TRANSITION AGE YOUTH WITH BEHAVIORAL HEALTH CHALLENGES: CURRENT STATUS AND FUTURE DIRECTIONS

AN INFORMATIONAL REPORT AND RECOMMENDATIONS
TO IMPROVE OUTCOMES
FOR COLORADO'S TRANSITION AGE YOUTH AND THEIR FAMILIES

Submitted to:
The Colorado Department of Human Services

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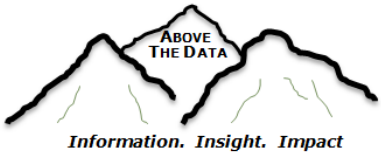

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EXECUTIVE SUMMARY

The transition to adulthood (ages 14 -25) can be a challenging time for many youth but especially for those with behavioral health challenges. This period of life comes not only with developmental changes, but also with a variety of changes to public services access and navigation options.

The Colorado Department of Human Services Office of Behavioral Health (OBH) is committed to helping develop a system of care that aids youth with serious behavioral health challenges to successfully transition to adulthood. As part of this vision, OBH recognized the need to critically evaluate, from a number of perspectives, the components that influence outcomes of TAY and their families. OBH contracted an investigation to compile quantitative and qualitative data to describe Colorado's current TAY services and their impact on youth outcomes. The investigation included: a review of current policies related to transition age services; collection of qualitative focus group and interview data from providers, families, youth, and other stakeholders; analysis of population characteristics and outcomes for persons who accessed the behavioral health system within fiscal year 2010-11; and a review of best-practices nationally and locally.

This report:

- Describes characteristics and outcomes unique to adolescents and young adults receiving services in the public mental health system
- Provides a review of policy and programs directed towards transition age youth
- Includes themes and qualitative findings from key informant interviews and focus groups
- Presents Best Practice literature for improving outcomes for TAY
- Outlines recommendations to improve systems and services for TAY

Data were available for a total of 83,511 persons who had active treatment episodes in the public mental health system during Fiscal Year 2010-11. FY10-11 data were chosen so there would be sufficient follow-up data (through FY12-13) to assess outcomes.

The population of interest encompasses adolescents and young adults (N=20,489). Complete data was available for 18,811 of the TAY population. CCAR and outcomes analyses are based on these 18,811 TAY. Some analyses included only the population of interest (TAY) and others also include the adjacent age groups for more relevant comparisons.

Almost 60% of youth (0-13 years of age) involved in the public mental health system are male. However, during the transition years, the percent of males in treatment drops from 50% to 40%, and then continues to decline to just over 30% during older adult years.

The proportion of minorities served also decreases over time. Over 60% of youth served were racial/ ethnic minorities. This drops to 40.1% by the end of the transition years, and drops even further to 23.7% by the older adult years.

A variety of diagnoses show clear trends across age groups. Essentially, the transition age youth as a group are experiencing adult-onset disorders while still suffering childhood disorders, as well as those that consistently affect all ages.

In addition to the developmental factors that affect the distribution of clinical factors across the life span, there are system-level factors that impact the ability of people to access public behavioral health services across the life span.

Access to publically funded services is more difficult for young adults than youth because eligibility criteria are more stringent[1]. A portion loses eligibility at age 18 and do not re-qualify for SSI due to adult definitions of disability. The number of young people receiving mental health services plummets during the early adult years. The number served drops by nearly 28% between ages 17 and 18 and another 30% between 18 and 19.

Colorado is fortunate to have a common evaluation for all persons served in the public mental health system. The Colorado Client Assessment Record (CCAR) is conducted with all individuals (regardless of age or diagnoses) and includes a clinician rating of 25 domains that relate to wellbeing, mental health, and social functioning.

These clinical domain scores at admission to services show that transition age youth are distinct from both children and adults.

- Additionally, there is significant change between adolescent and young adult years.
- Young adult scores are much closer to adult scores, and adolescent scores are closer to children's in the majority of domains.
- Overall Symptom Severity, in which transition age youth of both categories exceed both child and adult rates of clinical severity.
- During the transition age, individuals begin to look like the population of adults with serious mental illness (SMI) and severe and persistent mental illness (SPMI).

In order to assess the extent of treatment for co-occurring substance use disorders (SUD) and mental health challenges, substance use treatment records were obtained from the Drug/Alcohol Coordinated Data System (DACODS) for a ten year period (2003-2013). DACODS provides records of all persons served by Colorado licensed substance use providers. These records were matched to the file of TAY in the mental health system in FY2010-11.

- Out of 18,811 TAY in the public mental health records, 4,949 (26.3%) received treatment from public SUD providers at some point during the ten years.
- Approximately one third (31.0%) of males and 22.5% of females received SUD services.
- A slightly higher percentage of minority youth (27.3%) than white youth (25.5%) had SUD services.

[1] http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/Medicaid-and-CHIP-Eligibility-Levels-Table.pdf

- One in three (33.6%) of the young adult age group has received SUD services, more than adolescents whose rate of SUD is closer to one in five (19.2%).
- Across both TAY age groups, involvement with the Child Welfare system was associated with a slightly higher rate of SUD service involvement (28.0% of those with Child Welfare involvement, versus 25% for those without Child Welfare involvement).

TRANSITION AGE YOUTH OUTCOMES

The Transition to Independence Process (TIP) model, is the only evidence-supported approach for Transition Age Youth with mental health challenges to-date. The model is strengths-based and encourages youth to explore their futures in the domains of Education, Employment, Living Situation, Well-being/Personal Effectiveness, and Community Life/Functioning.

- A number of CCAR domains reflect those same TIP constructs. The Overall Symptom Severity rating reflects Well-being in symptom level and management. The Role Performance CCAR rating reflects activities in the primary occupational role of the person, whether that be school or work. Community life/functioning is a component of the Overall Level of Functioning (LOF) domain on the CCAR. The TIP model provides the justification of choosing Symptom Severity, Role Performance, and Overall Level of Functioning as the critical CCAR outcome measures for this analysis.

The link between mental health and criminal justice involvement has been a widely discussed topic in Colorado and throughout the country. Colorado Division of Youth Corrections (DYC) records were matched to adolescent public mental health system records to determine the overlap in the two populations. A variety of analyses were then conducted to determine factors related to juvenile justice involvement.

At treatment discharge, there are improvements in clinical severity across both transition age groups. However, a significant percent of TAY still have CCAR symptom ratings of five or above (defined as a clinically elevated score), indicating remaining clinical-level need and a lack of treatment success.

Nearly half of adolescents and young adults still have clinically elevated Symptom Severity ratings at discharge. This high rate of unsuccessful discharge from mental health services is quite alarming and suggests a need for efforts to increase engagement and improve outcomes across this age group.

At discharge, youth with a history of SUD service have a consistent profile of clinical concern. Youth with SUD service history have a higher rate of clinically elevated discharge scores than those without SUD service history, across ***every*** domain.

Statistical analysis confirmed that adolescent and young adults had significantly different group profiles across the primary outcomes of interest. Due to the differences between the two age groups of the TAY population, statistical analyses of outcomes were conducted separately for each group. Predictive Modeling Revealed the following factors significantly impacted outcomes in each of the three domains:

Significant Predictors of Discharge Outcomes

OUTCOME	Significant Demographic and System Predictors	Significant[2] Admission CCAR Clinical Predictors
Adolescent Discharge Symptom Severity	Race, Child Welfare, Public Substance Use Disorder Service	Legal Problems, Self-Harm, Aggression, Cognition, Mania, Drug Use, Symptom Severity
Adolescent Discharge Role Performance	Race, Child Welfare, Public Substance Use Disorder Service	Legal Problems, Aggression, Attention, Drug Use, Activity Involvement, Role Performance
Adolescent Discharge Level of Functioning	Child Welfare, Public Substance Use Disorder Service	Legal Problems, Self-Harm, Cognition, Mania, Drug Use, Activity Involvement, LOF
Young Adult Discharge Symptom Severity	Public Substance Use Disorder Service	Physical Health, Self-Care, Need for Supervision, Self-Harm, Aggression, Psychosis, Cognition, Mania, Anxiety, Interpersonal Relationships, Activity Involvement, Symptom Severity
Young Adult Discharge Role Performance	First Admission Age, Gender, Public Substance Use Disorder Service	Legal Problems, Self-Care, Aggression, Psychosis, Cognition, Mania, Anxiety, Role Performance
Young Adult Discharge Level of Functioning	Gender, Child Welfare, Public Substance Use Disorder Service	Legal Problems, Self-Care, Physical Health, Self-Harm, Aggression, Psychosis, Cognition, Mania, Anxiety, Interpersonal Relationships, Empowerment, Activity Involvement, LOF
Adolescents In DYC	Age at First Admission, Gender, Race, Child Welfare, Public Substance Use Disorder Service	Legal Problems, Self-Care, Need for Supervision, Mania, Depression[3], Alcohol Use, Socialization

More severe admission scores were related to poorer outcomes in all cases except in the relationship between depression and DYC involvement. Youth who were more severely depressed when they began mental health treatment were less likely to become involved in DYC.

In the general population, the prevalence for DYC involvement is ***20.8 out of 10,000*** (0.2%) youth in the juvenile population. Strikingly, in an adolescent mental health population, ***one in four*** (25%) youth has DYC detention or commitment. Males with mental health service have a greater than ***one in three*** (35%) chance for DYC involvement, adding Child Welfare involvement increases that risk to nearly ***one in two*** (43%) further adding SUD services, results ***three of four*** (73.7%) adolescent boys with DYC involvement. The additional factor of an elevated admission score on Socialization elevated the chance to more than ***eight out of ten*** (82.5%) involved with DYC

TRANSITION AGE YOUTH: POLICY REVIEW

[2] Reported findings are significant at p=.05.
[3] Lower depression scores at admission were related to DYC involvement.

The goal of this review is to describe the systems with which TAY with serious behavioral health challenges may come into contact. To achieve this, public policy components related to the provision of mental health services for TAY with behavioral health challenges are described.

One of the first findings was that agency-level policy was broad in scope and did not detail services specific to the transition age group. Each agency, however, had a variety of programs with information about program-specific target populations and eligibility criteria as well as service descriptions, and program guidelines The policy review became a program inventory, revealing policy elements through program descriptions, and providing the appropriate level of detail to capture the needed cross-system picture of transition age services.

Many transition age youth services are operated in the local community and by community agencies, thus community programs with relevant initiatives were an important part of the inventory.

While the following review provides brief program descriptions, the focus is a statewide look at the:

- Availability of programs and services (i.e. eligibility requirements)
- Inclusion of System of Care (SOC) principals in program designs (Family-driven, Youth-guided, Culturally Competent, Interagency, and Developmentally Appropriate)
- Alignment of programming with Transition to Independence (TIP) functional areas of focus

Many of Colorado's child-serving agencies offer behavioral health services to youth in their systems. While many include evidence-supported criteria for transition age youth, there is a dearth of programming that is specifically geared towards this developmental window. Additionally, navigating and accessing the available services is a challenge.

While most of the state-level programs include evidence supported elements (SOC, TIP) in programming design, they are not available across the full 14-25 transition age window.

In contrast, community based programming may have less rigid eligibility criteria, and be specifically designed to target the developmental level of transition age youth. However, these agencies tend to have a narrow target population.

The gaps in service options based on age and other eligibility criteria exacerbate existing access and service navigation challenges, however, and there is still a lack of developmentally appropriate services that support youth in successful transition to adult lives.

BEST PRACTICES REVIEW

At this time there are no fully evidence-based practices for transition age youth with mental health challenges. There is more in the literature about treatment models for transition age youth with other challenges, such as developmental disabilities or substance use and translation of these models to a mental health population is a consideration in the field.

The inventory of promising practices for transition age youth with serious behavioral challenges reveal commonalities among approaches:

- Strengths Based
- Youth Directed
- Fostering Supportive Relationships with Caring Adults
- Developing Transition Life Skills

There are several Colorado Programs that incorporate best practices principles, however, they serve a relatively small number of youth are limited in their target population.

RECOMMENDATIONS

SYSTEM LEVEL

Integration: There are many programs to serve TAY with behavioral health challenges, and little integration or coordination between programs. Systems need to work together to create a *seamless system of services* without rigid requirements to create coordination between child and adult serving agencies, and interagency collaboration between state agencies.

Leadership: With many agencies providing services within distinct programs, guidance around an effective mental health service system and future *direction for TAY programming* is needed. OBH has the opportunity to oversee the planning and implementation of services for people with early signs of mental illness, focusing on transition age youth.

Access: Services must be available for youth who were served in the children's system who do not meet diagnostic eligibility for adult services to help in transitioning to adulthood at this critical time.

Workforce Development: Clinical staff must recognize the youth culture of this age group and adapt service locations and modalities. Program staff also must be reflective of the population served in terms of gender and race, specifically increasing males and persons of color. In addition, compensation for clinical staff has to be adjusted to *decrease staff turnover* and to maintain longevity and stability in therapeutic relationships.

Education: Stigma related to behavioral health must be reduced through social marketing and outreach efforts. *Education of the public and the system* around TAY-specific issues are necessary to ensure support for effective programming

PROGRAM LEVEL

Programs must be:

Developmentally Appropriate: Services must be designed for the increasing autonomy and emerging adult roles that TAY are adopting. In addition, it is necessary to recognize and incorporate youth culture into the delivery of services.

Youth Guided: The youth's own goals must be taken into account and they must be actively engaged in their own treatment planning. Without the youth becoming an active participant in their own recovery engagement and positive outcomes will be limited.

Culturally Competent: The integration of cultural knowledge (including youth culture), behaviors, and attitudes into service delivery increases engagement, leading to improved outcomes. This is critical to maintain engagement of minority and young adults who the data indicate are leaving services.

Trauma Informed: Understanding the pervasiveness and effects of trauma in the lives of Transition Age Youth is critical to providing effective services. Trauma impacts emotional, cognitive and social development. Providing trauma informed care means that staff understand these effects and provide services that feel safe to clients while encouraging healing and the development of hopeful trusting relationships.

Strengths Based: Capitalizing on the strengths young people have is another key component of successful programming with Transition Age Youth. By the time they have reached Transition Age, young people have had professionals who have tried to "fix" their problems. Youth consistently stated that they reacted much more favorably when service providers recognized and focused on their uniqueness and talents rather than their deficits.

Engaging All Individuals: This recommendation is related to cultural competence but goes a step farther. We must break down cultural, societal, and system barriers to make access to services a reality for all individuals. Service providers must make every effort to engage individuals in need where they are physically located, developmentally, and culturally.

Programs need to promote:

Relationships with Supportive Adults: Transitioning to adulthood can be difficult for any individual but especially so for those with behavioral health challenges who may have strained or absent relationships with caring committed adults. Establishing and maintaining these trusting safe relationships is key to attaining successful outcomes.

Peer Supports: The utilization of peer mentors with adults with SPMI has yielded positive results and there is limited support that this may be an effective program component with youth and young adults as well. Youth express a strong desire to connect with other young people who have had similar experiences and feel this is a positive component of their development.

Caution should be taken to protect peer mentors from re-traumatization and aid in establishing appropriate boundaries as they may still be developmentally immature and may not have sufficient distance from their own behavioral health history to fully engage in the demands of helping others.

Programs need to include:

Education: Youth expressed a clear need to learn about symptoms, prognoses, and treatment of mental illness. Such *knowledge* would have helped them cope and adapt to life with a mental health challenge. In addition, they identified *family education,* around their mental health challenges, as necessary to facilitate connection and support with family members.

Naturalistic settings: As youth mature the importance of the peer group increases and concerns about stigma is one reason for providing services in *a non-clinical environment*. Additionally, young adults express reticence to visit adult drop-in centers or clinics because they don't identify with adults with long-term mental illness. Providing services in settings that youth typically are in, such as coffee houses or Laundromats, helps reduce barriers to access.

All Transition Areas: At this time of life youth are facing graduation from high school, continuing education, vocational training, financial sufficiency, living independently, integrating into the community, and a number of life options. In addition, this is a common age range for the appearance of more serious mental health symptoms and increased substance use disorders. As such, programs should include the array of services addressing *Education, Employment, Living Situation, Well-being,* and *Community Life.*

ADDITIONAL RECOMENDATIONS

Youth as a Resource: This age group is finding its voice and TAY who have faced or are facing behavioral health challenges are a *resource for knowledge and leadership*. Program and policy development should include this voice in a substantive and meaningful way.

Evaluation of Outcomes to Guide Best Practices: With the evolving practices for TAY with behavioral health challenges, it is critical that *programs and interventions be evaluated* rigorously for treatment outcomes, ensuring services that lead to successful transition to adulthood.

INTRODUCTION

The transition to adulthood can be a challenging time for many youth but especially for those with behavioral health challenges. For the purposes of this report young people are considered to be transition age youth (TAY) from age 14 until age their 26th birthday.

This period of life comes not only with developmental changes, but also with a variety of changes to public services access and navigation options. During this time, challenges include:

- Becoming an adult developmentally and legally;
- Transitioning from child services to adult services in the Public mental health system;
- Replacing parents in making treatment decisions;
- Completing high school;
- Achieving financial self-sufficiency;
- Switching to adult service systems for employment and education; and
- Understanding eligibility criteria for adult public assistance programs such as Supplemental Security Income, food assistance, housing assistance, and medical assistance.

TAY Project Vision: E*nsure a system of care that aids youth with serious behavioral health challenges to successfully transition to adulthood.*

To further complicate issues, not all systems transition from youth to adult services at the same age point, and there is very limited systems coordination, with no cross systems data matching[4]. The Colorado Department of Human Services Office of Behavioral Health (OBH) is committed to helping develop a system of care that aids youth with serious behavioral health challenges to successfully transition to adulthood. As part of this vision, OBH recognized the need to critically evaluate, from a number of perspectives, the components that influence outcomes of TAY and their families. OBH contracted a six-month long investigation to compile quantitative and qualitative data to describe Colorado's current TAY services and their impact on youth outcomes. The investigation included: a review of current policies related to transition age services; collection of qualitative focus group and interview data from providers, families, youth, and other stakeholders; analysis of population characteristics and outcomes for persons who accessed the behavioral health system within fiscal year 2010-11; and a review of best- practices in the national literature and locally. Please see Appendix A for a detailed account of methods.

[4] Pike, P., Bane, W., & Matera, D., (2011). What Comes Next? Behavioral Health and Transition-Age Youth in Colorado – White Paper I. Accessed online April 28, 2014 http://www.colorado.gov.

This report:

- Describes characteristics and outcomes unique to adolescents and young adults receiving services in the public mental health system;
- Provides a review of policy and programs directed towards transition age youth;
- Includes themes and qualitative findings from key informant interviews and focus groups;
- Presents Best Practice literature for improving outcomes for TAY, and
- Outlines recommendations for aligning Colorado's system with these principles.

Data were available for a total of 83,511 persons who had active treatment episodes in the public mental health system during Fiscal Year 2010-11. FY10-11 data were chosen so there would be sufficient follow-up data (through FY12-13) to assess outcomes.

Table 1. Persons Served by Age Group FY 2010-11

Children Age 0-13 19,114	Adolescents Age 14-17 10,484	Young Adults Age 18-25 10,005	Adults Age 26-59 38,743	Older Adults Age 60+ 5,165	*Total* *83,511*

The population of interest encompasses adolescents and young adults (N=20,489). Complete data were available for 18,811 of the TAY population. CCAR and outcomes analyses are based on these 18,811 TAY. Some analyses included only the population of interest (TAY) and others also include the adjacent age groups for more relevant comparisons.

CHARACTERISTICS OF COLORADO'S PUBLIC MENTAL HEALTH SYSTEM

There are important and significant differences in the characteristics by age group of those served in FY 2010-11. Developmental and system level differences across the lifespan impact the populations of those served.

WHO IS SERVED BY COLORADO'S PUBLIC MENTAL HEALTH SYSTEM?

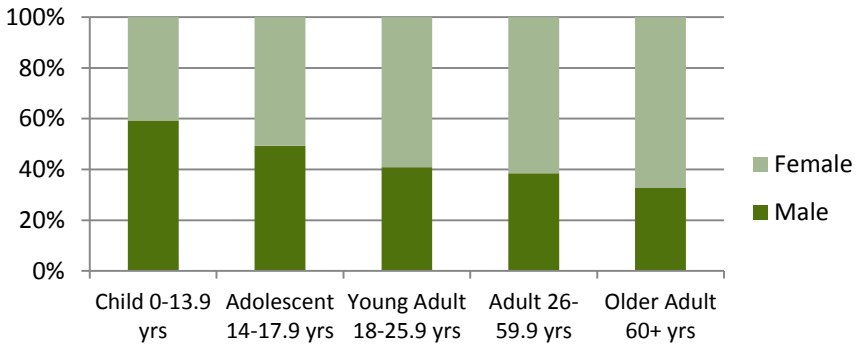
The following sections provide detailed demographic and clinical population descriptions by age group.

GENDER AND RACE BY AGE GROUP

Almost 60% of treated youth (0-13 years of age) are male. However, during the transition years, the percent of males in treatment drops from 50% to 40%, and then continues to decline to just over 30% during older adult years (Figure 1).

