

State Efforts To Expand Transition Supports for Adolescents Receiving Public Mental Health Services

December 2001

Report on a Survey of Members of the Children, Youth and Families Division of the National Association of State Mental Health Program Directors

Prepared by:

Maryann Davis, Ph.D., Assistant Professor
Center for Mental Health Services Research
Department of Psychiatry, University of Massachusetts Medical School

Prepared for:

National Technical Assistance Center
for State Mental Health Planning (NTAC)

This report was produced by the National Association of State Mental Health Program Directors (NASMHPD) and the National Technical Assistance Center for State Mental Health Planning (NTAC) and is supported under a Cooperative Agreement between the Division of State and Community Systems Development, Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), and the National Association of State Mental Health Program Directors. Its content is solely the responsibility of the author(s) and does not necessarily represent the position of SAMHSA or its centers.

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Preface

This report marks an important step in the ongoing efforts of the National Technical Assistance Center for State Mental Health Planning (NTAC) to focus attention on the need to improve and expand services and supports for young people with serious emotional disturbances who are making the transition from adolescence to adulthood. With funding from the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration, the National Association of State Mental Health Program Directors (NASMHPD) convened a National Experts Meeting in June 2000, in Washington D.C., that brought together family members, youth and experts in the field of transition to discuss and assess the status of progress in developing effective, comprehensive transition programs in public mental health systems. That meeting resulted in the drafting of an initial report, *Developing Partnerships for Youth with Serious Emotional Disturbances in Transition to Adulthood* (National Association of State Mental Health Program Directors, 2001).

Meeting participants agreed that there was a need to learn more about the status of transition initiatives across the country and to identify factors that support the improvement and expansion of transition services as well as those factors that serve as barriers to progress in this area. To accomplish this goal, NTAC collaborated with the Center for Mental Health Services Research of the University of Massachusetts Medical School to implement a CMHS-funded survey of members of NASMHPD's Children, Youth and Families Division. This report, *State Efforts To Expand Transition Supports for Adolescents Receiving Public Mental Health Services,* describes and assesses the information gleaned from these interviews and provides a new stepping stone in efforts to ensure that youth with serious emotional disturbances have access to effective and comprehensive transition services and supports.

Acknowledgments

Providing services and supports to young people with serious emotional disturbances who are making the transition from adolescence to adulthood is one of the essential tasks of a comprehensive and effective public mental health system. Yet as this report makes clear, the nation's public mental health systems are only beginning to address the needs of transition-age youth. One of the people who have been instrumental in focusing the field's attention on this important topic is Maryann Davis, Ph.D., who served as author of the report and who conducted the interviews that provided the material for its content. We would like to express our gratitude to Dr. Davis, whose expertise, experience and leadership in the area of transition ensured that this report would make a valuable contribution to the field.

We are grateful to the Center for Mental Health Services (CMHS) for its leadership and financial support in carrying out this project. We would like to thank Diane L. Sondheimer, Deputy Chief of the Child, Adolescent and Family Branch within the CMHS Division of Knowledge Development and Systems Change, for her support and guidance during each phase of the project and for her contributions to the development and shaping of the questions that were included in the interviews with child mental health administrators.

We also want to express our appreciation to the Division of State and Community Systems Development and its Director, Joyce T. Berry, Ph.D., J.D., through whom CMHS has supported and facilitated our efforts on this and a wide range of other projects. Our thanks also go to Gail P. Hutchings, M.P.A., President and Chief Executive Officer of the Behavioral Health Policy Collaborative, for her insights and guidance.

This projected benefited greatly from the many contributions of Janice Robert, Secretary for the Center for Mental Health Services Research, University of Massachusetts Medical School, whose efforts in arranging and scheduling interviews and ongoing support for this project were invaluable.

Thanks also go to Catherine Q. Huynh, M.S.W., NTAC's Assistant Director, for her leadership and guidance on this project; John D. Kotler, M.S.J., NTAC's Senior Writer/Editor for his editorial review and oversight; and Rebecca G. Crocker, NTAC's Media/Meeting Coordinator for her design, layout and production.

