.

The CMHS study, *Promising Practices*, indicates the growing concern that higher education is not sufficiently preparing students for the challenges of work on the real local level: "There are few examples of training programs that incorporate the values, aptitudes, and skills reflective of current practice, such as the involvement of parents and consumers, interdisciplinary collaboration, strengths-based assessment and intervention, wraparound services, cultural competence, and the use of natural informal supports and resources."<sup>97</sup> While it is obvious that faculty members most often come to the discipline with extensive experience in a

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<sup>97</sup> Meyers, J., Kaufman, M., & Goldman, S. (1999). Promising practices: Training strategies for serving children with serious emotional disturbance and their families in a system of care, in *Systems of care. Promising practices in children's mental health*. Volume V. Center for Children's Mental Health. SAMHSA. Georgetown University, p. 24.

particular community mental health agency, residential, or hospital program, it stands to reason that they may not all be aware of the current challenges regarding systems of care in the community.

University social work programs should engage in discussion with community mental health providers so that masters curriculum is more relevant to the current priorities and needs of young people and their families navigating local systems of care. In addition, as *Promising Practices* indicates, it is also important for universities to think of field placements in terms of systems of care, which would expose them to and promote participation in “family-

centered, community-based, interdisciplinary and interagency teams.”<sup>98</sup>

Finally, the Center will address more fully the critical problem of literacy in New York City through a collaboration with a social research academic institution, educators in secondary and post-secondary education, mental health professionals with expertise in this area, and specialized staff from probation and criminal justice to sponsor an event aimed at identifying and more effectively addressing the literacy needs of transition-age youth with SED in New York City.

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<sup>98</sup> *Ibid.*, p. 65.

# Conclusion

All of the recommendations and good ideas that came out of the deliberations of the Youth Initiative Work Group speak to a specific purpose and are of equal value. But the work does not stop here. The Center for Rehabilitation and Recovery considers *A Chance for Change: Supporting Youth in Transition in New York City* to be a work in progress, an on-going, collaborative effort between the mental health community and the many systems (child welfare, education, substance abuse, juvenile justice, etc.) with which young people interact. Because of its primary focus

on mental health, the Center recognizes that the recommendations contained within this report are not necessarily comprehensive, nor do they take into account all of the effective programmatic, advocacy and local, state, and federal government efforts related to improving the chances of success for youth in New York City. It does hope, however, that it will make a contribution to the way we all think about, reach out to and, most importantly, learn from young people.

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