"Boys in our culture are taught to be strong and self-reliant. Receiving any type of help is a sign of weakness at a time in their life when they are most trying to demonstrate strength and manliness."
-Family Member, Montrose, CO

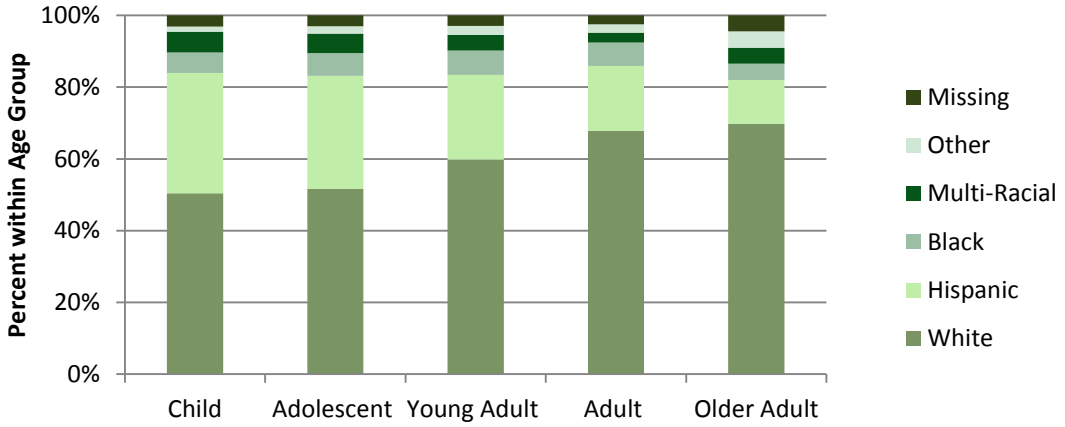
Figure 1. Gender by Age Group: Mental Health Services FY 2010-11



The proportion of minorities served also decreases over time (Figure 2.) Over 60% of youth served were racial/ ethnic minorities. This drops to 40.1% by the end of the transition years, and drops even further to 23.7% by the older adult years. These changes are likely influenced by individual and social factors.

"In the Latino culture you are taught to just keep pushing forward. You shouldn't talk about problems or ask for help."
-Youth, age 23, Commerce City, CO

Figure 2. Demographics by Age Group: Mental Health Services FY 2010-11



DIAGNOSES BY AGE GROUP

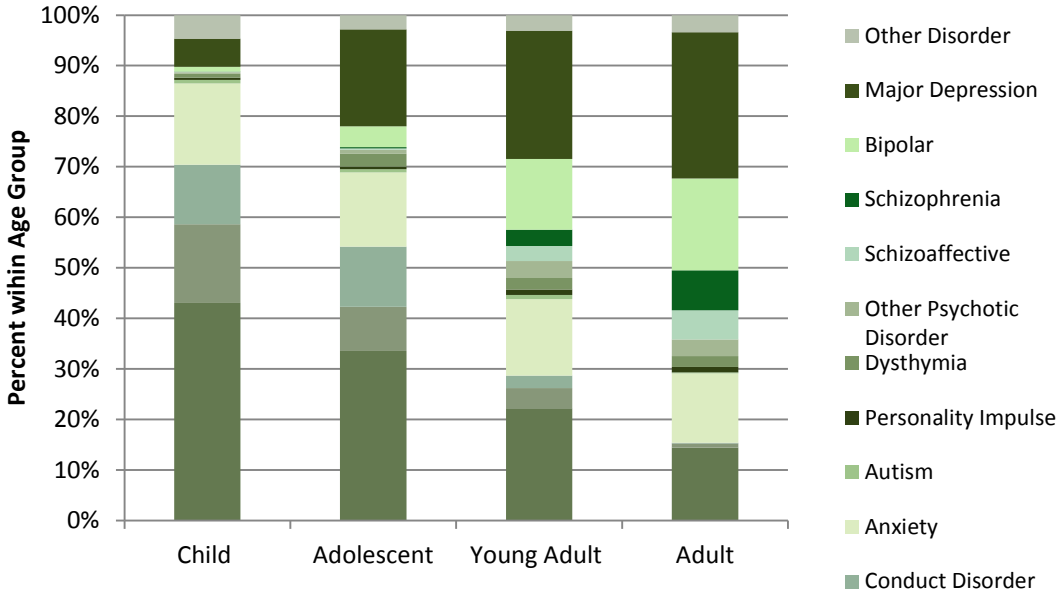
A variety of diagnoses show clear trends across age groups (Figure 3). Notably, rates of adjustment disorders and attention disorders decrease over the life span, while rates of depressive disorders, bipolar, and schizoaffective/ schizophrenia increase. Anxiety disorders, which account for about 15% of diagnoses, are one of the few with fairly consistent rates across all age groups.

"My child had been seeing the same private therapist since the age of five. At the age of 17 we switched to a community mental health center because we knew when he turned 18 we'd need publically funded services and they immediately changed his diagnoses to a more 'adult-like' one."

-Parent, Aurora, CO

The biggest change in depressive disorders occurs between child and adolescents, increasing almost 14% from 5.6% of children to 19.2% of adolescents served by the behavioral health system. The largest increases in bipolar disorder and schizophrenia/schizoaffective disorders occur across the transition years as well. This sample shows a bipolar disorder rate increase from 4.1% to 14.1% for bipolar from adolescent to young adult years, and a collective 5.7% increase in the thought-related disorders during this same time. There is an additional 7.5% increase across thought-related disorders moving from young adult to adult years. Essentially, the transition age youth as a group are experiencing adult-onset disorders while still suffering childhood disorders as well as those that consistently affect all ages. Admission diagnoses for all age groups are described but not included in the predictive factors since it tends to change with time and age.

Figure 3. Diagnoses by Age Group: Behavioral Health Services FY 2010-11



Results show interesting trajectories in the composition of those served by the behavioral health system across the life span, with significant changes during the transition to adulthood. These changes could be important considerations when designing programming for these young people.

HOW DO SYSTEM-LEVEL FACTORS IMPACT PERSONS SERVED?

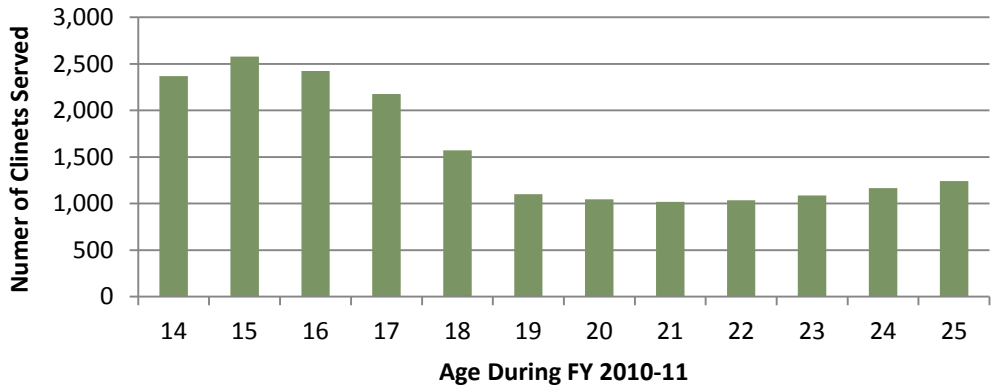
In addition to the developmental factors that affect the distribution of factors across the life span, there are system-level factors that impact the ability of people to access public behavioral health services across the life span.

CHANGING DISABILITY ELIGIBILITY CRITERIA

Access to publically funded services is more difficult for young adults than youth because eligibility criteria are more stringent[5]. A portion loses eligibility at age 18 and do not re-qualify for SSI due to adult definitions of disability. The number of young people receiving mental health services plummets during the early adult years. The number served drops by nearly 28% between ages 17 and 18 and another 30% between 18 and 19 (Figure 4).

[5] http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/Medicaid-and-CHIP-Eligibility-Levels-Table.pdf

Figure 4. Transition age youth Served by Age FY 2010-11



Due to the change in service eligibility that occurs at age 18, the population of adolescents is different than the population of young adults receiving services through the public mental health system[6]. The young adults receiving services are the most severe subset of adolescents who maintained their service eligibility across the adolescent to young adult transition. Fully two-thirds of young adults in the FY 2010-11 sample met the eligibly criteria for the designations of SMI or SPMI, illustrating the serious nature of their behavioral health challenges. When comparing these populations, we need to remember the inherent characteristic difference due to policy regarding provision of services.

Despite the inability of many young adults (18-25) to meet more stringent diagnostic criteria, they still have elevated service needs and are facing the challenges of all transition age youth. Graduating from high school, moving on to college, training, or a job, living independently, developing a community life, and being well are challenges faced by all youth, and complicated greatly for youth with a history of behavioral health challenges. This is an age group of particular concern because these needs remain yet they cannot access the services of the adult public behavioral health system.

"My son stopped therapy immediately upon reaching his 18th birthday. He was told by the mental health center that he would no longer be able to receive services from the child therapist he was used to and would have to switch to the adult team. He did not want to even set foot into the waiting room. The other clients scared him and he couldn't relate to any other clients. My son told me, "everyone is trying to make me sicker than I am so then they will know what to do with me." There were programs that likely could have helped him but he couldn't bring himself to access those services."

- *Parent and Family Advocate, Ft. Collins,*

[6] National Collaborative on Workforce Disability Policy Brief 37. Accessed online on May 13, 2014 at http://www.ncwd-youth.info/policy-brief-02

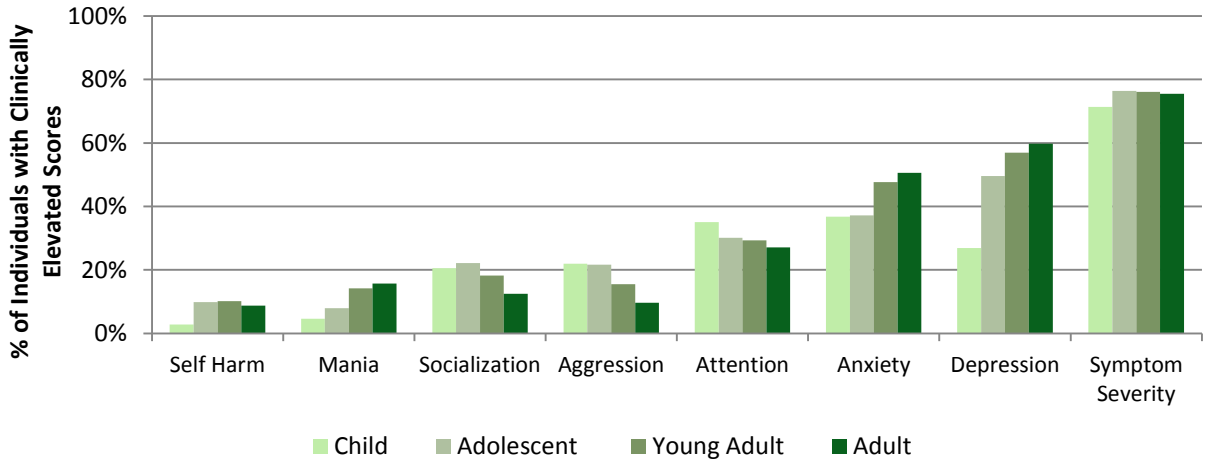
WHAT IS THE CLINICAL PRESENTATION OF INDIVIDUALS AT ADMISSION TO MENTAL HEALTH SERVICES?

Colorado is fortunate to have a common evaluation for all persons served in the public mental health system. The Colorado Client Assessment Record (CCAR) is conducted with all individuals (regardless of age or diagnoses) when they enter treatment, at six month intervals, when there is a significant change in level of care, and at discharge from services. A number of demographic/administrative variables are recorded as well as a clinician rating of 25 domains that relate to wellbeing, mental health, and social functioning.

CLINICAL ADMISSION SCORES

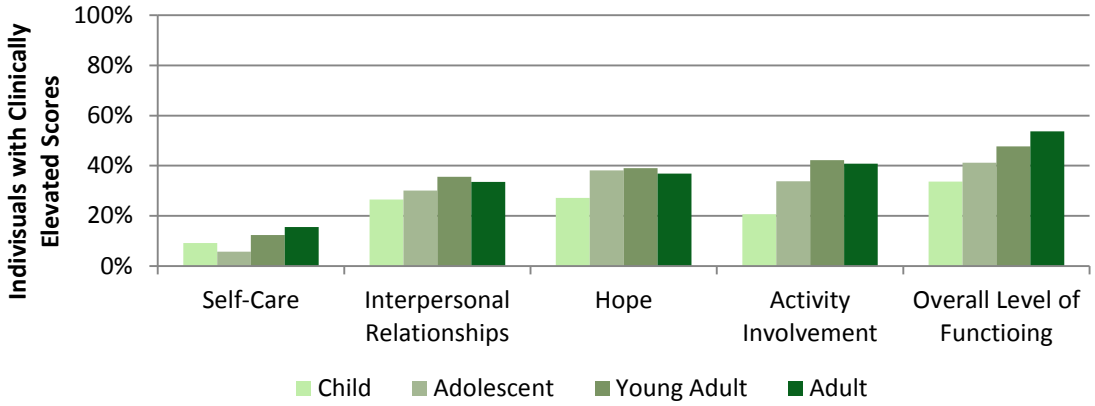
The clinical domains on the CCAR are rated on a one to nine point scale (Please see Appendix B for CCAR domain areas and descriptions). Higher scores *always* indicate a greater level of impairment. Scores of five or higher on any domain indicate a clinically significant elevation (i.e. the domain construct is of current clinical concern and a focus of treatment). The following figures depict the percent of each age group with admission CCAR scores that meet or exceed 'Clinically Elevated' designation (≥ 5 on the 9-point scale). Figure 5 presents these clinical domain scores, showing that transition age youth are distinct from both children and adults. Additionally there is significant change between adolescent and young adult years. Young adult scores are much closer to adult scores, and adolescent scores are closer to children's, except in the domains of Self- Harm (Suicidal Ideation) and Overall Symptom Severity, in which transition age youth of both categories exceed both child and adult rates of clinical severity. During the transition age, individuals begin to look like the population of adults with SMI and SPMI.

Figure 5. CCAR Symptom Domains: Individuals with Clinically Elevated Admission Scores by Age Group



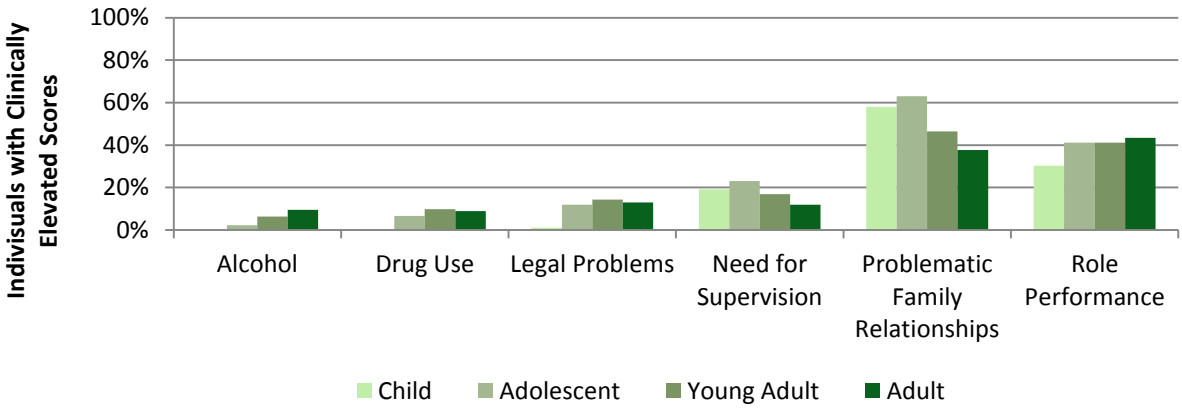
Several of the strength domain scores also show consistent, increasingly severe trends across the age groups, with larger changes in the proportion of clinically elevated scores seen between children and adolescents (Figure 6). Young adults display consistently greater impairment in these domains.

Figure 6. CCAR Strength Domains: Individuals with Clinically Elevated Admission Scores by Age Group



The domains in Figure 7 relate to environmental or system-level factors. Young adults have the highest clinically elevated rates of Legal Problems, with adolescents only slightly better, similar to adults. Role performance is similar in the two TAY groups, and slightly better than adults. However, need for supervision and problematic family relationships peak in adolescence with a trend towards adults in the young adult population. Like the diagnostic data, these CCAR data show the complexity of this transition period and the burden of both childhood and adult challenges.

Figure 7. CCAR System Domains: Percent of Clinically Elevated Admission Scores by Age Group



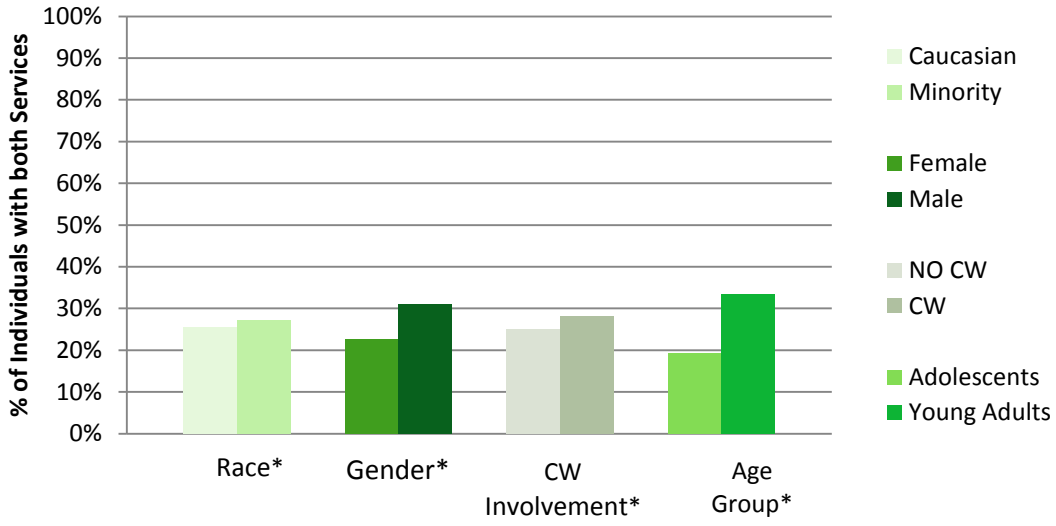
SUBSTANCE USE DISORDER SERVICES

This project was charged to examine the transition age youth with behavioral health challenges including substance use disorders (SUD). In order to do this, substance use treatment records were obtained from the Drug/Alcohol Coordinated Data System (DACODS) for a ten year period (2003-2013). DACODS provides records of all persons served by Colorado licensed substance use providers. These were matched to the file of TAY in the mental health system in FY2010-11. Out of 18,811 TAY in the public mental health records, 4,949 (26.3%) received treatment from public SUD providers at some point during the ten years. It is important to note that the people in the DACODS data set are those who received services from licensed SUD service providers. Youth and young adults could have been treated

by private providers for whom no data are available, though the number of is minimal. The DACODs data does, however, allow for further analysis of factors within transition age youth who had received public SUD services, and compare these youth to TAY who had not received SUD services.

Of the 18,811 TAY in the fiscal year sample, 31.0% of males and 22.5% of females had SUD services (Figure 8). A slightly higher percentage of minority youth (27.3%) than white youth (25.5%) had SUD services. One in three (33.6%) of the young adult age group has received SUD services, more than adolescents whose rate of SUD is closer to one in five (19.2%). Across both TAY age groups, involvement with the Child Welfare system was associated with a slightly higher rate of SUD service involvement (28.0% of those with Child Welfare involvement, versus 25% for those without Child Welfare involvement).

Figure 8. Percent of Individuals Who Received both Mental Health and Substance Use Disorder Services by Demographic Categories



Those with SUD services are more likely to be male, between the ages of 18-25, and minorities. They are also more likely to have had contact with Child Welfare. The CCAR admission profiles of TAY with a SUD service history show higher severity ratings in the system domains of Legal Problems, Security/Supervision, and Role Performance. Elevated clinical domains for those with SUD service history are Socialization (indicating a larger degree in deviance from social norms), Aggression, Psychosis, and Mania. Elevated CCAR clinical scores for those with

"There is an estimated 28,990 substance abusers 10-18 years of age in Colorado. Of these at least 50-60% were diagnosed with a mental health issue in addition to their substance abuse. With approximately 5,000 youth completing treatment in our licensed programs, that leaves 23,586 young people that do not receive services."

- *OBH Website*

SUD services describe an individual experiencing the symptoms of mental illness, along with the legal ramifications of aggression and socialization issues.

ADMISSION SUMMARY

In summary, despite falling under the same eligibility requirements and mental illness definition, adolescents are not the same treatment population as children; nor are young adults the same treatment group as adults. The adolescent and young adult age groups are different demographically and clinically from each other as well. There are significant differences between clinical characteristics of the two TAY age groups. The exception is in overall symptom severity, where they are equal to each other and more severe than the adjacent age groups. Adolescents show greatest overall impairment in the systems areas such as security/supervision, and family relationships, providing evidence that this should be the focus of intervention with these youth. More young adults have clinically elevated score on many domains than adolescents, but fewer than adults, indicating that successful intervention may interrupt the developmental trajectory toward increased severity.