We believe that readers will find this report to be both informative and inspiring and that it will contribute to the growing knowledge base about transition and to efforts to improve and expand transition services in public mental health systems around the country.

—Kevin Ann Huckshorn, R.N., M.S.N., C.A.P., Director
National Technical Assistance Center
for State Mental Health Planning

Executive Summary

Recent publications and meetings highlight a great concern about the well-being of youth with serious emotional disturbance as they enter adulthood. The literature provides ample evidence that these young people struggle tremendously in meeting society's expectations that they complete high school, get jobs, move out of the family home, become adult members of the community, and stay out of trouble. Testimonials from these youth and their families attest to the many challenges they face in achieving these goals. Unhappily one of the common challenges most often mentioned is an inadequate system response to their needs. Studies confirm that after age 16, and particularly after age 18, youth who have received significant supportive services often stop receiving these services. Furthermore, youth want many services but are unable to obtain them. Although numerous exemplary services have been developed for this population, these services appear to be offered on an extremely limited basis.

This report summarizes findings from interviews with members of the Children, Youth and Families Division of the National Association of State Mental Health Program Directors. These members were reporting on transition-related activities in their states, focusing on efforts by state child mental health systems.

- With rare exceptions, each state child mental health system has made some effort to address the transition needs of adolescents receiving their mental health services. This has resulted in a wide array of innovations, from programmatic strategies and knowledge development and dissemination to committee work and policy development. These innovations often involve interagency efforts including collaboration with the adult mental health system.

- This richness of effort provides the field with a broad knowledge base that can be built upon to enhance transition support capacity in individuals states and nationally.

- However, these innovations are spread thinly around the country, with only one state providing comprehensive transition supports to most of its adolescent clients. The majority of states reported implementing only one type of transition support service. For many of these states, the one type of service was located at only one site.

- In every state, a significant proportion of adolescents and young adults receiving public mental health services did not have access to transition services or supports after they reached the upper age limit of eligibility for child mental health services or had reached their 22nd birthday.

- Most states have funded a program or approach to work with some older adolescents as they approached the upper age limit for children's services, most commonly 18. None of the states had found a means to ensure continued transition support to all adolescents they served once these youth were too old to receive services from the child mental health system.

- In an attempt to ensure continued transition supports for youth who are no longer eligible for children's mental health services, a few states have instituted procedures to link youth with the adult mental health system in the hope that the adult system would provide needed transition supports.

- Only one state, and a few sites in other states, appear to have made a concerted effort to identify youth who would eventually enter adult mental health services and to provide an array of transition services beginning when the youth are still eligible for children's services and continuing with them into adulthood.

- Only two states have found a way to continue to provide transition supports for young people who do not qualify for the adult mental health system after reaching the upper age limit for child services. One state offers comparatively comprehensive services built around vocational support to consumers in about half the area of the state. Another state provides automatic eligibility for youth who receive child mental health services to access the adult mental health system.

- Division members consistently identified three factors that were major hindrances to the development of comprehensive transition services and supports: fiscal limitations; categorical and inflexible funding requirements that result in turf struggles; and failure of transition services to be accorded a high enough priority to generate the momentum needed to make system change.

Conclusions

Nationally among child mental health administrators, there is an increasing consensus that child mental health services, and public mental health systems in general, need to do a better job of providing effective transition supports for all adolescents who receive public mental health services. It is apparent from the comments of these administrators that even states that have made the most progress still have much work to do in this area. Because state mental health systems around the country have developed significant expertise in a wide variety of approaches to transition, now is an ideal time for them to bring that expertise to bear in helping each other build comprehensive transition support capacity and guide federal leadership in this area.

Recommendations

- Make transition a national, state and local priority:

    - Increase awareness of the issue by holding conferences or trainings with key stakeholders that clarify the importance of transitions services and invite input on how to proceed.

    - Invite advocacy organizations, young people and other stakeholders to collaborate in developing a plan to make transition a high priority.

- Develop a task force of stakeholders for whom transition is a priority who can help promote system change.

- Identify transition advocates within child and adult mental health systems and related child and adult systems.

- Gather locally relevant data and anecdotes that highlight the poignancy and importance of the transition issue in ways that appeal to each relevant audience.