The typical adolescent in mental health services is 16 years old, equally likely to be male or female, and mostly likely diagnosed with adjustment, depressive, conduct, anxiety, or attention disorder. Clinically, adolescents display similar levels of anxiety to children. Most notably adolescents display the most severe ratings of all age groups in System areas. Involvement with alcohol and drugs by adolescents is also evident.

Young adults in the public mental health system are on average 22 years old, and more likely to be female. Common diagnoses are adjustment, anxiety, and depression. There are increased incidences of SMI. Young adults have the highest severity scores in Legal Problems and Self-Harm domains. Young adults display higher severity of alcohol problems than adolescents, but lower than adults; drug use severity in young adults exceeds all other age groups.

Furthermore, youth involved with the SUD system present a different clinical picture at admission. Overall Symptom Severity and Level of Functioning are slightly worse, and system problems are considerably worse in Legal and Role Performance. An increase in symptoms of mental illness, especially in the 18-25 years old group is apparent.

TRANSITION AGE YOUTH OUTCOMES

The current section describes outcomes for youth and young adults in the public mental health system. Four age groups were used in the description of admission factors to explore whether TAY are the same as our child or adult populations. The other age groups provided context for the assertion that they are not the same. The presentation of outcomes focuses on discharge scores in the two TAY age groups, adolescents age 14-17 and young adults age 18-25.

In a successful treatment trajectory, Transition age youth engage in activities to reduce symptom severity, utilize strengths, and become successful adults. The Transition to Independence Process (TIP) model, while not reaching the level of being an "evidence-based practice", is supported by empirical evidence as an effective intervention with Transition age youth with mental health challenges. The model is strengths-based and encourages youth to explore their futures in the domains of Education, Employment, Living Situation, Well-being/Personal Effectiveness, and Community Life/Functioning.

A number of CCAR domains reflect those same constructs. The Overall Symptom Severity rating reflects Well-being in symptom level and management. The Role Performance CCAR rating reflects activities in the primary occupational role of the person, whether that be school or work. Community life/functioning is a component of the Overall Level of Functioning domain on the CCAR. While specifics of the TIP model will be discussed in more detail in the Best Practices section of this report, this model provides the justification of choosing Symptom Severity, Role Performance, and Overall Level of Functioning as the critical outcome measures.

The link between mental health and criminal justice involvement has been a widely discussed topic in Colorado and throughout the country. Over the course of this project, it became clear that this link needed to be explored. Colorado Division of Youth Corrections (DYC) records were matched to adolescent public mental health system records to determine the overlap in the two populations. A variety of analyses were then conducted to determine factors related to juvenile justice involvement.

WHAT IS THE CLINICAL PRESENTATION OF TRANSITION AGE YOUTH AT DISCHARGE?

People may be discharged from mental health services for a variety of reasons not just upon successful treatment completion. For this analysis, all discharge types were retained because a lack of engagement is reflected in discharge scores.

TREATMENT SUCCESS AS MEASURED BY CCAR SCORES

At treatment discharge, there are improvements in clinical severity across both transition age groups. However, a significant percent of TAY still have CCAR symptom ratings of five or above, indicating remaining clinical-level need and a lack of treatment success. A CCAR rating of five on the Symptom Severity Rating is defined by the continued need for “professional mental health intervention”. Ratings of five or higher on this domain suggest that the clinician does not feel the mental health symptoms are at a level where no further treatment is necessary. Table 2 indicates that nearly half of adolescents and

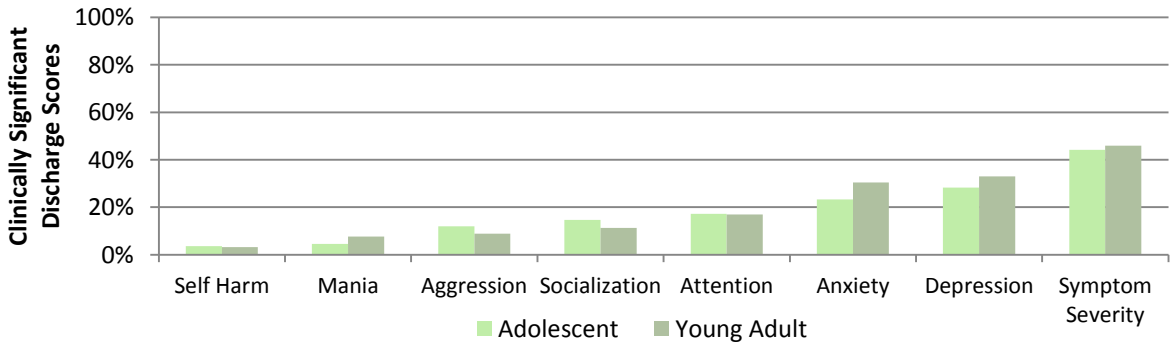
young adults fall into this category at discharge. This high rate of unsuccessful discharge from mental health services is quite alarming and suggests a need for efforts to increase engagement and improve outcomes across this age group. The other two outcome domains show fewer individuals with elevated scores at discharge but still more than a quarter of TAY are discharging from services before their functioning in these domains reaches a sub-clinical level.

Table 2. Percent of Transition age youth: Clinically Elevated at Treatment Admission and Discharge

CCAR Domain	Adolescents:		Young Adults	
	Admission	Discharge	Admission	Discharge
Symptom Severity	76.1%	44.1%	76.4%	45.4%
Role Performance	41.1%	27.6%	43.4%	26.5%
Level of Functioning	41.2 %	22.6%	47.7%	26.2%

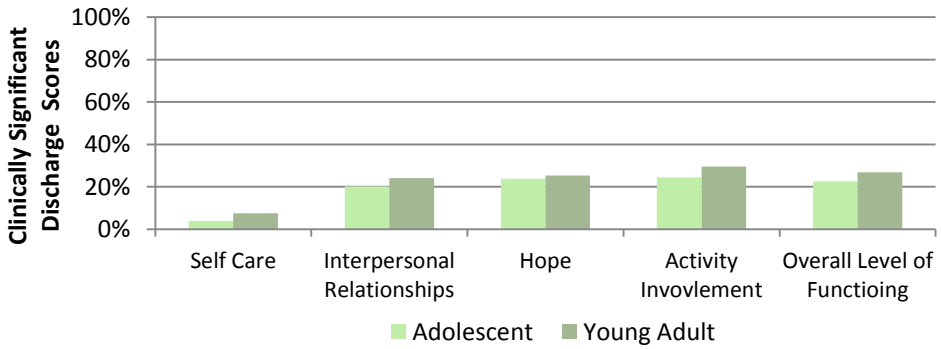
While other domain scores from admission to discharge for both adolescent and young adults did improve overall, it is important to note that a significant number of individuals still had clinically elevated scores at discharge. Young Adults had higher rates of clinically elevated scores across most symptom domains except for Socialization and Aggression where adolescents outpaced them.

Figure 9. Clinically Elevated CCAR Scores at Discharge by Age Group



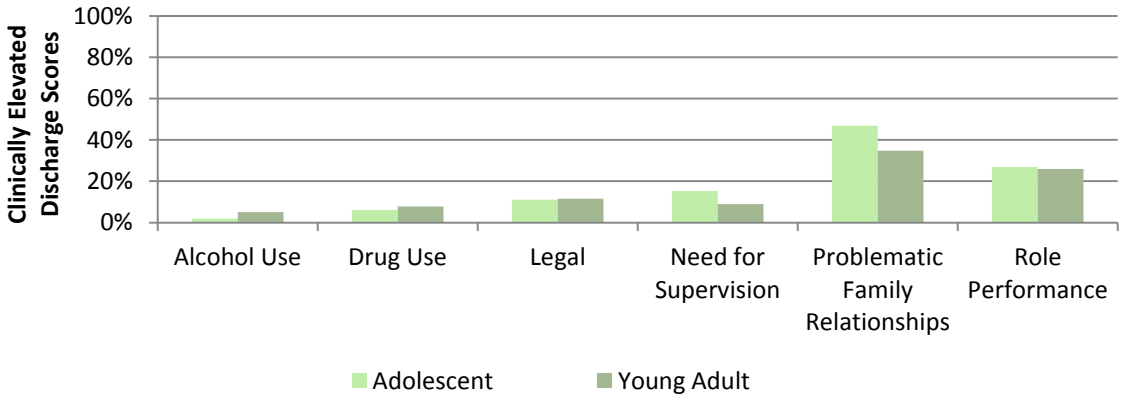
There is a similar pattern across strength domains at discharge. Figure 10 shows higher rates of clinically elevated scores for young adults versus adolescents across all CCAR strength domains.

Figure 10. CCAR Strength Domains: Clinically Elevated Scores at Discharge



In contrast, the system level domains Need for Supervision and Problematic Family Relationships are more severe for adolescents than for young adults at discharge, and the two TAY groups are essentially equal in rates of clinically elevated Legal Problems and Role Performance domain scores.

Figure 11. CCAR System Domains: Clinically Elevated Scores at Discharge



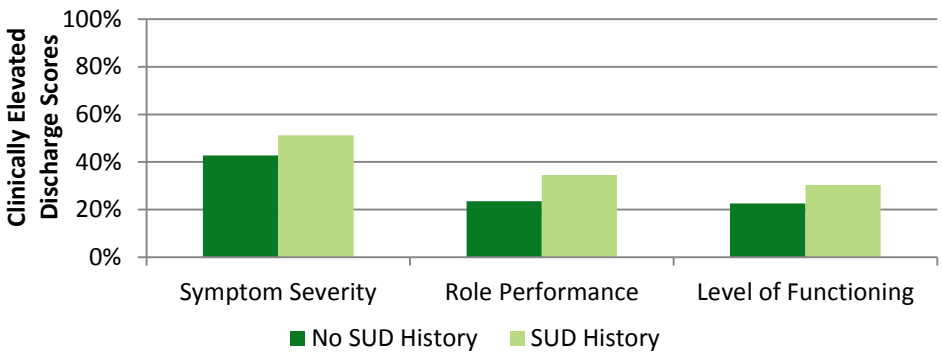
DO THOSE INDIVIDUALS WHO PARTICIPATE IN SUBSTANCE USE DISORDER SERVICES HAVE A DIFFERENT CLINICAL PROFILE THAN THOSE WHO DO NOT?

The participation in both mental health and SUD services indicates the presence of a co-occurring mental health and substance use disorder. This population of individuals is typically more complex to treat successfully and thus a population requiring increased emphasis when developing programming for this age group.

SUBSTANCE USE DISORDER SERVICES

At discharge, youth with a history of SUD service have a consistent profile of clinical concern. Youth with SUD service history have a higher rate of clinically elevated discharge scores than those without SUD service history, across ***every*** domain. The following figure depicts the difference between the two groups on the three outcome domains.

Figure 12. Clinically Elevated Discharge CCAR Scores: TAY With and Without SUD Service History



It is important to remember that the youth and young adults included in this analysis is likely an underrepresentation of the co-occurring population because only those served by Colorado's licensed substance abuse providers are included. There are a number of TAY being served by SUD providers outside this system, either by private providers in Colorado or by providers in other states, further increasing the need for programming for youth with both SUD and MH challenges.

WHAT FACTORS INFLUENCE CLINICAL OUTCOMES?

Analyses were conducted to determine the factors that significantly[7] impact the clinical outcomes of interest, Overall Symptom Severity, Role Performance, and Level of Functioning. Overall Symptom Severity is the severity of mental health symptoms. Role Performance is the extent to which one performs their occupational role (e.g., student). The extent to which a person can carry out the activities of daily living despite the presence of mental health symptoms is captured by Level of Functioning. The first set of analyses depicts the relationship of individual factors on each of the outcome measures. These results were used to inform the construction of predictive models.

STATISTICAL ANALYSIS OF OUTCOMES

Statistical analysis confirmed that these age groups were significantly different across the primary outcomes of interest, such that young adults had significantly higher rates of clinically elevated discharge Symptom Severity and Level of Functioning scores than did adolescents. The difference between the two age groups in discharge Role Performance was marginally significant and in the opposite direction, with adolescents showing poorer outcome.

Due to the differences between the two age groups of the TAY population, statistical analyses of outcomes were conducted separately for each group. Result summaries and age group-specific figures are included below. Please see Appendix C for admission severities by age group.

ADOLESCENTS

Gender, age at first admission to public mental health services, involvement in the child welfare system, receipt of SUD treatment services, and race were tested with Chi-Square analyses to determine if they were significantly related to the three outcome measures. Results indicated that all five factors were significantly[8] related to clinical elevation of discharge scores in Overall Symptom Severity and Role Performance. Race was not significantly related to clinical elevation of Overall Level of Functioning at discharge, but the other four factors were. Please see Figure 13 below for a depiction of the four binary

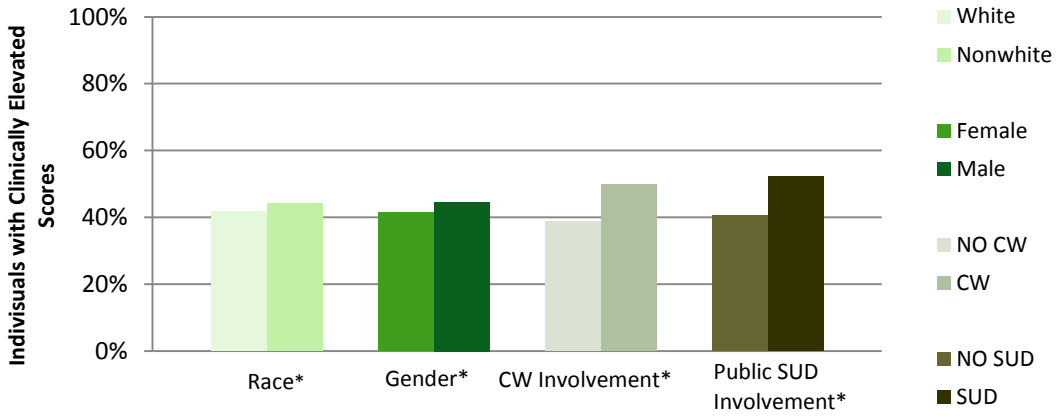
[7] It is important to note that with large sample sizes, group differences that are consistent may be statistically significant even when they are small in magnitude.

[8] *Results statistically significant at $p<.001$

factors in relation to Symptom Severity. Profiles looked very similar for Role Performance and Overall Level of Functioning (Please see Appendix D for Chi Square results).

Overall, statistical findings indicate that males, those who were younger when they entered mental health services, those who had child welfare involvement, those who received SUD services and minority adolescents were more likely to discharge with a clinically elevated (CCAR score of five or greater) Symptom Severity and Role Performance scores. The same pattern emerged for Overall Level of Functioning at discharge except minority youth are no more likely than white youth to have clinically elevated scores in this domain.

Figure 13. Adolescents: Discharge Symptom Severity CCAR Scores



YOUNG ADULTS

Chi Square analyses also revealed significant relationships between demographic and service factors and the three primary outcomes within the young adult population. Race was not significantly related to any of the three outcomes. Only gender and SUD involvement were consistently related to all three outcome domains. Across all three outcome domains, males were significantly more likely to have clinically elevated scores at discharge. The largest gender-based difference was in Role Performance, with 11% more males discharging with clinically elevated scores in this domain (See Appendix E for Chi Square results).

Like adolescents, young adults with SUD service history had worse outcomes across all three domains. Child Welfare involvement had a significant and negative relationship with Role Performance and Level of Functioning. Age at first mental health admission was significantly related to all three outcome domains; those with clinically elevated scores in Role Performance and Level of Functioning were likely to be younger when they began public mental health services. The direction of the difference in Symptom Severity is opposite, with older age of first admission associated with more clinical elevation. See the Table 3 for a description of which factors were related in univariate tests to the three outcome measures.

Table 3. Factors Significantly Related to Clinically Elevated Discharge Scores

CCAR Domain	Adolescents	Young Adults
Symptom Severity	Gender, First Admission Age, Race, CW Involvement, Public SUD Involvement	Gender, First Admission Age*, Public SUD Involvement
Role Performance	Gender, First Admission Age, Race, CW Involvement, Public SUD Involvement	Gender, First Admission Age, CW Involvement, Public SUD Involvement
Level of Functioning	Gender, First Admission Age, CW Involvement, Public SUD Involvement	Gender, First Admission Age, CW Involvement, Public SUD Involvement

It is notable that the factors related to discharge Symptom Severity for young adults look different than for the other outcome domains. Neither race nor childhood involvement with the child welfare system were significantly related to clinical elevations on discharge Symptom Severity. Additionally, older age at first admission was associated with poorer outcomes for young adults. These analyses provide further evidence that the young adults being served by the public mental health system is a different population than adolescents and points out that earlier entrance into services is critical.

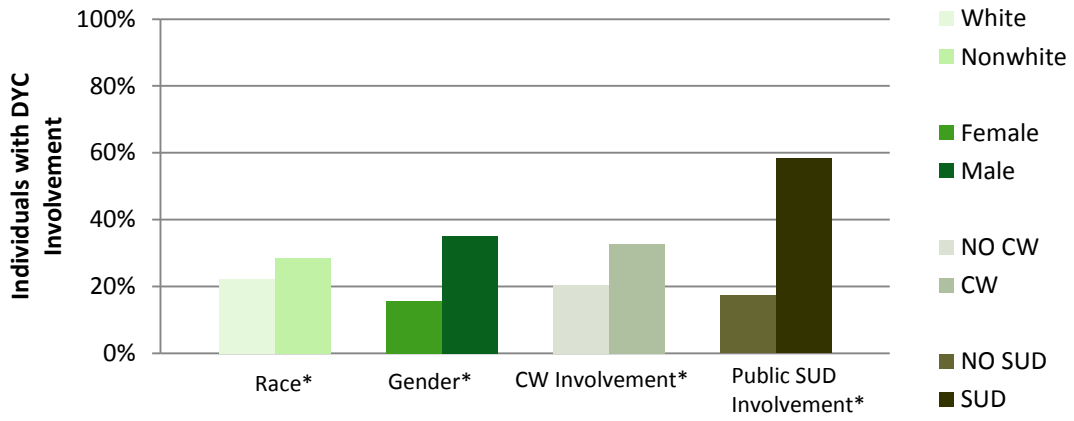
WHO BECOMES INVOLVED IN THE CRIMINAL JUSTICE SYSTEM?

As analyses of data progressed, the connection of youth in the public mental health system to the legal system became apparent. Discharge data show the legal problems of adolescents in mental health increasing. As such, it was decided to undertake a special analysis of involvement with youth corrections. Involvement in juvenile justice was defined as having been detained or committed to the Division of Youth Corrections (DYC) during the period between July 1, 2006 and June 30, 2013. The selection of this seven year time period was sufficient to capture any involvement by the adolescents receiving mental health services in FY2010-11. Because Colorado Division of Youth Corrections is limited to under age 21, the analysis included only the adolescents in the mental health system.

TREATMENT SUCCESS AS MEASURED BY JUVENILE JUSTICE INVOLVEMENT

Relationships between demographic (gender, age, race) and system factors (Child Welfare involvement, SUD services), and involvement with DYC were examined. The outcome was binary, involvement with DYC or not. Chi-square analyses revealed significant relationships between Gender, Age at first admission to mental health services, Race, Child Welfare involvement and SUD services. See Figure 14 for a depiction of how these factors are related to DYC involvement.

Figure 14. Factors Associated with DYC Involvement



One in three males had involvement with DYC while 15.6% females did so. Age at first mental health contact was less for those with DYC involvement, and minorities have a 6% higher rate of DYC involvement (28% v. 22%). Involvement with the CW and SUD system significantly increased risk for contact with DYC. Thirty-two percent of those with Child Welfare had DYC contact, and over half of those with SUD services (58%) were in detention, commitment or both.

WHAT MODEL FACTORS INFLUENCE OUTCOMES?

The previous section detailed the univariate analyses that revealed significant relationships between demographic and systems level factors and outcome measures. These results were used to inform the development of predictive models that were expanded to include clinical measures at admission to mental health services to further understand their influence on the outcomes of TAY.

OUTCOMES MODELING

Multivariate analyses were conducted to determine the concomitant relationships between factors and each of the CCAR outcomes, Symptom Severity, Role Performance and LOF. Since the outcomes of interest were clinically elevated discharge scores as determined by a rating of five or higher on each outcome domain, logistic regression was utilized. In the case of DYC involvement, the outcome was a Yes/No, therefore also requiring a binary logistic regression.

Models were run separately for adolescents and young adults for each of the outcome domains. The demographic factors included were Race (Caucasian/non-Caucasian), Gender, and Age at first contact with public mental health. System factors were Child Welfare involvement and SUD services. All of the CCAR domain scores at admission were entered into the model to determine significant relationships with outcomes. Variables were entered in blocks, with demographic factors of Gender, Race, and Age entered stepwise within the block; systems factors (CW involvement, SUD services) comprised the second block entry, and the CCAR domain scores were entered in the last block. Admission ratings for the discharge outcomes were included as covariates.

The following table summarizes the results of the models. It is important to note that while the models were statistically significant, the model fit was not optimal which is to be expected with a behaviorally based data set[9]. (See Appendix F for factors and significance levels).

Table 4. Significant Predictors of Discharge Outcomes

OUTCOME	Significant Demographic and System Predictors	Significant[10] Admission CCAR Clinical Predictors
Adolescent Discharge Symptom Severity	Race, Child Welfare, Public Substance Use Disorder Service	Legal Problems, Self-Harm, Aggression, Cognition, Mania, Drug Use, Symptom Severity
Adolescent Discharge Role Performance	Race, Child Welfare, Public Substance Use Disorder Service	Legal Problems, Aggression, Attention, Drug Use, Activity Involvement, Role Performance
Adolescent Discharge Level of Functioning	Child Welfare, Public Substance Use Disorder Service	Legal Problems, Self-Harm, Cognition, Mania, Drug Use, Activity Involvement, LOF
Young Adult Discharge Symptom Severity	Public Substance Use Disorder Service	Physical Health, Self-Care, Need for Supervision, Self-Harm, Aggression, Psychosis, Cognition, Mania, Anxiety, Interpersonal Relationships, Activity Involvement, Symptom Severity
Young Adult Discharge Role Performance	First Admission Age, Gender, Public Substance Use Disorder Service	Legal Problems, Self-Care, Aggression, Psychosis, Cognition, Mania, Anxiety, Role Performance
Young Adult Discharge Level of Functioning	Gender, Child Welfare, Public Substance Use Disorder Service	Legal Problems, Self-Care, Physical Health, Self-Harm, Aggression, Psychosis, Cognition, Mania, Anxiety, Interpersonal Relationships, Empowerment, Activity Involvement, LOF
Adolescents In DYC	Age at First Admission, Gender, Race, Child Welfare, Public Substance Use Disorder Service	Legal Problems, Self-Care, Need for Supervision, Mania, Depression[11], Alcohol Use, Socialization

LOF=Level of Functioning, DYC= Division of Youth Corrections

More severe admission scores were related to poorer outcomes in all cases except in the relationship between depression and DYC involvement. Youth who were more severely depressed when they began mental health treatment were less likely to become involved in DYC.

[9] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2791967/
[10] Reported findings are significant at p=.05.
[11] Lower depression scores at admission were related to DYC involvement.

OUTCOME SUMMARY

Adolescents and young adults are neither children nor adults, yet have been treated as one or the other in receiving mental health services. In this analysis of TAY it is clear that while some needs are uniform across these TAY groups, these two groups are different.

Almost 50% of adolescents have significant family problems at discharge, despite showing improvement since admission, and 45% have clinical Symptom Severity still requiring treatment. They show no improvement in drug or alcohol problems and in fact, show greater Legal Problems at discharge. Other system domains show some improvement but continued problems for adolescents. Strength domains exhibit similar improvement to young adults, but still a quarter discharge from mental health services with an Overall Level of Functioning that is rated as clinically significant.

Young adults show the least success in discharge Symptom Severity, with nearly half discharging with a clinically elevated score of five or higher. Other clinical symptoms exceed adolescents in severity at discharge. In this group, we see a noted increase in psychotic and manic severity mirroring the findings that 75% of mental illnesses emerge by the age of 25[12]. System problems remain, most notably in Role Performance, Problematic Family Relationships, and Legal Problems domains (Please see Appendix G for all discharge severities). Furthermore, young adults are dropping out of mental health services at alarming rates. This constellation of results makes it clear that developmentally appropriate, engaging services are critical for young adults with behavioral health concerns.

Modeling the outcomes revealed interesting patterns in both adolescents and young adults. The most significant predictor of discharge status is severity at admission in the corresponding domain. In adolescents, race is related to Symptom Severity and Role Performance outcomes, as are the CCAR domains of Legal Problems and Drug Use, with Activities Involvement and Aggression significantly related to two of the three CCAR outcomes. The finding that Attention problems are related to Role Performance, which for most in this group is school-related, is not surprising. The evidence for suicidality (Self-Harm) and thought issues (Cognition) at admission are telling, as is the consistent finding of Drug Use in adolescents. A positive

PERSISTENT CLINICAL NEED

Young adults are dropping out of services at alarming rates without significant mental health symptom reduction.

75% of mental illnesses emerge by the age of 25, making intervention with the age group critical.

[12] Age of Onset and Timing of Treatment for Mental and Substance Use Disorders
Implications for Preventive Intervention Strategies and Models of Care
Patrick D. McGorry, Rosemary Purcell, Sherilyn Goldstone, G. Paul Amminger
Curr Opin Psychiatry. 2011;24(4):301-306

finding is that more participation in positive activities as reflected by the Activity Involvement score is related to better outcomes, suggesting this might be a successful intervention strategy.

The models for young adults showed regular effects of Gender, Child Welfare, SUD services, and CCAR domains Legal Problems, Self-Care, Self-Harm, Aggression, Cognition, Mania, Physical Health, Aggression, Anxiety, Interpersonal Relationships, and Activity Involvement. Young adults are also exhibiting evidence of thought issues, aggression and problems interpersonally. Physical Health is an issue already for a significant portion of this population and relates to worse outcomes. It is encouraging that Activity involvement exhibits a protective factor in this population also.

The results of modeling for the DYC outcome reveal similar findings. Additional factors for these youth are Need for Supervision, Socialization, and Alcohol Use (though not Drug Use). Not surprisingly, the legal problems domain is elevated for those in DYC also. The finding of significance for Socialization is not surprising, as this refers to adherence to cultural and social norms. Alcohol Use as measured by CCAR is unique to this model, although Drug Use was significant in all three adolescent outcome models, suggesting co-occurring services are needed. Mania is a factor related to DYC as well as to all other outcomes in one or both populations. As such, it is a more reliable indicator of potential poor outcomes.

The complex nature of factors in the data that impact likelihood of outcome is illustrated in risk of DYC involvement. In the general population, the prevalence for DYC involvement is ***20.8 out of 10,000*** youth in the juvenile population. Strikingly, in an adolescent mental health population, ***one in four*** (25%) youth has DYC detention or commitment. Males with mental health service have a greater than ***one in three*** (35%) chance for DYC involvement, adding Child Welfare involvement increases that risk to nearly ***one in two*** (43%) further adding SUD services, results ***three of four*** (73.7%) adolescent boys with DYC involvement. The additional factor of an elevated admission score on Socialization elevated the chance to more than ***eight out of ten*** (82.5%) involved with DYC.

TRANSITION AGE YOUTH: POLICY REVIEW

INTRODUCTION

A critical component to understanding the outcomes results is a comprehensive picture of the systems and system influences in which services are operated. The goal of this review is to describe the systems with which TAY with serious behavioral health challenges may come into contact. To achieve this, public policy components related to the provision of mental health services for TAY with behavioral health challenges are described. As previously noted, the vision of this project is to ensure a system of care that aids youth with serious behavioral health challenges to successfully transition to adulthood. One step toward that vision was to formulate a system-level picture of the mental health services that are currently available to all or some portion of the TAY population.

QUALITATIVE ANALYSIS METHOD

Multiple state agencies serve transition age youth, so the policy review began with an online review of state agency webpages and policy links. One of the first findings was that agency-level policy was broad in scope and did not detail services specific to the transition age group. Each agency, however, had a variety of programs with information about program-specific target populations and eligibility criteria as well as service descriptions, and program guidelines The policy review became a program inventory, revealing policy elements through program descriptions, and providing the appropriate level of detail to capture the needed cross-system picture of transition age services. All of the information in this review was gathered from internet searches, agency websites, and informant interviews from October 2013 through December 2013.

Many transition age youth services are operated in the local community and by community agencies, thus community programs with relevant initiatives were an important part of the inventory. Community programs are defined as organizations where primary reporting authority is not to a government entity. The inventory of state and local programs generated by this investigation is not meant to be exhaustive. The intention was to capture the systems and support programs with which youth and young adults with behavioral health challenges were most likely to come into contact. Please see Appendix H for the complete inventory matrix.

While the following review provides brief program descriptions, the focus is a statewide look at the:

- Availability of programs and services (i.e. eligibility requirements)
- Inclusion of System of Care (SOC) principals in program designs
- Alignment of programming with Transition to Independence (TIP) functional areas of focus

An SOC is a coordinated network of community-based services, where families and youth work in partnership with both public and private organizations so that services and supports are effective, build on an individual's strengths, and address each person's cultural and linguistic needs. The five principles

assessed here measure the extent to which a program is: Family-driven, Youth-guided, Culturally Competent, Interagency, and Developmentally Appropriate. The first four dimensions were assessed according to SOC definitions of fidelity. The fifth dimension, Developmentally Appropriate, was strictly defined as whether services were designed for youth in the transition age spectrum for this project (14-25). Determination of fidelity was accomplished through review of program description and philosophy published online.

The Transition to Independence Process (TIP) model, an evidence-supported service for young adults, identifies five functional domains associated with positive outcomes for the transition age population with behavioral health challenges. Colorado's programs and services were evaluated for inclusion of these five domains: Education, Employment, Housing, Well-being, and Community living (http://tipstars.org/).

QUALITATIVE ANALYSIS RESULTS

The four System of Care (SOC) principles measure the extent to which a program is: Family-driven, Youth-guided, Culturally Competent, and Interagency.

As noted above, to capture a sufficiently detailed picture of population-specific services, the policy review was shifted to a review of state and local programming. While the majority of results focus on program detail, it is also important to describe major policy issues that affect youth access to services. At a federal level the Affordable Care Act extended the maximum age of youth eligibility starting in 2014. Transition age youth may now retain coverage under their parents' health insurance policies through age 25. An additional development at the federal level sets aside 5% of Block Grant funds for young adults with early signs of mental illness. At a state level, the Office of Behavioral Health recently instituted a policy regarding service planning for youth age 15 and older that requires all state funded behavioral health services to include case plans with goals and objectives for successful transition to adulthood.

COLORADO STATE AGENCY PROGRAMS

The number of programs with services and supports for transition age youth is impressive. The Colorado Department of Human Services (CDHS) offers a comprehensive array of services for youth with serious behavioral health challenges. Within CDHS, the primary behavioral health authority lies in the Office of Behavioral Health (OBH). Mental health services are delivered primarily through 17 community mental health centers, eight specialty clinics, and two mental health institutes. OBH has a policy regarding transition planning, and at least nine program areas that treat all or some subset of TAY. Programs are generally split into child-serving (age 0-17) and adult-serving (age 18+), per mental health Federal Block Grant definitions.

Federal funding guidelines require the System of Care approach for the delivery of mental health services, which is reflected in the agency-level programming principles of OBH. Despite OBH's new

The Transition to Independence Process (TIP) model includes five functional domains: Education, Employment, Housing, Well-being, and Community living.

transition planning policy, a review of specific programs finds an overall lack of developmentally appropriate services designed for TAY, thought there is movement in planning. The Federal Block Grant also specifies that treatment in public mental health targets the five domains of Education, Employment, Living Situation, Well-being, and Community life. OBH's programs for co-occurring mental health and substance use disorders do emphasize all domains, while OBH's other TAY programs tend to target fewer domains.

A number of community mental health centers have developed some programming specific for TAY. These programs are typically drop-in centers that provide opportunities for youth to grow through an array of services. "The Road" at Jefferson Center for Mental Health and a very new program at the Mental Health Center of Denver called "The Downstairs" are two examples of programs tailored specifically for TAY. Age of eligibility varies slightly within the overall transition ages and the program components vary by the geographic area of the mental health center. The SOC principles are foundational to the implementation of these programs even when they are difficult to achieve.

"Families are welcome to participate in programming but few of them do. Many youth don't want their families involved.

- *"The Road" Program Coordinator, Lakewood, CO*

OBH also oversees the provision of Substance Use Treatment and Prevention services. There are over 350 licensed providers of adolescent SUD services and even more that serve adults. There are a number of existing programs that offer substance use services to TAY, though they tend to be more focused than all five transition domains, and generally adhere to SOC principles. OBH was recently awarded a SAMHSA grant called the Cooperative Agreements for State Adolescent and Transition age youth Treatment Enhancement and Dissemination. This project adheres to both the SOC principles and TIP domains.

Also within CDHS are programs in the Office of Children, Youth, and Families. The Tony Grampsas Youth Services Program supports a variety of community-based programs for youth up to age 18. They are designed to prevent/mitigate crime and violence, and child abuse and neglect. The Tony Grampsas programs are all community-based and grant funded, so can change with funding cycles. Programming reflects SOC principles and currently there are two programs designed for TAY that address all five domains.

In the Division of Child Welfare, six programs are specifically aimed at adolescents or young adults. Mental health services are supported through Core Services (typically up to age 18), and there are two

programs aimed at TAY independence; Emancipation Services (ages 16-21), and Chafee Foster Care Independence Program (ages 16-21). Federal goals do not reflect SOC principles in that they are not strengths-based, interagency, or culturally competent. Core Services incorporates SOC principles to a degree by incorporating a youth-involvement treatment focus, but do not offer youth-guided services, and do not have mental health services designed specifically for TAY. Core Services do address three TIP dimensions: Living Situation, Well-being, and Community Life. Emancipation Services and Chafee incorporate some SOC principles, with Emancipation Services designed for TAY. Both address all five TIP domains.

In the Division for Intellectual and Developmental Disabilities, mental health services are delivered through the child (ages 0-17) and adult (ages 18+) programs, as well as through a specific program for youth transitioning out of school (ages 16-21). SOC principles are not evident in programming, however all five TIP domains are addressed.

The Division of Youth Corrections provides mental health services to youth in custody through their administrative services program (up to age 18; or 21 for youth completing sentences for youth adjudications). The SOC principles of cultural competence and interagency work are evident. The program entails services for all SOC domains.

The Division of Criminal Justice (DCJ) has two programs where youth with behavioral health needs may receive services; Juvenile Diversion is a program for youth up to age 17, and Community Corrections offers specialized programs for ages 18 and up. SOC principles were not evident in DCJ documentation, though specific program information was limited.

The Division of Vocational Rehabilitation (DVR), also within CDHS, in partnership with the Colorado Department of Education offers an employment program for youth with a disability who are age 16-25. While the TIP domain of employment is an obvious focus, there is no evidence of developmentally appropriate considerations, or inclusion of SOC principles (beyond interagency collaboration) in the program description. DVR also publishes a navigation guide on transition to adulthood.

> "We need to invest in young people through case management – they may not have a family member to advocate for them so they need a peer mentor or another adult to assist them."
>
> - *Director of Office of Homeless Youth, Denver, CO*

The Department of Local Affairs, Office of Homeless Youth Services, offers programming for homeless youth through several programs including, the Family Reunification Project (FUP), the State Housing Voucher Program, the Ft. Lyon Homeless Transition Program, the Shelter Plus Care Project. All of these programs offer housing assistance to individuals over the age of 18 except for FUP which provides support to youth who are in foster care at age 16 or older.

The Colorado Department of Education (CDE) oversees the mental health services provided through the schools that are available for youth with a disability up to age 21. Within the school system, youth with behavioral health challenges/diagnoses are identified as having an educational disability (SIED) and fall

under the same special education rubric as children with developmental and learning disabilities. SOC principles are included to a degree, with family and youth involvement, interagency work, and cultural competence apparent in program descriptions. CDE offers transition planning to youth age 15-21 with a Significant Identifiable Educational Disability (SIED). SOC principles are evident in the Transition planning area, and all domains are targeted.

The primary charge of the Colorado Department of Corrections (CDOC) is to ensure public safety through services for adults 18 and above. The Youth Offender System within CDOC, however, is a system designed to rehabilitate (and protect from the adult corrections population) youth age 14-19 who have been charged as adults. Programs in YOS provide an array of services targeted to all TIP domains. Services are designed specifically for the transition age population, but there is limited family and youth involvement in treatment decision making.

The Department of Labor and Employment has the Guideposts to Success program for youth aged 14-24. This program supports an array of services in communities who have applied and received funding. The number awarded in the state is limited. All SOC principles except interagency collaboration are included in programming, and all domain areas are addressed.

For youth under age 25, the Department of Local Affairs, Office of Homeless Youth Services, offers programming for homeless youth. The OHYS was created with the intent that services to homeless youth statewide could be improved by coordinating current services and facilitating interagency collaboration in order to identify gaps, remove barriers, improve access and increase information sharing. OHYS sponsors The Colorado Homeless Youth Action Plan, designed to prevent and address youth homelessness in Colorado and to ensure that the primary objectives outlined in the Homeless Youth Services Act are accomplished. The five areas of focus in the plan are: Prevention, Housing, Supportive Services, Planning and Awareness, and Outreach.

The Department of Higher Education supports TRiO student support services at Metropolitan State University for students with disabilities including behavioral health conditions. TRiO refers to the three federal programs that originally funded the program. Proven services include Academic Support and Guidance, Tutorial Assistance, Skill-building Workshops, Peer Mentoring, Graduate School and Career Preparation, Financial Aid Application Assistance and Financial Literacy, Scholarship Opportunities, Computer Lab, Social and Cultural Events, Leadership Development, and Community Resources.

The Colorado Department of Public Health and Environment supports the CO9to25 platform advocating the Positive Youth Development principles for all youth. The goal is to build a coordinated, comprehensive system for youth to improve health and well-being through positive change in state/local programs and alignment of systems. The Colorado Prevention Leadership Council is a multi-agency collaborative (ten state agencies, two universities, and others) supported by state statute, and promotes coordinated planning, implementation, and evaluation of quality prevention, intervention and treatment services for children, youth, and families. The SOC approach is a stated philosophy.

COMMUNITY PROGRAMS

There are a number of community services and supports for TAY that exist outside of state agencies. Community organizations may be funded with some public dollars but are primarily supported through other means such as grants. Mile High United Way has two programs targeting young adults in foster care: the Family Unification Program which provides housing vouchers to eligible youth, and Bridging the Gap, a program for current and former foster care youth aged 16-24 living in Adams, Arapahoe, Denver, Douglas and Jefferson counties.

Urban Peak serves youth aged 15-24 who are homeless or at risk of homelessness in two urban areas. A comprehensive array of services and supports are available to youth, including mental health services in the Denver area that are contracted for through the Mental Health Center of Denver.

The Source in Boulder, The House in Grand Junction, and The Matthews House in Ft. Collins provide a variety of services to at risk youth and will be discussed further in the Best Practices section of this report.

The Colorado Federation of Families for Children's Mental Health sponsors the national Youth M.O.V.E. program in Colorado, which is a youth-led effort intended to build positive growth and development for children who have been in one or more state systems (e.g., DYC, SUD). The Colorado chapter is Colorado Youth Voice, which is a coalition of youth advocates who provide training to work at the policy level.

The Family to Family Health Information Centers, out of Family Voices Colorado, creates a collaborative entity of family-driven organizations and Family Navigators to assist families across the state. The centers collaborate with Colorado health care systems so families may better navigate services through agencies and entities such as Medicaid, CHP+, Healthy Communities, HCPF, and Title V/HCP, mental health, human services, and protection and advocacy. They assist families who request information, support, system navigation, and advocacy.

The Social Security Administration funds the Youth Wins program, designed to facilitate movement from school to work for youth with disabilities aged 14-25 who are receiving social security benefits or who are at risk of needing them. These are time-limited and availability is limited by geography.

The faith-based community provides a major source of support for many persons with behavioral health challenges. There are numerous faith-based organizations in the metro area that have programs and supports for TAY. Examples include Agape Christian Church, Church in the City, Second Chance, and Cathedral of the Immaculate Conception, Center of Hope, Catholic Charities, Charity House, New Genesis, Providence Network/First Steps, Denver Urban Ministries, and Empowerment Program for Young Women.

POLICY AND PROGRAMMING DISCUSSION

Many of Colorado's child-serving agencies offer behavioral health services to youth in their systems. While many include evidence-supported criteria for transition age youth, there is a dearth of programming that is specifically geared towards this developmental window. Additionally, navigating and accessing the available services is a challenge. The number of methods to access these services is

nearly as high as the number of programs. There is no single "door" to access behavioral health services. This is due in part to services being provided within distinct programs, all with their own staff, funding, and administrative structures, and further existing within the numerous structures, policies, and practices of their varied parent state agencies.

While most of the state-level programs include evidence supported elements (SOC, TIP) in programming design, they are not available across the full 14-25 transition age window. Some programs provide services up to age 21, but eligibility for children's services most often ends at age 18. When youth "age out" of the children's systems, there may not be an adult system with corresponding supports, or the adult system supports may not be developmentally appropriate for young adults. If an adult system exists, the transition is not seamless. Notable, eligibility requirements for government funded services tend to be rigid. These program policies are often defined by statute and are not inclusive enough to serve the demographic and clinical profiles of all in need.

In contrast, community based programming may have less rigid eligibility criteria, and be specifically designed to target the developmental level of transition age youth. However, many of these programs are missing critical elements (SOC, TIP) associated with positive treatment outcomes.

Another significant challenge to transition age youth is the change in service eligibility criteria between youth and adult systems. Youth with serious emotional disturbance (SED) in the children's system, who meet criterion to receive public services in the youth system, frequently do not meet criteria for SMI or SPMI, the designation needed to access services in the adult system once they turn 18.

APPROPRIATE AND ACCESSIBLE SERVICES ARE KEY

"It is a struggle to design services in a way that youth will continue participation. Many youth won't go to outside agencies because of the environment. We try to work with providers to give services in the Urban Peak building where youth can develop trusting relationship on their turf. Then the youth might be willing to go to another location.

Our services are very trauma informed, culturally responsive, youth friendly. We value youth input. Graduates of programs sometimes stay on as staff."

-Deputy Director and Director of Programs, Urban Peak, Denver, CO

"There needs to be a 'warm handoff' when a child is moving into the adult system. It would be best if there was a period of time when both systems were involved for transition."

- *Parent, Gunnison, CO*

Overall, the inventory of state and community programs includes a wide variety of programs and services available to treat transition age youth with behavioral health challenges in Colorado. The large number of programs, and agencies invested in providing behavioral health services to

Colorado's youth indicates a state-wide investment in positive youth outcomes. The gaps in service options based on age and other eligibility criteria exacerbate existing access and service navigation challenges, however, and there is still a lack of developmentally appropriate services that support youth in successful transition to adult lives.

BEST PRACTICES REVIEW

Mental health services have been traditionally split into child and adult services, sometimes with the child- and adult-serving agencies in different departments. Child services models have been utilized up to age 18, with adult service models starting at 18. These are still the most common models for service provision. The recognition of the unique needs of TAY related to mental health trajectory, life phases and developmental considerations has been recognized for some time and has been gaining movement to action recently. As such, the available data and field of best practices for the particular age group of transition age youth is in its infancy, but growing.

WHAT PROGRAMMING IS EFFECTIVE FOR TRANSITION AGE YOUTH WITH SERIOUS MENTAL HEALTH CONDITIONS?

At this time there are no fully evidence-based practices for transition age youth with mental health challenges, though there is more in the literature about treatment models for transition age youth with other challenges, such as developmental disabilities or substance use. Consideration of application of these models to the behavioral health population is accepted. A description of interventions and programs that are deemed promising for youth will be provided. The primary treatment model that has been identified as evidence-supported for transition age youth, the Transition to Independence Process (TIP) model is presented. An emerging framework, Positive Youth Development (PYD) that can help conceptualize the approaches will be discussed.

PROGRAMS WITH TRANSITION AGED YOUTH WITH BEHAVIORAL HEALTH CONCERNS

TRANSITION TO INDEPENDENCE PROCESS (TIP) MODEL

There are few programs designed specifically for TAY with mental health challenges, and fewer that have been evaluated. However, a number of program models are showing promise in improving outcomes. The TIP model is the only evidence-supported practice targeted at transition age youth with mental health challenges[13]. It focuses on assets, youth-driven planning, and supportive relationships.

Evaluation of TIP implementation has demonstrated increases in employment and educational advancement, and decreases in mental health issues and criminal justice involvement.

[13] Haber M.G., Karpur A., Deschenes N. & Clark,H.B. (2008). Predicting improvement of transitioning young people in the Partnerships for Youth Transition Initiative: Findings from a multi-state demonstration. Journal of Behavioral Health Services and Research, 35, 488-513.

The model involves youth ages 14-29, their families, and allies in the process of transitioning into adulthood. Youth are encouraged to consider their goals in the critical growth areas of Education, Employment, Living Situation, Personal Effectiveness/Well-being, and Community Life/Functioning. TIP is operationalized through seven principles: 1) person-centered planning, focus on future; 2) building on strengths; 3) prioritize personal choice and responsibility; 4) a safety net of support in the community; 5) enhance competencies; 6) outcome focus; and 7)involve young people and supports in TIP system at all levels.

THE EARLY ASSESSMENT AND SUPPORT ALLIANCE (EASA)

Outcomes show that longer tenure in EASA is associated with greater employment rates and educational engagement.

The Early Assessment and Support Alliance (EASA) is a program for youth to maintain life when psychotic symptoms first occur. Services are strengths focused and rely on family and community support to help youth achieve their goals. Supported Employment and occupational therapy are also available to each EASA participant. Evaluation of the program has shown a significant decrease in hospitalizations for participants.

YOUTH ADULT SERVICES (YAS)

In an evaluation of the YAS program, three variables proved related to outcomes. The program demonstrated higher quality of life, satisfaction, functioning, and less loneliness. There was also a reduction in arrests and fewer symptoms.

Connecticut's Department of Mental Health initiated the Young Adult Services (YAS) program for youth 18 and older with moderate to severe symptoms to facilitate transition into adult services. The approach incorporates strengths focused treatment planning and community focused treatment planning. Services include clinical, residential, case management, vocational and social rehabilitation. Principles dictate that services must be comprehensive and integrated, there is a focus on facilitating transitions to greater autonomy, and participants are not removed from YAS.

Results of a RENEW demonstration pilot with 16-21 year olds showed positive education and employment outcomes.

REHABILITATION, EMPOWERMENT, NATURAL SUPPORTS, EDUCATION, AND WORK (RENEW)

The RENEW program targets youth with behavioral challenges and addresses education, employment, and community inclusion. The program

provides individualized services, offering options in futures planning, mentors, and alternative education. Services promote the principles of 1) self-determination; 2) community inclusion; 3) unconditional care; 4) strengths-based; and 5) flexible resources.

PROGRAMS/COMPONENTS FOR OTHER POPULATIONS

SEEKING SAFETY

Seeking Safety is an evidence-based program for youth with co-occurring history of trauma and substance use that is applied in Los Angeles County in transition age youth with behavioral difficulties. It was designed for flexible use in both genders, in different treatment modalities, and different treatment settings. The focus is on coping skills and psycho-education. The five key principles include 1) safety; 2) integrated treatment; 3) ideals, and loss of; 4) four content areas of cognitive, behavioral, interpersonal, and case management; and 5) clinician processes.

MY LIFE

My Life is an intervention that has been used with youth in special education and foster care. It enhances youth self-determination through recognizing accomplishments, offers mentors, and promotes self-regulation strategies. Each participant receives 50 hours of coaching in self-determination skills, and attends mentor workshops. There is a transition plan that the youth presents in a planning meeting. The goals of My Life are to increase youth planning, quality of life, education, employment, and living stability.

My Life has demonstrated improved education and employment outcomes.

ACHIEVE MY PLAN! (AMP)

Achieve My Plan! (AMP) is designed specifically for youth with mental health conditions who are utilizing the team planning process. Coaches prepare youth to participate meaningfully and constructively in team meetings. AMP intends to increase youth involvement in planning, to have plans that accurately reflect youth's goals, and to increase the extent to which youth are actively involved in carrying out the plan.

AMP results have shown greater empowerment of youth, and increased confidence in managing their own mental health.

PROJECT STAY OUT (STRATEGIES TEACHING ADOLESCENT YOUNG OFFENDERS TO USE TRANSITION SKILLS)

This program bases its approach on youth-directed planning, system collaboration, positive relationships, and increasing education, employment and living skills. The Oregon program is for

Project STAY OUT demonstrated increased school engagement and reduced recidivism.

incarcerated youth with behavioral disorders. The goal is to decrease recidivism, and increase education and employment attainment.

COMMUNITY REINFORCEMENT APPROACH (CRA)

A program that provides counseling to homeless youth, The Community Reinforcement Approach at Homeless Drop-in Centers, provides services in a drop-in center instead of a mental health clinic. This approach utilizes social, recreational, family, and vocational resources for homeless youth.

Decreased substance use and internalizing problems, and increased housing and social stability were associated with CRA.

SUPPORTED EMPLOYMENT

While Supported Employment is an evidence-based practice for adults, the application of it with transition age youth has yet to be evaluated. The approach includes job coaches, transportation assistance, assistive technology, job training, and individualized supervision. In a survey of the state's behavioral health service providers[14] Supported employment services are reportedly used with transition age youth by 16% of Colorado community providers.

PEER SUPPORT SERVICES

Peer Support Services must be mentioned as a possible promising component. Peer support comprises a person with lived experience providing emotional, social, and instrumental support to another with a mental health condition[15]. These approaches may be particularly effective for young people as they individuate and separate from adults and further turn to peers for critical relationships and support. This is supported by evidence at the national consumer advocacy level, with Mental Health America calling for states to incorporate peer services in a 2008 position statement[16] Currently there is no evidence that peer support services are more effective than services delivered by a mental health professional, but they have not been evaluated specifically in TAY.

[14] Bane, W. (2012) Youth and Young Adults in Transition: Report on a Survey of Behavioral Health Providers in Colorado. CDHS, OBH Report, February, 2012.
[15] Solomon, P. (2004). Peer support/peer provided services underlying processes, benefits, and critical ingredients. Psychiatric Rehabilitation Journal, 27, 392-401.
[16] MHA, (2008). Position Statement 37: The Role of Peer Support Services in the Creation of Recovery-Oriented Mental Health Systems. Accessed online May 15, 2014 at http://www.mentalhealthamerica.net/positions/peer-services.

POSITIVE YOUTH DEVELOPMENT FRAMEWORK

A framework that is gaining use is the Positive Youth Development (PYD) approach that focuses on strengths, healthy development, and well-being across the life span. The context has been applied to programs for youth among a growing research base and studies of effectiveness in the transition age years. The PYD focuses on how to prepare young people for adulthood by promoting assets and capacities in the areas of 1) positive identity and sense of purpose; 2) ability to make decisions and plans consistent with goals; 3) skills that contribute to taking on adult roles; and 4) supportive relationships. The driving theory behind the approach is that building on strengths is more effective than focusing on deficits. Research has shown that young people with more assets are more likely to succeed[17]. The practices described above can be regarded within this framework, adhering to the principles to varying degrees. The TIP model is consistent with all guidelines.

WHAT FACTORS DO BEST PRACTICES HAVE IN COMMON?

The inventory of promising practices for transition age youth with serious behavioral challenges reveal commonalities among approaches. All models or components have the element of a ***strengths/assets based approach***. Strengths are incorporated in identifying existing assets in the youth and protective factors in the environment on which to build. Youth also identify potential and future areas of growth, integrating a second common element, that of self-determination.

Youth in transition years are experiencing individuation, separation, and development of autonomy. The model of child service provision where treatment decisions are made by others is not appropriate or effective. While the System of Care philosophy encompasses youth-guided care throughout the years, adolescents' developmental trajectory predisposes them to a desire for greater control over decisions that affect their lives. The call for ***youth-directed care*** is consistent.

While youth increasingly adopt greater responsibility for their care and lives, ***supportive relationships with caring adults*** are vital. All youth face challenges as they develop into adults and take on adult roles. Having the guidance and support to make these decisions and to have a safety net to fall back on when needed are crucial. The components may include family members, treatment providers, teachers, coaches, other caring adults, and mentors.

All youth must acquire and apply ***transition life skills*** that are required for successful development. A focus on ensuring capacity for and the attainment of these skills in all youth is a common theme.

[17] Condly, S.J., (2006). Resilience in children: A review of literature with implications for education. Urban Education, 41(3), 211-236.

WHAT PRACTICES ARE SEEN IN COLORADO'S PUBLIC BEHAVIORAL HEALTH SYSTEMS?

In an exploratory analysis of the status of services for transition age youth in Colorado, in 2012 Office of Behavioral Health conducted an online survey of behavioral health and treatment providers[18]. The 76 respondents included mental health centers, substance use providers, prevention programs and Therapeutic Residential Child Facilities. Less than half (42%) reported that they had capacity to serve transition age youth.

The strategies to engage youth were counseling (75.3%), outreach staff (52.1%), prevention (53.4%), youth-friendly service environments (64.4%), family advocates/support providers (45.2%) and peer specialists (39.7%). Less common were social networking (23.3%), computer access (32.9%), drop-in programs (27.4%), and video conferencing (11.0%). Less than 20% of respondents reported all staff trained in providing transition services; over half of respondents had essentially no training for staff.

Survey respondents conveyed a variety of models and approaches utilized in providing services. Most common were Cognitive Behavioral Therapy (71.6%), Motivational Interviewing (66.2%), Dialectical Behavioral Therapy (58.9%), Evidence-based prevention approaches (43.2%), Wellness (43.2%), Functional Family Therapy (29.7%), Multisystemic Therapy (28.4%), and TIP (24.3%). Other interventions seen in less than 20% were Supported Employment, Assertive Community Treatment, and Guideposts to Success.

The survey results indicate that Colorado's behavioral health providers have initiated services for TAY. There is variation among the providers in the extent to which practitioners have been trained and have adopted these services. However, there is clear evidence for awareness of transition youth issues and approaches for treatment.

Key Informant Interviews were conducted with a variety of individuals across the state who oversee or directly administer programs for youth with behavioral health challenges. Interviews were conducted using a serial informant referral protocol which involved asking each key informant to recommend another individual who was doing work with TAY at either a policy or program level. This approach was not intended to be comprehensive but rather to provide a snap shot of the programming currently underway in Colorado. Descriptions of these programs follow in the subsequent sections and are divided into two categories; those at Community Mental Health Centers and those administered by Community Agencies (non-profits). See Appendix A for description of methods.

[18] Bane, W. (2012) Youth and Young Adults in Transition: Report on a Survey of Behavioral Health Providers in Colorado. CDHS, OBH Report, February, 2012.

COMMUNITY MENTAL HEALTH CENTER PROGRAMS DESIGNED SPECIFICALLY FOR TRANSITION AGE YOUTH

THE ROAD

The Road's foundations are in being youth led or youth directed. Youth are able to pick the areas they would like to focus on and grow. Youth really expand their social maturity.

- Program Director, The Road, Lakewood, CO

Jefferson Center for Mental Health (JCMH) houses a program called "The Road" within an alternative high school in Jefferson County. The primary component is a drop in center serving youth between the ages of 15-22. A mental health clinician is present for all drop in hours and provides both therapy and case management. The target audience for the program is youth with chronic mental health issues but most of the participants are high school students who are struggling socially and academically. Programming is very individualized and focuses on the TIP domains. The location in a high school may deter young adults over the age of 18 from participating and everyone must be cleared by school security to enter. The location was changed from a standalone house due to funding limitations, but the goal is still to engage youth in a friendly safe environment. The Road is the only drop in program in Jefferson or Clear Creek Counties which are geographically very large, thus preventing participation of youth who may have transportation challenges.

THE DOWNSTAIRS

"We would like to focus on a bigger population of those youth and young adults who are not being served. Right now we are going to focus on those who are classified SMI or SPMI but there are so many more people who need services."

- *Program Manager for Psychiatric Rehabilitation and Supported Education, MHCD*

The "Downstairs" is a new program at the Mental Health Center of Denver (MHCD) targeting youth age 16 to 24. The program is being run by the Psychiatric Rehabilitation and Supported Education team, which is accustomed to promoting wellness with adults. This team recognized that they needed to serve young people better and that young people did not identify with the population of adult consumers, typically around 40 years of age. The aim of "The Downstairs" program is to incorporate clinical services, case management, psychiatry, pharmacy, as well as education and employment. Services will be tailored toward the transition age group and delivered in a culturally competent way. The program is located in the lower level of one of MHCD's offices. There is some concern that this location may be undesirable to young people who have experienced "therapy fatigue" and no longer want to be part of the mental health system. The plan is to work on outreach to these individuals to overcome this possible barrier.

WHAT PROMISING APPROACHES ARE BEING USED BY COLORADO'S COMMUNITY AGENCIES?

THE HOUSE

"The House" is a program for homeless youth administered by a community based non-profit organization (Karis, Inc.) in Grand Junction, Colorado. This is a short-term intensive program that provides mental health services, case management, and life skills development that address all of the TIP domains. The physical location of "The House" makes it accessible to youth because it is designed to be a home; there are no signs or other indicators of institutional living. Most services are provided on site or at other casual community locations such as coffee shops in an effort to reduce barriers to service. Mental health services are provided by a Licensed Clinical Psychologist whose salary is paid through the community mental health center and supplemented by Karis. Currently, there are no psychiatric services offered by any of the programs, thus participants are referred to other agencies for these services. This can prove a barrier to access for some individuals. In addition to the Psychologist, there is a case manager, a program director, and Americorp volunteers who meet weekly to discuss cases and provide support to one another around effective strategies with the youth they serve. Additional training for staff comes through a process group twice per month facilitated by a supervisory level staff member at the community mental health center. This process group focuses on topics such as trauma informed care and harm reduction so staff have the opportunity to practice skills in this area.

> **"We strive to provide 'Wildly Integrated Mental Health Care' which means breaking down barriers and providing services wher-ever youth feel comfortable."**
>
> - *Executive Director, Karis, Inc., Grand Junction,*

In addition to services for homeless youth, there is a program for "The House's" alumni. These are organic communities called pods that keep youth with similar interests and experience connected. "The House" provides funding to supply food and materials to the pods to further support youth development as they become independent. Recently, a facility called "The Other House" opened. It provides longer term supported housing to young adults 18 and over as they begin attending college or getting a job. Participants are mostly graduates of "The House" program.

> **"We are very relationship focused. Many of these kids lack a caring adult in their life. Once we build trust the youth often show up and participate."**
>
> - *Executive Director, Matthews House., Ft. Collins, CO*

THE MATTHEWS HOUSE

The Matthews House provides strengths-based, family-driven, future-oriented and relationship-focused programming to youth in transition and their families. Their Empowering Youth program

focuses on youth age 16-21, many of whom are transitioning out of DYC or foster care. They tailor their programming to capitalize on the strengths of the youth and help them achieve their unique goals. This program incorporates all of the TIP domains and places an emphasis on becoming positive contributors to the community. The Matthews House also has a Housing Opportunities Supporting Transition (HOST) Home Program which utilizes volunteer HOST families who provide temporary support to youth in need of housing. Unlike some of the other programs described in this section The Matthews House does not have shelter beds available for youth so they utilize a volunteer network to provide this service. Due to the great need for stable housing it is the goal to expand this network further in the future.

THE SOURCE

A Boulder based teen drop in center and homeless shelter, the Source provides a variety of services to youth ages 12-24. The parent agency of The Source is Attention Homes which has been a residential treatment provider in Boulder since the 1960's. Services are co-located to provide HIV testing, medical care, Chaffee workers, yoga classes, family therapy, crisis counseling, SUD services, workforce development, GED preparation and practice tests. The Source has professionals from other agencies (nurses and therapists) who are present to provide services in a casual un-structured setting. The nurse can provide basic medical advice and help to make appointments and accompany the young people to the physical health clinic which also includes a behavioral health professional. This "warm hand off" helps break down barriers to accessing services.

"We are continually working and growing to build community relationships that interconnect us with the services our young people need."

- *Director of Programs, Attention Homes,*

One of the goals of the Source is to continue to grow relationships directly with the community mental health center to establish a seamless referral system to the services that the youth and young adults need. The referral system has been challenging to establish because the mental health center has a large number of programs that serve Transition Age Youth so there has not been a single point of contact to directly access services.

URBAN PEAK

The work of Urban Peak was mentioned by several other key informants, who also strive to provide services to TAY, as being outstanding. Other providers rely on the services provided by Urban Peak because it is one of the only homeless shelters in the Denver metro area for adolescents and young adults. Urban Peak served 2,331 unique individuals in Denver in FY2013. Urban Peak's services are youth guided and are founded in the principles of Positive Youth Development and Trauma Informed Care (TIC). Over the last year, Urban Peak was a member of the Trauma informed Care Learning Community through the National Council on Behavioral Health. As part of the Learning Community, Urban Peak continued the process of infusing TIC throughout the agency by ensuring that all staff are extensively trained and held accountable to trauma informed interactions, that policies and procedures are reflective of TIC, that staff are supported through appropriate staffing structure and in acknowledging and addressing vicarious trauma, etc. Positive Youth Development and Trauma Informed services are crucial in working with a population who has experienced so much trauma. Other practices utilized at Urban Peak include Motivational Interviewing, Harm Reduction, Restorative Justice and Strengths-Based Case Management. Recently, Urban Peak received funds to support the hiring of a Peer Navigator. The individual who is being hired was a former participant in a number of Urban Peak programs and will be working with the youth living on the streets to assist them in the process of obtaining housing. The staff members at Urban Peak provide intensive case management services, crisis counseling/intervention and family mediation services to youth and their families. Urban Peak partners with other agencies to provide more intensive, long-term behavioral health services. This can be a drawback of the program because of the barriers to service it creates for the youth. Many individuals are not accessing the treatment services they need because the barriers (lack of services/funding, transportation, appointment times, lack of comfort with the treatment setting, lack of clinically and developmentally appropriate services, etc.). Another gap that Urban Peak would like to address is providing emergency shelter services for young adults ages 21 through 24. This group of young adults are often fearful of adult shelters and will instead choose to sleep or hide outside during the night. In order to provide emergency shelter for this group, Urban Peak would need to secure an appropriate location and the resources to provide a physically and emotionally safe environment.

> **"Youth experiencing homelessness come from a variety of backgrounds. To be culturally responsive is to be aware that into each interaction individuals bring all that has shaped how they think, feel, behave and interact. The youth served by Urban Peak are often responding from experiences that have negatively impacted their trust of adults and systems."**
>
> - *Deputy Director, Director of Programs Urban Peak, Denver, CO*

RECOMMENDATIONS

SYSTEM LEVEL

INTEGRATION: There are many programs to serve TAY with behavioral health challenges, and little integration or coordination between programs. Systems need to work together to create a *seamless system of services* without rigid requirements to create coordination between child and adult serving agencies, and interagency collaboration between state agencies.

LEADERSHIP: With many agencies providing services within distinct programs, guidance around an effective mental health service system and future *direction for TAY programming* is needed. OBH has the opportunity to oversee the planning and implementation of services for people with early signs of mental illness, focusing on transition age youth.

ACCESS: Services must be available for youth who were served in the children's system who do not meet diagnostic eligibility for adult services to help in transitioning to adulthood at this critical time.

WORKFORCE DEVELOPMENT: Clinical staff must recognize the youth culture of this age group and adapt service locations and modalities. Program staff also must be reflective of the population served in terms of gender and race, specifically increasing males and persons of color. In addition, compensation for clinical staff has to be adjusted to *decrease staff turnover* and to maintain longevity and stability in therapeutic relationships.

EDUCATION: Stigma related to behavioral health must be reduced through social marketing and outreach efforts. *Education of the public and the system* around TAY-specific issues are necessary to ensure support for effective programming.

PROGRAM LEVEL

Programs must be:

DEVELOPMENTALLY APPROPRIATE: Services must be designed for the increasing autonomy and emerging adult roles that TAY are adopting. In addition, it is necessary to recognize and incorporate youth culture into the delivery of services.

YOUTH GUIDED: The youth's own goals must be taken into account and they must be actively engaged in their own treatment planning. Without the youth becoming an active participant in their own recovery engagement and positive outcomes will be limited.

CULTURALLY COMPETENT: The integration of cultural knowledge (including youth culture), behaviors, and attitudes into service delivery increases engagement, leading to improved outcomes. This is critical to maintain engagement of minority and young adults who the data indicate are leaving services.

TRAUMA INFORMED: Understanding the pervasiveness and effects of trauma in the lives of Transition Age Youth is critical to providing effective services. Trauma impacts emotional, cognitive and social development. Providing trauma informed care means that staff understand these effects and provide services that feel safe to clients while encouraging healing and the development of hopeful trusting relationships.

STRENGTHS BASED: Capitalizing on the strengths young people have is another key component of successful programming with Transition Age Youth. By the time they have reached Transition Age, young people have had professionals who have tried to "fix" their problems. Youth consistently stated that they reacted much more favorably when service providers recognized and focused on their uniqueness and talents rather than their deficits.

ENGAGING ALL INDIVIDUALS: This recommendation relates to cultural competence but goes a step farther to break down cultural, societal, and system barriers to make access to services a reality for all individuals. Service providers must make every effort to engage individuals in need where they are physically located, developmentally, and culturally.

Programs need to promote:

RELATIONSHIPS WITH SUPPORTIVE ADULTS: Transitioning to adulthood can be difficult for any individual but especially so for those with behavioral health challenges who may have strained or absent relationships with caring committed adults. Establishing and maintaining these trusting safe relationships is key to attaining successful outcomes.

PEER SUPPORTS: The utilization of peer mentors with adults with SPMI has yielded positive results and there is limited support that this may be an effective program component with youth and young adults as well. Youth express a strong desire to connect with other young people who have had similar experiences and feel this is a positive component of their development. Caution should be taken to protect peer mentors from re-traumatization and aid in establishing appropriate boundaries as they may still be developmentally immature and may not have sufficient distance from their own behavioral health history to fully engage in the demands of helping others.

Programs need to include:

EDUCATION: Youth expressed a clear need to learn about symptoms, prognoses, and treatment of mental illness. Such *knowledge* would help them cope and adapt to life with a mental health challenge. In addition, they identified *family education,* around their mental health challenges, as necessary to facilitate connection and support with family members.

NATURALISTIC SETTINGS: As youth mature the importance of the peer group increases and concerns about stigma is one reason for providing services in *a non-clinical environment*. Additionally, young adults express reticence to visit adult drop-in centers or clinics because they don't identify with adults with long-term mental illness. Providing services in settings that youth typically are in, such as coffee houses or Laundromats, helps reduce barriers to access.

ALL TRANSITION AREAS: At this time of life youth are facing graduation from high school, continuing education, vocational training, financial sufficiency, living independently, integrating into the community, and a number of life options. In addition, this is a common age range for the appearance of more serious mental health symptoms and increased substance use disorders. As such, programs should include the array of services addressing *Education, Employment, Living Situation, Well-being,* and *Community Life.*

ADDITIONAL RECOMENDATIONS

YOUTH AS A RESOURCE: This age group is finding its voice and TAY who have faced or are facing behavioral health challenges are a *resource for knowledge and leadership*. Program and policy development should include this voice in a substantive and meaningful way.

EVALUATION OF OUTCOMES TO GUIDE BEST PRACTICES: With the evolving practices for TAY with behavioral health challenges, it is critical that *programs and interventions be evaluated* rigorously for treatment outcomes, ensuring services that lead to successful transition to adulthood.

APPENDIX A. METHODS

KEY INFORMANT INTERVIEWS

Key Informant Interviews were conducted with eight individuals across the state who oversee or directly administer programs for youth with behavioral health challenges. Interviews were conducted using a serial informant referral protocol which involved asking each key informant to recommend another individual who was doing work with TAY at either a policy or program level. This approach was not intended to be comprehensive but rather to provide a snap shot of the programming currently underway in Colorado. A semi-structured interview protocol was utilized to assess strengths and gaps in programming as well the adherence to TIP and SOC domains. A list of participants is included in Table A1.

Table A1: Key Informant Interviews

Name	Position	Program	Organization
Michelle Coldiron, MA CPRP	Program Manager	2 Succeed in Education	Mental Health Center of Denver
Lynn Garst	Associate Director of Community Services for Child & Family Services.	Mental Health Center of Denver	
Ann Sullivan, LCSW	Transition Age Youth	Community Coordinator	Boulder County Housing and Human Services
Kendall Rames, MA, LPC	Deputy Director/Director of Programs		Urban Peak
Autumn Gold	Colo. Dept. Local Affairs, Div. of Housing	Office of Homeless Youth Services	
Kristin Burns	Family Services Manager,	Jefferson Center for Mental Health.	
Jerri Schmitz	Executive Director	Matthews House	
John Mok-Lamme	Executive Director	The House	Karis, Inc.
Chris Nelson	The Source		
Katie Wells	Manager of Adolescent Substance Use Disorder Programs	State Youth Treatment – Bridges Project Cooperative agreements for state adolescent and TAY treatment enhancement and dissemination	Office of Behavioral Health

FOCUS GROUPS

A total of three focus groups were conducted. There were two focus groups comprised of youth who have lived experience with the behavioral health system, another child serving system (child welfare), or are family members of individuals with behavioral health challenges. An additional focus group was comprised of family members of individuals with behavioral health challenges. All three focus groups were conducted using a semi structured interview technique designed to elicit discussion and free sharing of experience and information.

The first youth focus group was a Denver based group of seven young people who are now involved in peer leadership/mentoring programs at the Metro State University of Denver. The second focus group was a Boulder County based youth leadership group whom the majority of members were youth who had participated in the foster care system. A total of 15 youth participated in the focus groups and the median age was 23.

The family member focus group was comprised of individuals attending training to become Family Advocates. All areas of the state were represented so it was possible to discuss issues of rural/urban service delivery and access. Family members were asked to discuss strengths as well as gaps in the services and systems their family received.

All comments made by focus group participants were analyzed for common themes which appear throughout the report and in the recommendations.

DATA ANALYSES

Data were extracted from legacy systems and pulled into the SPSS 22.0 statistical package for analyses. Univariate tests of relationships were generated via test options on Tables or Crosstabs commands, or via ANOVA commands.

Modeling was completed using Binary Logistic Regression. CCAR outcomes were coded for clinical elevation, with 0 indicating a CCAR rating of 4 or less and 1 indicating a CCAR rating of 5 or higher (clinical elevation). Involvement in the Division of Youth Corrections was also binary, with 1 indicating involvement in the regression model. For all models the possible predictors were entered in blocks defined by demographic, system, or CCAR variables. Within blocks, variables were entered in forward stepwise entry. Demographic factors were Gender, Caucasian/Minority Race, and Age at first admission to public mental health services. Factors indicating system involvement in Child Welfare and Substance Use services were included. All CCAR domains at admission were entered as possible predictors. These are: Physical Health, Self Care/Basic Needs, Legal, Security/Supervision, Suicide/Danger to Self, Aggression/Danger to Others, Psychosis, Cognition, Attention, Mania, Anxiety, Depression, Alcohol Use, Drug Use, Family Functioning, Interpersonal, Socialization, Social Supports, Hope, Empowerment, Activity Involvement, and Recovery.

POLICY AND PROGRAM REVIEW

An online search of policies and programs offering services to Colorado youth aged 14-25 with mental health challenges was conducted from October-December, 2013. The intent was to capture policies related to service provision, and policy proved embedded in program rules. Specific policies are included were relevant. Programs and policies were evaluated based on information on websites and related links. Each were evaluated along the following System of Care dimensions:

- **Family-driven:** Families have a primary decision-making role in the care of their children, as well as in the policies and procedures governing care for all children in their community, state, tribe, territory, and nation
- **Youth-guided:** Youth are engaged as equal partners in creating systems change in policies and procedures at the individual, community, state, and national levels
- **Culturally Competent:** The integration and transformation of knowledge, behaviors, attitudes, and policies that enable policy makers, professionals, caregivers, communities, consumers, and families to work effectively in cross-cultural situations
- **Interagency:** Services are integrated at the system level, with linkages between child-serving agencies and programs across administrative and funding boundaries and mechanisms for system-level management, coordination, and integrated care management

The final dimension assessed, **Developmentally Appropriate,** was the extent to which programming has been developed with the specific needs and developmental challenges of Transition age youth in mind.

Programs were also reviewed for whether they addressed transition life areas of **Education, Employment, Living Situation, Well-being, and Community Life-Functioning.**

BEST PRACTICES REVIEW

Practices were identified through a literature review of national evidence and promising practices. With no fully evidence-based practice youth with serious mental health challenges, there was a shift to describe programs serving Transition age youth with other challenges that show some element of promise. Promising practices at the community level were identified through discussions with Office of Behavioral Health staff and community leaders from the Under 26 Transition Work Group. Key informant interviews provided additional insight into local programming.

APPENDIX B. CCAR DOMAINS AND DESCRIPTIONS

Table B.1. CCAR Domains and Descriptions

	CCAR DOMAIN DESCRIPTION
Physical Health	Extent to which a person's physical health or condition is a source of concern
Self-Care	Extent to which mental health symptoms impact a person's ability to care for self and provide for needs
Legal	Extent to which a person is involved in the criminal justice system
Sec./Supervision	Extent to which the person is in need of increased supervision
Suicide/Self Harm	Extent to which a person experiences self-harming thoughts and/or behaviors
Aggressiveness	Extent of aggressiveness in interactions with others
Psychosis	Extent to which a person experiences delusional, disorganized and irrational thought processes
Cognition	Extent to which a person performs cognitive tasks and experiences symptoms such as, but not limited to, confusion, poor problem solving, and impaired judgment
Attention	Extent to which a person experiences attention issues such as, but not limited to, distractibility, inability to concentrate, and restlessness
Manic	Extent to which a person experiences manic symptoms such as, but not limited to, excessive activity level, elevated mood, and decreased need for sleep
Anxiety	Extent to which a person experiences anxiety symptoms such as, but not limited to, nervousness, fearfulness, and tension
Depression	Extent to which a person experiences depressive symptoms such as, but not limited to, sadness, worrying, irritability and agitation
Alcohol	Extent to which a person's use of alcohol impairs daily functioning
Drug Use	Extent to which a person's use of legal or illegal drugs impairs daily functioning
Family	Extent to which issues within the individuals identified family and family relationships are problematic
Interpersonal	Extent to which a person establishes and maintains relationships with others
Socialization	Extent to which a person's conduct deviates cultural and social norms
Role Performance	Extent to which a person adequately performs his/her occupational role
Symptom Severity	Rate the severity of the persons mental health symptoms
Empowerment	Extent to which a person uses available resources that contribute to personal health, welfare, and recovery
Activity Involvement	Extent to which a person participates in positive activities
Social Supports	Extent to which a person has relationships with supportive people that contribute to recovery
Hope	Extent to which a person is optimistic about future outcomes
Recovery	Extent to which a person is involved in the process of getting better and developing restoring/maintaining a positive and meaningful sense of self
Level of Functioning	Extent to which a person is able to carry out activities of daily living despite the presence of mental health symptoms

APPENDIX C. CCAR SCORES: PERCENT OF CLINICALLY ELEVATED SCORES AT ADMISSION

Table C.1 Percent of Clinically Elevated Admission CCAR Scores by Age Group

	Child	Adolescent	Young Adult	Adult
Physical Health	4.0%	5.5%	10.4%	28.0%
Self-Care	9.1%	5.8%	12.3%	15.6%
Legal	1.0%	11.9%	14.3%	12.9%
Sec./Supervision	19.1%	23.0%	16.9%	11.9%
Suicide/Self Harm	2.8%	9.9%	10.2%	8.7%
Aggressiveness	22.0%	21.6%	15.5%	9.7%
Psychosis	2.2%	4.6%	13.0%	17.2%
Cognition	7.3%	10.5%	17.2%	18.8%
Attention	35.1%	30.2%	29.3%	27.1%
Manic	4.6%	7.9%	14.2%	15.7%
Anxiety	36.8%	37.2%	47.7%	50.6%
Depression	26.9%	49.6%	56.9%	59.8%
Alcohol	0.1%	2.2%	6.4%	9.4%
Drug Use	0.2%	6.6%	9.8%	8.9%
Family	58.0%	63.0%	46.4%	37.6%
Interpersonal	26.5%	30.1%	35.5%	33.6%
Socialization	20.6%	22.2%	18.3%	12.5%
Role Performance	30.2%	41.1%	41.2%	43.4%
Symptom Severity	71.4%	76.4%	76.1%	75.5%
Empowerment	13.6%	26.5%	27.2%	27.6%
Activity Involvement	20.7%	33.8%	42.2%	40.8%
Social Supports	10.8%	16.2%	20.1%	24.8%
Hope	27.2%	38.1%	39.0%	36.9%
Recovery	39.9%	54.2%	57.9%	59.2%
LOF	33.7%	41.2%	47.7%	53.7%

APPENDIX D. STATISTICAL SUMMARY OF OUTCOME ANALYSES FOR ADOLESCENTS

Table D.1. Adolescents: Significant Demographic and System Factors at Admission

	Unsuccessful Discharge-	Chi-Square Value	*p*-value
Role Performance			
No CW	23.5%	86.289	.000
CW Involved	32.6%		
Male	30.9%	65.092	.000
Female	23.2%		
No SUD	24.1%	146.182	.000
SUD	38.5%		
Symptom Severity			
No CW	38.9%	98.870	.000
CW Involved	49.8%		
Male	44.6%	7.925	.005
Female	41.6%		
No SUD	40.7%	74.883	.000
SUD	52.2%		
Overall Level of Functioning			
No CW	19.6%	51.370	.000
CW Involved	26.2%		
Male	24.6%	29.552	.000
Female	19.7%		
No SUD	20.2%	72.331	.000
SUD	29.7%		

APPENDIX E. STATISTICAL SUMMARY OF OUTCOME ANALYSES FOR YOUNG ADULTS

Table E1. Young Adults: Significant Demographic and System Factors at Admission

	Unsuccessful Discharge-	Chi-Square Value	*p*-value
Role Performance			
No CW	24.3%	26.348	.000
CW Involved	30.0%		
Male	32.8%	120.865	.000
Female	21.6%		
No SUD	22.2%	99.798	.000
SUD	32.5%		
Symptom Severity			
No CW	44.6%	2.032	.154
CW Involved	46.5%		
Male	47.1%	7.359	.007
Female	44.0%		
No SUD	42.6%	39.064	.000
SUD	49.9%		
Overall Level of Functioning			
No CW	24.7%	13.295	.000
CW Involved	28.8%		
Male	31.1%	68.659	.000
Female	22.6%		
No SUD	23.2%	52.008	.000
SUD	30.6%		

APPENDIX F. STATISTICAL SUMMARY OF OUTCOMES MODELING

Table F.1. Adolescent Outcomes

Outcome: Adolescent Role Performance	FACTOR	WALD STATISTIC	SIGNIFICANCE
	Caucasian/Minority	7.015	.008
	SUD Services	23.710	.000
	Child Welfare	26.187	.000
	Admit Legal	6.540	.011
	Admit Aggression	4.587	.032
	Admit Attention	12.218	.000
	Admit Drug Use	9.552	.002
	Admit Activity Involvement	5.967	.015
	Admit Role Performance	505.912	.000
Outcome: Adolescent Symptom Severity	**FACTOR**	**WALD STATISTIC**	**SIGNIFICANCE**
	Caucasian//Minority	7.794	.005
	SUD Services	12.025	.001
	Child Welfare	38.667	.000
	Admit Legal	9.449	.002
	Admit Self-harm	9.566	.002
	Admit Aggression	5.542	.019
	Admit Cognition	4.344	.037
	Admit Mania	5.877	.015
	Admit Drug Use	5.242	.022
	Admit Symptom Severity	256.991	.000
Outcome: Adolescent Level of Functioning	**FACTOR**	**WALD STATISTIC**	**SIGNIFICANCE**
	SUD Services	11.545	.001
	Child Welfare	11.128	.001
	Admit Legal	5.425	.020
	Admit Self-harm	16.038	.000
	Admit Cognition	5.168	.023
	Admit Mania	4.349	.037
	Admit Drug Use	5.790	.016
	Admit Activity Involvement	5.922	.015
	Admit LOF	400.271	.000

Outcome: Adolescent DYC Involvement	FACTOR	WALD STATISTIC	SIGNIFICANCE
	Caucasian/Minority	29.966	.000
	Gender	106.285	.000
	Age at 1st MH Admit	17.527	.000
	SUD Services	346.859	.000
	Child Welfare	61.482	.000
	Admit Legal	651.315	.000
	Admit Self-care	8.664	.003
	Admit Security	28.232	.000
	Admit Mania	13.527	.000
	Admit Depression	4.580	.032
	Admit Socialization	10.203	.001
	Admit Alcohol Use	9.377	.002

Table F.2. Young Adult Outcomes

Outcome: Young Adult Role Performance	FACTOR	WALD STATISTIC	SIGNIFICANCE
	Gender	10.308	.001
	SUD Services	23.896	.000
	Age at 1st MH admit	5.600	.018
	Admit Legal	6.192	.013
	Admit Aggression	5.438	.020
	Admit Self-care	7.940	.005
	Admit Psychosis	4.677	.031
	Admit Cognition	4.932	.026
	Admit Mania	7.829	.005
	Admit Anxiety	4.397	.036
	Admit Role Performance	526.878	.000
Outcome: Young Adult Symptom Severity	**FACTOR**	**WALD STATISTIC**	**SIGNIFICANCE**
	SUD Services	15.712	.000
	Admit Physical Health	3.996	.046
	Admit Self-care	4.488	.034

	Admit Security	5.164	.023
	Admit Aggression	7.820	.005
	Admit Self-harm	34.802	.000
	Admit Psychosis	4.705	.030
	Admit Cognition	11.583	.001
	Admit Mania	13.816	.000
	Admit Anxiety	5.365	.021
	Admit Interpersonal	6.441	.011
	Admit Symptom Severity	277.431	.000
Outcome: Young Adult Level of Functioning	**FACTOR**	**WALD STATISTIC**	**SIGNIFICANCE**
	Gender	7.620	.006
	SUD Services	13.501	.000
	Child Welfare	6.877	.009
	Admit Legal	5.420	.020
	Admit Aggression	7.565	.006
	Admit Self-care	14.000	.000
	Admit Physical Health	4.489	.034
	Admit Psychosis	13.142	.000
	Admit Cognition	4.934	.026
	Admit Mania	5.802	.016
	Admit Anxiety	7.369	.007
	Admit Interpersonal	4.069	.044
	Admit Empowerment	4.487	.034
	Admit Activity Involvement	7.115	.008
	Admit LOF	576.222	.000

APPENDIX G. CLINICALLY ELEVATED CCAR SCORES AT DISCHARGE

Table G.1 Percent of Clinically Elevated Discharge CCAR Scores by Age Group

	Adolescent	Young Adult
Physical Health	3.8%	7.5%
Self-Care	3.9%	7.5%
Legal	11.9%	12.9%
Sec./Supervision	16.6%	9.1%
Suicide/Self Harm	3.6%	3.1%
Aggressiveness	12.0%	8.8%
Psychosis	2.2%	5.3%
Cognition	6.6%	10.0%
Attention	17.2%	16.9%
Manic	4.5%	7.6%
Anxiety	23.2%	30.8%
Depression	28.9%	33.9%
Alcohol	1.9%	5.0%
Drug Use	6.1%	7.9%
Family	48.2%	36.8%
Interpersonal	20.2%	23.9%
Socialization	14.7%	11.2%
Role Performance	27.6%	26.5%
Symptom Severity	44.1%	45.4%
Empowerment	18.2%	18.6%
Activity Involvement	24.4%	29.5%
Social Supports	11.1%	12.3%
Hope	24.7%	25.7%
Recovery	35.5%	39.0%
LOF	22.6%	26.2%

APPENDIX H. SUMMARY OF POLICIES AND PROGRAMS

Table H.1. Overview of Policies and Programs

AGENCY	PROGRAM	BENEFITS/ ELIGIBILITY REQUIREMENTS	FAMILY DRIVEN?	YOUTH GUIDED?	CULTURAL COMPETENCE?	INTERAGENCY?	TAY DEVELOPMENTALLY APPROPRIATE?	TIP DOMAINS? *(Education, Employment, Living Situation, Personal Effectiveness/Well-being, Community-life functioning)*	LIMITATIONS/ BARRIERS TO TAY SUCCESS
Colorado Department of Human Services, Office of Behavioral Health (OBH)	Federal Block Grant	Adolescents 12-17; Adults 18-59	SOC for youth	SOC for youth	SOC for youth	SOC for youth	No	Education, Employment, Living , Community, Health	Child/Adult definitions; no TAY specific
	Federal Block Grant 5% set aside	TAY with early signs of mental illness					Yes		
	Community Mental Health Programs		Family Participation	Youth Participation	Yes	Yes	No	Well-being	Limited TAY programming
	Policy regarding transition planning	Age 15 and older					yes		
	Child Mental Health Treatment Act	Age 0-18 at risk of out-of-home place-ment / social services, Social Security benefit	Parent Involvement	No	Yes	Yes	No	Education, Employment, Living, Community, Well-being	Non-Medicaid must apply for disability

Appendix H Table H.1. Overview of Policies and Programs

AGENCY	PROGRAM	ELIGIBILITY?	FAMILY DRIVEN?	YOUTH GUIDED?	CC?	IA?	TAY DA?	TIP DOMAINS?	BARRIERS
Colorado Department of Human Services, Office of Behavioral Health (OBH, *continued*)	WRKE	Age 18+ with SMI, in JCMH, MHCD, or MHP	No	Yes	Yes	Yes	No	Employment, Well-being	limited geographically
	SUD - Minors' Curricula	Depends on program; Ages 12-17 or 14-18.	Parent Involvement	Youth involvement	Yes	No	No	Community, Well-being	Focused programming
	SUD -Youth DUI Offender, Minor in Possession	Less than age 21	Family Involvement	Youth involvement	Yes	No	Yes	Community, Well-being	Age limited
	SUD-DUI Offenders and Offender Curricula	Depending on curriculum, Adolescents and Adults (18+), criminal involvement	Family may be involved	Youth involvement	Yes	No	No	Community, Well-being	Age cut-offs for programs
	Prevention and Reduction of Under 18 Alcohol, Drug, and Tobacco	Under age 18	Yes	Yes	Yes		No	Prevention of Substance Use	Time limited federal funding in limited geographic areas
	SUD - Prevention and Intervention	Education and Training for all ages	Family Involvement	Youth involvement	Yes	Yes	No	Prevention of Substance Use	Limited focus

Appendix H Table H.1. Overview of Policies and Programs

AGENCY	PROGRAM	ELIGIBILITY?	FAMILY DRIVEN?	YOUTH GUIDED?	CC?	IA?	TAY DA?	TIP DOMAINS?	BARRIERS
OBH *(continued)*	Adolescent Co-occurring Disorders Guidelines	Integrated treatment model for adolescents	Family Involvement	Youth involvement	Yes	MH/SUD	No	Education, Employment, Living, Well-being, Community	No TAY developmentally specific programming
	Managing Co-occurring Disorders	Age 21 plus with MH and SUD with criminal involvement	No	Yes	Yes	No	No	Education, Employment, Living, Community, Well-being	No TAY developmentally specific programming
Community Mental Health Centers (CMHCs)	JCMH- The Road	Age 15-22, Jefferson, Gilpin		Yes	Youth culture	Yes	Yes	Education, Employment, Living, Community, Well-being	
	MHC of Boulder - Integrated Management Partnership for Adolescent Community Treatment (IMPACT)	Under age 18	Yes	Yes	Yes	Yes	No	Education, Employment, Living, Community, Well-being	
	MHC of Denver - Emerging Adults Programs	Dependent on program; 16-24 or 13+ (Urban Peak)	As appropriate	Yes	Yes	Yes	Yes	Education, Employment, Living, Community, Well-being	

Appendix H Table H.1. Overview of Policies and Programs

AGENCY	PROGRAM	ELIGIBILITY?	FAMILY DRIVEN?	YOUTH GUIDED?	CC?	IA?	TAY DA?	TIP DOMAINS?	BARRIERS
	Arapahoe /Douglas-TRACS	Age 17-25, Arapahoe, Douglas		Yes	Youth culture	Yes	Yes	Education, Employment, Living Situation, Community, Well-being	
Colorado Department of Human Services, Division of Child Welfare (CW)	CMHI - Pueblo, CMHI- Ft. Logan	CMHIP- Adults (age 18+) and adolescents (age 12-17); CMHI-FL- Adults	Family Involvement	Consumer Involvement	Yes	No	No	Return to community	Separate Adolescent and Adult programs
	CMHIP Circle Program	Adults with SUD and MH		Yes	Yes	No	No	Education, Employment, Community, Well-being	Available to age 18+
	Federal Goals		No	No		No	No	Education, Employment, Living Situation, Well-being	
	Youth in Conflict, Children in Need of Protection, Children/Families in Need of Specialized Services	Less than 18, up to 21 if in system prior to 18	Yes	Youth involvement	Yes	No	No	Education, Living Situation, Community, Well-being	
	Emancipation Services	Youth age 16-21 and in OOH care	As appropriate	Youth involvement	Yes	Limited	Yes	Education, Employment, Living Situation, Community, Well-being	

Appendix H Table H.1. Overview of Policies and Programs

AGENCY	PROGRAM	ELIGIBILITY?	FAMILY DRIVEN?	YOUTH GUIDED?	CC?	IA?	TAY DA?	TIP DOMAINS?	BARRIERS
	Core Services	Less than 18, up to 21, OOH placement,	Yes	Youth involvement	Yes	Yes	No	Living Situation, Community Well-being	Services provided for 18 months; maybe extended six months
Child Welfare (Continued)	Chafee Foster Care Independence Program	Age 16-21 in OOH placement, or 18-21 who were in OOH; age 16 and under in OOH planning	No	Yes	yes	Yes	Yes	Education, Employment, Living Situation, Community, Well-being	
	Collaborative Management Program	Building management approach	Yes	Youth involvement	Yes	Yes	No	Education, Employment, Living Situation, Community, Well-being	
Colorado Department of Human Services, Division for Intellectual and Developmental	Adult Programs (HCBS-DD, HCBS-SLS, SLS)	Age 18 or older, Disability identified by age 22	Family Involvement	Youth involvement	No	Yes	No	Residential Services, Living Supports, Employment	
	Transition Planning from School to Adult	Age 16-21	Family Involvement	Youth involvement	No	Yes	No	Education, Employment, Living Situation, Well-being, Community	Services to co-occurring cannot be "duplicative"

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AGENCY	PROGRAM	ELIGIBILITY?	FAMILY DRIVEN?	YOUTH GUIDED?	CC?	IA?	TAY DA?	TIP DOMAINS?	BARRIERS
	Child and Family Programs (HCBS-CES, FSSP)	Services thru age 17 with significant medical or behavioral need	Family Involvement	Youth involvement	No	Yes	No	Living Situation	
Colorado Department of Human Services, Division of Youth	Administrative Services	Detained youth age 10-18, committed up to 21	Family involvement	No	Yes	Yes	No	Education, Employment, Living Situation, Community, Well-being	
Colorado Department of Human Services, Division of Vocational Rehabilitation	It's Your Move - Transition to Adulthood Navigation Guide	Navigation Guide for Youth	No	Yes	Yes	No	Yes	Education, Employment, Living Situation, Well-being, Community	
Department of Health Care, Policy, and Financing, Behavioral Health	Wraparound Teen Pregnancy Prevention Services	Up to age 19 in impoverished, high teen pregnancy rate, or other risk conditions neighborhood	Yes	Yes	Yes	Yes	Yes	Well-being (Teen pregnancy)	
Colorado Department of Public Safety, Division of Criminal Justice	OAJJA-Juvenile Diversion	Age 10-17 in the community							
	Community Corrections Specialized Programs	Age 18+			No	No	No		

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AGENCY	PROGRAM	ELIGIBILITY?	FAMILY DRIVEN?	YOUTH GUIDED?	CC?	IA?	TAY DA?	TIP DOMAINS?	BARRIERS
Colorado Department of Education	Mental Health Services/IDEA	Through age 21 with a disability	Family involvement	Youth involvement	Yes	Yes	No	Education, Well-being, Community	Poorer outcomes for SED
	Transition Planning	Age 15-21 with disability	Yes	Yes	Yes	Yes	Yes	Education, Employment, Living, Well-being, Community	
Colorado Department of Education/Division of Vocational Rehabilitation	SWAP (partnering with DVR)	Age 16-25 with disability	Family Involvement	Youth involvement	No	CDE partnering with DVR	No	Employment	
Colorado Department of Corrections	Youth Offender System	Youth 14-19 charged as adults, sentenced before 21	No	Youth involvement	Yes	Yes	Yes	Education, Employment, Living, Well-being, Community	Youth has felony upon release
Colorado Department of Public Health and Environment	CO9to25	No services; Ages 9 to 25	Families are involved	Youth involvement	Youth culture	Partnership emphasized	Yes	Education, Employment, Living, Community, Well-being	Child Welfare and DYC not identified as partners

Appendix H Table H.1. Overview of Policies and Programs

AGENCY	PROGRAM	ELIGIBILITY?	FAMILY DRIVEN?	YOUTH GUIDED?	CC?	IA?	TAY DA?	TIP DOMAINS?	BARRIERS
Department of Labor and Employment	Guideposts to Success	Age 14-24 with all types of disabilities in awarded areas (limited geographically)	Yes	Yes	Yes	No	Yes	Education, Employment, Living, Community, Well-being	Tightened federal resources
Department of Local Affairs	Office of Homeless Youth Services	Homeless youth under age 25	Yes	Youth involvement	Yes	Yes	Yes	Education, Employment, Living, Community, Well-being	
Department of Local Affairs (continued)	Office of Children, Youth, and Families	Various programs through age 18	SOC principles	SOC principles	Yes	Yes	Two programs focused on TAY	Education, Employment, Living, Community, Well-being	
Department of Higher Education	Metro TRiO Student Support Services	U.S. Citizen, 1st gen college, low income, or documented disability and enrolled at Metro	No	Yes	Yes	No	Yes	Education, Community	
Social Security Administration	Youth Transition Demonstrations - Colorado Youth WINS	Ages 14 to 25, receiving SSI, SSDI, or CDB, or at high risk of receiving benefits	Yes	Yes	Yes	No	Yes	Education, Employment	Waived certain SSA eligibility rules; Demonstration Projects with end in funding

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AGENCY	PROGRAM	ELIGIBILITY?	FAMILY DRIVEN?	YOUTH GUIDED?	CC?	IA?	TAY DA?	TIP DOMAINS?	BARRIERS
Urban Peak		Age 15-24 who are homeless or at risk of homeless	No	Yes	Yes	No	Yes	Education, Employment, Living, Community, Well-being	
Mile High United Way	Family Unification Program	Age 18-21; in foster care on or after age 16; criminal background check					Yes	Living Situation	
Mile High United Way	Bridging the Gap	Ages 16-24, current and former foster youth in Adams, Arapahoe, Denver, Douglas and Jefferson Counties		Yes				Education, Employment, Community, Well-being	Limited geographically
Faith-based Initiatives							Yes		
Family Voices Colorado	Family to Family Health Information Centers		Yes	Yes	Yes	Yes	Yes	Education, Employment, Living, Community, Well-being	

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AGENCY	PROGRAM	ELIGIBILITY?	FAMILY DRIVEN?	YOUTH GUIDED?	CC?	IA?	TAY DA?	TIP DOMAINS?	BARRIERS
Colorado Federation of Families for Children's Mental Health	Youth Voice Colorado		Yes	Yes	Yes	Yes	Yes	Education, Employment, Living, Community, Well-being	
Colorado Prevention Leadership Council		Focus is on Children and Families	SOC	SOC	SOC	SOC	No	Education, Living Situation, Community, Well-being	No focus on TAY
Rocky Mountain Children's Law Center		Children who have been abused, neglected, and are at -risk							
Affordable Care Act	Mental Health Parity	All covered; youth now covered up to age 26							

Table H.2. Program Descriptions

AGENCY	PROGRAM	Web-link	DESCRIPTION
CDHS Office of Behavioral Health (OBH)	Federal Block Grant	OBH Community Programs - http://www.colorado.gov/cs/Satellite/CDHSBehavioralHealth/CBON/1251581077594	Block grant funding allowing for maximum flexibility in state's use of funds for approved services, activities and programs. Since FY2011 MH and SU block grant funding applications have been combined.
	Federal Block Grant 5% set aside		SAMHSA has made available 5% of Block grant funding as a set aside for planning and implementing services and supports for persons with early signs of mental illness. OBH is focusing these dollars on TAY.
	Community Mental Health Programs	OBH Community Programs - http://www.colorado.gov/cs/Satellite/CDHSBehavioralHealth/CBON/1251581077594	• Continually improve the quality of prevention, intervention, and treatment services; Advance collaboration with internal and external stakeholders; Enhance knowledge, understanding, and awareness of behavioral health disorders; Secure, preserve, and maximize resources; Strengthen the system infrastructure and workforce; Design, develop, and maintain a comprehensive evaluation and reporting system
	Policy		If a youth is fifteen (15) years of age or older the service plan shall address services and supports necessary for the individual to successfully transition to adulthood including, when indicated, accessing developmentally appropriate services and supports in the adult behavioral health system.
	CMHTA	CMHTA webpage - http://www.colorado.gov/cs/Satellite/CDHSBehavioralHealth/CBON/1251581518087	The Act allows families to access community, residential, and transitional treatment services for their child without requiring a dependency and neglect action, when there is no child abuse or neglect. Transition services provided to children served through the Act includes case management and post-discharge services provided by a CMHC to children admitted to a residential facility. Community-Based services include, but are not limited to, therapeutic foster care, intensive in-home treatment, intensive case management, and day treatment.
	WRKE	Supported Employment webpage- http://www.colorado.gov/cs/Satellite/CDHSBehavioralHealth/CBON/1251631987055	The Wellness and Recovery for Thousands through Education and Employment funds supported employment and education services to adults with SMI. The WRKE program is designed to improve capacity by increasing employment and education for adults diagnosed with SMI using evidence-based and best practice models of supported employment and supported education in multiple communities across the state. WRKE funds evidence based supported employment at MHCD, JCMH, and MHP and best practice supported education at MHCD and MHP.

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AGENCY	PROGRAM	Web-link	DESCRIPTION
CDHS Office of Behavioral Health (continued)	SUD-Minors' Curricula	SUD Minors webpage- http://www.colorado.gov/cs/Satellite?c=Page&childpagename=CDHS-BehavioralHealth%2FCBONLayout&cid=1251581449445&pagename=CBONWrapper	Minors' Curricula include Assertive Continuing Care, case management provided mainly in the home to prevent relapse and continue recovery; Youth Cannabis Treatment Series; Suicide Prevention (TSAT); Group-based Outpatient Treatment for SUD; Keep it Direct and Simple (KIDS); Pathways to Self-Discovery and Change; Triad Girls' Group; Voices (for Girls)-Interactive Journaling;
	SUD-Youth DUI Offender, Minor in Possession	SUD Youth Offender webpage- http://www.colorado.gov/cs/Satellite?c=Page&childpagename=CDHS-BehavioralHealth%2FCBONLayout&cid=1251581449445&pagename=CBONWrapper	Efforts have been underway to train and implement a supplement for current DUI providers to use for the youth 20 and under that have received a DUI. This supplement includes operational guidelines and enhancements for the delivery of Underage Impaired Driving Offenders, how modifications and enhancements are presented, underage-specific groups vs. mixed age groups, interventions that are youth focused, and getting parents involved. DBH recognizes the importance of young people receiving age appropriate services for all of their issues, and this is another area that requires specialized attention. Minor in Possession citations require progressively more education and treatment up to the third citation.

Appendix H Table H.2. Program Descriptions

AGENCY	PROGRAM	Web-link	DESCRIPTION
CDHS Office of Behavioral Health (continued)	SUD-DUI Offenders and Offender Curricula	SUD Offenders webpage- http://www.colorado.gov/cs/Satellite?c=Page&childpagename=CDHS-BehavioralHealth%2FCBONLayout&cid=1251581449445&pagename=CBONWrapper	Driver Education Program, Driving with Care, PRIME for life, Drug Abuse Education, Pathways to Responsible Living, Corrective Actions, Non-residential and Residential Drug Abuse Treatment.
	Prevention and Reduction of Under 18 Alcohol, Drug, and Tobacco	Under 18 webpage- http://www.colorado.gov/cs/Satellite/CDHS-BehavioralHealth/CBON/1251581449373	The program, funded by federal block grant dollars, is designed to reduce usage and prevent initiation to substances through evidence-based practices and approaches.
	SUD - Prevention and Intervention	Prevention and Intervention webpage - http://www.colorado.gov/cs/Satellite/CDHS-BehavioralHealth/CBON/1251581449373	Community Prevention Programs relies on organizations to implement evidence-based strategies and practices in reducing the current alcohol, tobacco, and other drug use rate. The Community Prevention The staff ensures quality of services and advocates for greater public awareness of alcohol, tobacco, and other drug use and abuse issues. The Community Prevention Programs contributes and provides guidance to the development, expansion, and maintenance of the state prevention system using strategies to reach identified outcomes. The state priority areas in Prevention are:. • Parenting Education Prevention • Prevention of Prescription Drug Abuse • Statewide Prevention Evaluation Technical Assistance and Training • Statewide Regional Prevention Technical Assistance and Training • Workplace Prevention Services • Synar Amendment Compliance – Tobacco • Prevention Resource Center • Fetal Alcohol Spectrum Disorder/ATOD Prevention

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AGENCY	PROGRAM	Web-link	DESCRIPTION
CDHS Office of Behavioral Health	Adolescent Co-occurring Disorders Guidelines	Adolescent Co-occurring webpage- http://www.colorado.gov/cs/Satellite?c=Page&childpagename=CDHS-BehavioralHealth%2FCBONLayout&cid=1251581557830&pagename=CBONWrapper	The Division of Behavioral Health contracted with several local consultants with national expertise to develop practice guidelines for the care and treatment of youth with co-occurring disorders. These practice guidelines include sections that outline why it is important to address both issues at the same time, how common the problem is, guiding principles for integrated assessment and treatment, models of integration and issues of implementation.
	Managing Co-occurring Disorders		Uses Interactive Journaling to apply skills for positive behavior change. Uses cognitive behavioral approach provides structure, knowledge, and coping strategies to those with SUD and mental health issues in a single comprehensive resource. There are 12 journals which include: Orientation, Responsible Thinking, My Change Plan, Values, SUD, Emotions, Life Skills, Relationships, Maintaining Positive Change, Transition, Employment, Mental Health Needs.
Community Mental Health Centers	JCMH - The Road	JCMH The Road Webpage - http://www.jeffersonmentalhealth.org/programs/FamilyServices/TheRoad.cfm	A drop-in resource center for youth to prepare for adulthood by fostering empowerment, leadership, and responsibility; offering independent living skills (Passport program), GED assistance, counseling, wellness programs, job preparation and search, peer mentoring, community resources, wraparound, and a drop-in center.
	MHC of Boulder	IMPACT - http://www.mhpcolorado.org/Services/IMPACT.aspx	A collaborative program based on a cooperative arrangement to blend staff, resources and funding between partner agencies. IMPACT works with children and adolescents who are at imminent risk of, or are transitioning from, out-of-home placement, psychiatric hospitalization, or commitment in youth corrections. The primary focus is to provide community and family-based services for youth and families as an alternative to placing youth in institutional settings. Boulder County IMPACT is a multi-agency partnership that involves all of the public agencies that serve this target population. IMPACT is part of a statewide initiative that supports a collaborative management model.

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AGENCY	PROGRAM	Web-link	DESCRIPTION
Community Mental Health Centers	MHC of Denver - Emerging Adults Programs	MHCD Emerging Adults Webpage - http://mhcd.org/what-we-do/child-family-services/emerging-adults	Emerging Adult Services is an intervention program supporting healthy living skills and smart lifestyle choices including suicide awareness and prevention. H.I.K.E., outreach workers are located at the drop-in center at Urban Peak. They go out into the community and engage homeless youth and help to get them needed treatment. The Voz y Corazon suicide prevention program was developed to provide free, community-based, culturally sensitive, mentoring and suicide prevention services to teens and their families.
	Arapahoe/Douglas Mental Health Network - TRACS	TRACS webpage - http://www.admhn.org/Services/Adults/AdultsAges1824.aspx	For teens and young adults who are transitioning to the responsibilities of adulthood, this group helps individuals develop positive social relationships and gain the necessary skills to live a healthy, independent life. Transition skills — Learn life skills; Recreation — Have fun! Advocacy — Learn to advocate for yourself!; Community — Find your place; Support — Discover friendship and resources.
CDHS, Colorado Mental Health Institutes	CMHI - Pueblo, CMHI- Ft. Logan	CMHI webpage- http://www.colorado.gov/cs/Satellite/CDHS-BehavioralHealth/CBON/1251580853076	The Colorado Mental Health Institute at Pueblo (CMHIP) operates 451 inpatient psychiatric beds, including 144 beds for civilly committed individuals and 307 beds for individuals involved in the criminal justice system. CMHIP also serves the Adolescent and Geriatric population. CMHIP provides services utilizing Trauma Informed Care and Recovery principles. The Colorado Mental Health Institute at Fort Logan operates 94 inpatient psychiatric beds for adults with a serious mental illness. The hospital staff works with community mental health center staff, mental health professionals, patients, families, and mental health advocacy groups to return patients to the community as rapidly as possible. .
	CMHIP - Circle Program	CMHIP webpage- http://www.colorado.gov/cs/Satellite?c=Page&childpagename=CDHS-BehavioralHealth%2FCBONLayout&cid=1251580627423&pagename=CBONWrapper	Circle Program is an intensive inpatient treatment program which serves adults who suffer from co-occurring disorders. The program addresses mental illness, chemical dependence, personality disorders and criminal behavior. The treatment team consists of a board certified addiction psychiatrist, a master's level team leader, a licensed social worker, registered nurses, licensed psychiatric technicians, mental health workers and a recreational therapist, the majority of whom are also certified addiction counselors or licensed addiction counselors. The team is supported by psychological, vocational, educational, spiritual and nutrition services. Program components include Abstinence Based focus, Behavior Awareness, Tobacco, Psychiatric treatment.

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AGENCY	PROGRAM	Web-link	DESCRIPTION
CDHS, Division of Child Welfare	Federal Goals	Child Welfare Federal Goals	Achieving or maintaining economic self-support to prevent, reduce, or eliminate dependency; Achieving or maintaining self-sufficiency, including reduction or prevention of dependency: Preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests, or preserving, rehabilitating, or reuniting families: Preventing or reducing inappropriate institutional care by providing for community based care, home based care, or other forms of less intensive care, and: Securing referral or admission for institutional care when other forms of care are not appropriate, or providing services to individuals in institutions.: Minimizing the number of children in out-of-home placement for 24 or more months.
	Youth in Conflict, Children in Need of Protection, Children/Families in Need of Specialized Services	Child Welfare Programs webpage-http://www.colorado.gov/cs/Satellite/CDHS-ChildYouthFam/CBON/1251588007302	These programs are intended to strengthen families, protect children, and ensure permanency planning. Goal is to support intact families. Youth in Conflict program aim to reduce or eliminate conflicts between youth and their family members or community. Focus is on alleviating conflicts, protecting youth and community, family stability, or emancipation. Children in Need of Protection program is to protect children whose physical, mental or emotional well-being is threatened by the actions or omissions of parents, legal guardians or custodians, or persons responsible for providing out-of-home care, including a foster parent, an employee of a residential child care facility, and a provider of family child care or center-based child care. The Specialized Services program is to provide statutorily authorized services to specified children and families in which the reason for service is not protective services or youth in conflict. These services are limited to children and families in need of adoption assistance, relative guardianship assistance, or Medicaid only services, or to children for whom the goal is no longer reunification. The purpose of services in Program Area 6 is to fulfill statutory requirements in the interests of permanency planning for children.
	Emancipation Services/Independent Living		Programs and services to prepare youth in OOH care for transition to living on their own. Services include efforts to build life skills and self-sufficiency competencies. Each youth receives Independent Living Plan based on capacity for self-sufficiency and support, and assessment of individual, family, community, and financial support resources.

Appendix H Table H.2. Program Descriptions

AGENCY	PROGRAM	Web-link	DESCRIPTION
CDHS, Division of Child Welfare (continued)	Core Services	Core Services webpage- http://www.colorado.gov/cs/Satellite/CDHS-ChildYouthFam/CBON/1251588683608	Consists of: Home Based Intervention (therapeutic, concrete, collateral, crisis intervention); Intensive Family Therapy; Life Skills; Day Treatment; Sexual Abuse Treatment; Special Economic Assistance; Mental Health Services; Substance Abuse; Aftercare; County Designed Services (innovative). Goals: Family strengths; prevent OOH placement; return children home; unite children with permanent families; protect child.
	Chafee Foster Care Independence Program	Chafee webpage - http://www.colorado.gov/cs/Satellite/CDHS-ChildYouthFam/CBON/1251589743194	Provides age-appropriate independent living services to age 16-21 who are in out-of-home placement or to young adults age 18-21 who were in out-of-home placement on or after 18th birthday. Services supplement existing resources and programs.
	Collaborative Management Program	CBM webpage - http://www.colorado.gov/cs/Satellite/CDHS-ChildYouthFam/CBON/1251588652534	The Collaborative Management Program (CMP) is the voluntary development of multi-agency services provided to children and families by county departments of human / social services and other mandatory agencies including local judicial districts, including probation; the local health department, the local school district(s), each community mental health center and each Mental Health Assessment and Service Agency (BHO). Collaborative Management Programs (CMP) use the input, expertise and active participation of parent or family advocacy organization to: reduce duplication/fragmentation, encourage cost sharing, improve quality, better outcomes and cost reduction.
CDHS, Division of Intellectual and Developmental Disabilities (IDD)	Adult Programs (HCBS-DD, HCBS-SLS, SLS)	Adult Programs webpage- http://www.colorado.gov/cs/Satellite/CDHS-VetDis/CBON/1251586997230	Individual and group Residential services and supports (age 18 and older), day services for vocational and community connections, non-integrated pre-vocational services (age 21 and older)
	Transition Planning from School to Adult	DD Services webpage- http://www.colorado.gov/cs/Satellite/CDHS-VetDis/CBON/1251586997202	Assists ages 16-21 in transitioning from school-based services to adult community-based services. Planning begins at 16 years old; when funds are available after 18th birthday student is enrolled into adult services.

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AGENCY	PROGRAM	Web-link	DESCRIPTION
IDD (Continued)	Child and Family Programs (HCBS-CES, FSSP)	Child Programs- http://www.colorado.gov/cs/Satellite/CDHS-VetDis/CBON/1251586997415	Medicaid benefits through age 17, additional services and supports to children living at home who are most in need; family supports for caregivers in the home
CDHS, Division of Youth Corrections	Administrative Services	Division of Youth Corrections Webpage http://www.colorado.gov/cs/Satellite/CDHS-ChildYouthFam/CBON/1251582358888	The mission of the Division of Youth Corrections is to protect, restore, and improve public safety through a continuum of services and programs that: effectively supervise juvenile offenders, promote offender accountability to victims and communities, and build skills and competencies of youth to become responsible citizens. DYC oversees the provision of services to each DYC youth, including the right type and intensity of medical, dental, mental health, substance abuse, and sex offense specific treatment. Services provided are individualized, strengths-based, and comprehensive. Resources allow for the provision of critical services to assist and support youth and families during the process of transition from residential care back to their home communities and while on parole. Services include but are not limited to Multi-Systemic Therapy, Functional Family Therapy, educational and vocational services, mentoring and substance abuse relapse prevention.
CDHS, Division of Vocational Rehabilitati	It's Your Move - Transition to Adulthood Navigation Guide	DVR website- http://www.dvrcolorado.com/community_partners_school.php	Includes information on getting identification, employment, housing, well-being, health, aimed at youth transitioning to adulthood.
HCPF, Behavioral Health Organizati	Teen Pregnancy Prevention Services	-	The BHO is also charged with ensuring access to wrap around services, including Teen Pregnancy Prevention Services. Teen Pregnancy Prevention Services are a package of support services developed to reduce teen pregnancy including: Intensive individual or group counseling. Guidance promoting self-sufficiency, self-reliance and the ability to make appropriate family planning decisions; and Home visits or visiting nurse services.
DPS, Division of Criminal Justice	OAJJA-Juvenile Diversion	Diversion webpage- http://dcj.state.co.us/oajja/GrantPrograms/Juv_Diversion.html	The goal of diversion is to prevent further involvement of juveniles in the formal justice system (19-1-103(44) C.R.S.). Juvenile diversion programs should be community-based alternatives to the formal court system for youth between the ages of 10-17 who have been taken into custody for misdemeanor or felony offenses. Diversion programs should concentrate on holding the youth accountable for their behavior while involving them in programs and activities to prevent future criminal and delinquent behavior

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AGENCY	PROGRAM	Web-link	DESCRIPTION
DPS, Division of Criminal Justice	Community Corrections - Specialized Treatment Services (IRT for SUD, RDDT for MH)	DCJ Specialized Programs webpage- http://dcj.state.co.us/occ/about.htm#placement	Offenders appropriate for community corrections may need more supervision and treatment than those on probation, but less physical confinement than that provided by a prison. Community-based supervision and treatment programs enhance public safety. These offenders necessitate specialized supervision as well as more intensive residential treatment in order to address their criminogenic risk factors. The Colorado community corrections system has a number of programs that have specialized funding and regulation in order to serve this growing population.
Department of Education	Mental Health Services/IDEA	CDE Mental Health webpage- http://www.cde.state.co.us/cdesped/mentalhealth	School psychologists help children and youth overcome barriers to success in school, at home, and in life. They use many different strategies to address individual needs, as well as enhance systems that support students on school and district-wide levels. School psychologists work with parents, educators, and other mental health service providers to help each child develop resiliency, competence, and self-esteem.
	Transition Planning	CDE Transition webpage- http://www.cde.state.co.us/cdesped/transition	Transition services are committed to supporting comprehensive systems that ensure positive post-school outcomes for all learners to be successful in their adult lives. An effective transition process is based on individual needs and consists of coordinated activities in: Education, Career, Community/Independent Living, Communication, Social Interaction, and Recreation.
Department of Education/Division of Vocational Rehabilitation	SWAP	SWAP webpage- http://www.dvrcolorado.com/community_partners_school.php	Year-round services including counseling and guidance, job development, job placement, on-the-job training and job-site support assist young people with disabilities to become employed and self-sufficient. Youth may qualify if they are in school or out-of school, drop-outs, at risk, under or unemployed or graduated. Locally based teams, including educators, Vocational Rehabilitation Counselors, SWAP providers, and partnering community agencies assist in structuring the program around the economic and employment needs of the local community. Programs are typically housed outside of the school setting and in centrally located facilities. SWAP is staffed and managed by community-based coordinators and specialists with experience in business, education, social work and public health.

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AGENCY	PROGRAM	Web-link	DESCRIPTION
Department of Corrections	Youthful Offender System	Colorado YOS Webpage http://cjdc.org/wp/juvenile-justice-policy/youthful-offender-system/	The mission of the Youthful Offender System (YOS) is to provide a controlled, regimented, and secure environment which ensures public safety. YOS promotes the value of education (academic and vocational), self-discipline, and develops pro-social skills and abilities through an individualized phase program which includes supportive aftercare. Every youth sentenced to YOS has a permanent adult felony conviction, even if they complete the program.
Department of Public Health and Environment	Colorado 9to25	CO 9to25 website - http://co9to25.org/	A platform utilizing Positive Youth Development for youth and adults working to align efforts to achieve positive outcomes for all youth; goal is to build a coordinated, comprehensive system for youth to improve health and well-being through positive change in state/local programs and alignment of systems; strategies include partnerships, public awareness, best/promising practices, accountability, and policy/environmental change; youth should be *safe, healthy, educated, connected, and contributing.*
Department of Labor and Employment	Guideposts to Success	DOL Guideposts to Success webpage- http://www.dol.gov/odep/documents/transition_programs.htm	The High School/High Tech (HS/HT) Program is a comprehensive transition program that uses a variety of activities and innovative approaches to expose transition-age youth with disabilities (ages 14 to 24) to careers in science, technology, engineering, and math (referred to as the STEM careers) and other technology-based professions. HS/HT programs are designed to reduce the likelihood that young people with disabilities will drop out of school, increase their chances of graduating from high school with a regular diploma, increase their participation in postsecondary education, and improve their chances of getting and keeping a job after graduation. The framework also identifies the additional services and supports that youth with disabilities need to successfully transition to adulthood. The five content areas are: School-based, Career-based, Youth Development/Leadership, Connecting Activities, and Family Involvement.

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AGENCY	PROGRAM	Web-link	DESCRIPTION
Department of Local Affairs	Office of Children, Youth, and Families - Tony Grampsas Youth Services Program	Tony Grampsas webpage - http://www.colorado.gov/cs/Satellite/CDHS-ChildYouthFam/CBON/1251645046184	The Tony Grampsas Youth Services (TGYS) Program is a statutory program providing funding to local organizations that work with youth and their families through programs designed to reduce youth crime and violence, and child abuse and neglect
	Office of Homeless Youth Services	OHYS webpage- http://www.colorado.gov/cs/Satellite/DOLA-Main/CBON/1251595346101	The OHYS was created with the intent that services to homeless youth statewide could be improved by coordinating current services and facilitating interagency collaboration to identify gaps, remove barriers, improve access and information sharing. In order to carry out this legislative intent, the Office of Homeless Youth Services, in conjunction with the Advisory Committee on Homeless Youth, developed and is implementing the Colorado Homeless Youth Action Plan. This statewide plan contains many key prevention and intervention strategies designed to collaboratively and comprehensively address the issue of youth homelessness in Colorado. The five areas of focus in the plan are: Prevention, Housing, Supportive Services, Planning and Awareness, and Outreach.
Department of Higher Education	Metro TRiO Student Support Services	Metro Student Support Services- http://www.msudenver.edu/sas/sss/	Student Support Services is one of seven federal TRiO programs funded by the U.S. Department of Education to provide academic support for low-income, first-generation students and students with disabilities. The program is designed to help students overcome social and cultural barriers to higher education, and does this through many proven services: Academic Support and Guidance, Tutorial Assistance, Skill-building Workshops, Peer Mentoring, Graduate School and Career Preparation, Financial Aid Application Assistance and Financial Literacy, Scholarship Opportunities, Computer Lab, Social and Cultural Events, Leadership Development, Community Resources.

Appendix H Table H.2. Program Descriptions

AGENCY	PROGRAM	Web-link	DESCRIPTION
Social Security Administration	Colorado Youth WINS	CO Youth WINS webpage- http://www.ucdenver.edu/academics/colleges/medicalschool/departments/pediatrics/research/programs/psi/AboutUs/Resources/Pages/SSA-Colorado-Youth-WINS.aspx	The Youth Transition Demonstration (YTD) projects were designed to help youth with disabilities maximize their economic self-sufficiency as they move from school to work. A key element of the initiative was the waiving of certain SSA disability program rules to provide enhanced financial incentives for youth with disabilities to initiate work or increase their work activity. During initial meetings with I-Team members, a participant and his or her family engaged in discussions of hobbies; interests; significant relationships; disabling conditions; family supports; goals for education, employment, and independent living; and other topics deemed relevant to determining the services the youth might require.
Urban Peak		http://www.urbanpeak.org/denver/about-us/about-urban-peak/about-urban-peak/	Urban Peak helps youth experiencing homelessness and youth at imminent risk of becoming homeless overcome real life challenges by providing essential services and a supportive community, empowering them to become self-sufficient adults.
Mile High United Way	Family Unification Program	http://www.unitedwaydenver.org/get-connected	The Family Unification Program housing choice voucher (FUP voucher) provides an 18-month housing voucher to eligible youth. At the heart of BTG is our coaching model of service delivery. Young people utilizing a FUP voucher are assigned an Independent Living Coach that works with the youth for the duration of the 18 months of housing support. ILC's concentrate their efforts on creating a safe, supportive and empowering environment where youth can identify their individual needs and goals. Once living in their own apartment utilizing a housing voucher, BTG participants are offered a financial literacy class and a one-to-one matched savings account. BTG staff and volunteers help youth get connected with peers and caring adults through networking, recreational activities and community involvement.

Appendix H Table H.2. Program Descriptions

AGENCY	PROGRAM	Web-link	DESCRIPTION
	Bridging the Gap	http://www.unitedwaydenver.org/what-is-bridging-the-gap	Bridging the Gap is a program that changes the lives of young adults who were in foster care. With the support of Independent Living Coaches and in collaboration with community partners, young adults are connected to supportive services that guide them as they transition to adulthood. - The Family Unification Program housing choice voucher (FUP voucher) provides an 18-month housing voucher to eligible youth.
Faith-based Initiatives	Numerous community resources and supports		A number of faith-based initiatives that address varying needs of TAY exist in the metro area, including: Agape Christian Church, Church in the City, Second Chance, Cathedral of the Immaculate Conception, Center of Hope, Catholic Charities, Charity House, New Genesis, Providence Network/First Steps, Denver Urban Ministries, Empowerment Program for Young Women. Note that this list is not exhaustive.
Family Voices Colorado	Family to Family Health Information Centers	Family Voices website-http://familyvoicesco.org/	Creates a Collaborative of Family-Driven Organizations and Family Navigators to assist families across the state. Collaborates with Colorado health care systems to better serve families, including Medicaid, CHP+, Healthy Communities, HCPF, and Title V/HCP, mental health, human services, protection and advocacy, Center on Excellence and many others; Assist families with information, support, system navigation, and advocacy. Provides Transition Guide by Age: Age 10-14: Awareness – Start Transition!; Age 15-17: Exploration – Explore Interests and Talents!; Age 18: Preparation – Welcome to Adulthood!; Age 19-21: Education/Training – Focus on Job Skills and Life Skills!; Age 22-26: Career – Explore Life! Put Talents and Skills to Use!
Colorado Federation of Families for Children's' Mental Health	Youth Voice Colorado	http://youth-voice.your-talk.com/	The mission of the Colorado Federation of Families is to be an advocate for children, youth and families impacted by mental health issues while striving to improve and strengthen related systems, programs and polices across the state of Colorado. Youth M.O.V.E National is a youth led national organization devoted to improving services and systems that support positive growth and development by uniting the voices of individuals who have lived experience in various systems including mental health, juvenile justice, education, and child welfare. The Youth Voice Colorado is a coalition of youth advocates who provide training and advocate on policy issues.

Appendix H Table H.2. Program Descriptions

AGENCY	PROGRAM	Web-link	DESCRIPTION
Colorado Prevention Leadership Council		PLC website- http://www.colorado.gov/cs/Satellite/PLC/PLC/1220610981601	The Colorado Prevention Leadership Council consists of representatives from ten state agencies, two universities and various partners, and is formed by interdepartmental MOUs and supported by state statute to promote coordinated planning, implementation, and evaluation of quality prevention, intervention and treatment services for children, youth, and families at the state and local level. Goals: Coordinate/streamline state processes; Utilize SOC approach; Coordinate/integrate training and TA resources for communities; Advance data sharing for improvement and evaluation of health and social indicators; Ensure collaborative planning/decisions between agencies and local stakeholders.
Rocky Mountain Children's Law Center		http://www.rockymountainchildrenslawcenter.org/	The mission of the Children's Law Center is to transform the lives of abused, neglected and at-risk children through compassionate legal advocacy, education and public policy reform. We are a nonprofit law firm serving 1,500 children each year, primarily those in foster care. We are committed to creating stability for the children we work with while pursuing a permanent, nurturing home. We also provide needed education programs for judges, fellow attorneys, law students and foster parents.
Affordable Care Act	Mental Health Parity	ACA Mental Health- http://aspe.hhs.gov/health/reports/2013/mental/rb_mental.cfm	For people living with mental illness, the law will result in health insurance coverage for some services and treatments that have traditionally been denied or were not included in health insurance coverage in the past. The law has a significant impact on all health insurance plans, including public sector (Medicaid, Medicare, CHIP, VA and other health care) as well as private sector health insurance plans. The law does not mandate plans to provide mental health or addiction coverage, but when they are provided, they must be provided "on par" with medical benefits covered under the plan.

Table H.3. Program Details

Program	Location	Number Served	Population of Focus	Strengths	Limitations
Urban Peak	Denver	2,331	Age 15-24 who are homeless or at risk of homeless	Intensive individualized case management services. Youth guided services.	No in house behavioral health services.
JCMH The Road	Lakewood	460	Age 15-22	Individualized programming. Skilled staff	Limiting location (school setting which inhibits access for older individuals). Transportation to site is difficult for many youth. Serve fairly low BH severity
The Matthews House	Ft. Collins		Age 0-25	Youth guided services. Focus on TIP domains.	No in house behavioral health services.
The Source	Boulder			Has an in house behavioral health component.	Only one location. Limited hours.
The House	Grand Junction	100			
MHCD The Downstairs Program	Denver	Just Opening	14-15	Youth focused. Separate from adult programming.	In a MHC space. Limited Hours.