- Combine data with an assessment of current resources and needs to help focus attention on areas where work is needed.

- Have conversations with interested parties at all levels to find out about their concerns and desires and share yours (i.e. focus groups of youth in transition, of their families, of direct care providers, of state agency administrators etc.).

- Reduce fiscal barriers (in combination with increased priority):

  - Be prepared to take advantage of opportunities such as new or unexpected influxes of funds that are not already encumbered or claimed.

  - Be ready to start small. Any funding dedicated to transition activities lays the foundation for further growth.

  - Blend or combine funding with other agencies that have responsibilities for the transition-age population, such as child welfare independent living programming for adolescents involved with both the mental health and welfare systems or adult mental health services focusing on adolescents who will enter adult services.

  - If there are pre-existing interagency child funding efforts, seek to include adult agencies and focus on a shared population (i.e., extending wraparound).

  - Collaborate with other stakeholders to advocate for increased state and federal funding as well as funding from other sources.

  - Explore any untapped resources for transition support. Several states have used Early Prevention, Screening, Diagnosis, and Treatment (EPSDT) funds to extend transition services from age 18 to age 21.

- Provide leadership:

  - Embrace the transition-age population.

  - Partner with advocacy organizations and individuals.

- Look for opportunities to make a difference.
- Increase awareness in the field about the transition-age population and their needs.
- Keep transition in the forefront.

Introduction

During the past several years there has been growing interest in the well-being of adolescents with serious emotional disturbance as they enter adulthood. Longitudinal studies have provided ample evidence that adolescents served by mental health systems or in special education fare poorly in the tasks of young adulthood (reviewed in Davis & Vander Stoep, 1997). While Clark and colleagues (Clark, Unger & Stewart, 1993) reviewed characteristics shared by effective programs that serve this unique age group, studies that have looked at service utilization after youth have reached the upper age limit of eligibility for child services indicate that few of these youth have gained access to transition services in the adult system, even when they want them (Silver, 1995; Evans, et al, 1996; Greenbaum, 2000). In general, youth and parents report that services that could support the transition to adulthood are not available or appealing to young people (Adams, Nolte, & Schalansky, 2000; Davis & Vander Stoep, 1996). However, testimonials of young people who have participated in the types of programs described by Clark and colleagues (1993) or that reflect the system of care values these researchers later developed (Clark, Deschenes, & Jones, 2000) are impressive and indicate that high-quality transition programming can be appealing to members of this age group (Clark & Davis, 2000)

Taken together these studies indicate that many youth with serious emotional disturbances need assistance in making the transition to adulthood, that there is considerable knowledge about the types of programs that appeal to members of this population (with initial indications of positive outcomes) but that there are barriers of access to high-quality programs and approaches (Clark & Davis, 2000). Davis and colleagues (2000) summarized the fiscal barriers that programs face in combining various funding sources and concluded that the tremendous difficulty in securing funding is a significant barrier to the development and availability of programs for youth in transition. Although there is clear justification for concern about the needs of the transitioning population and the lack of appealing and appropriate services and supports for this population, there has been no systematic assessment of the efforts of state child mental health systems to address this need.

Child mental health systems are the only systems with a specific mandate to serve children and adolescents with serious emotional disturbances and other mental health needs. Although the special education, juvenile justice and child welfare systems all serve youth with serious emotional disturbances, they also serve a broad array of other young people. Thus the child mental health system could be a tremendous resource for the development and promulgation of programs, strategies and technical assistance to improve transition support specifically targeted to adolescents with serious emotional disturbances.

For purposes of this report, the term child mental health system refers to the state-level authority that provides public mental health services and supports to children and adolescents. In most cases, the child mental health system is located within the state mental health agency, the statewide authority that oversees public mental health services in each state. In a handful of states, the child mental health system is included in a consolidated children's agency, which typically encompasses child mental health, child welfare and, in some cases, juvenile justice. In these cases, the child mental health system is separated from

the adult mental health system by more organizational levels than is the case when child mental health is housed within the state mental health agency.

The Child and Family Branch of the Center for Mental Health Services (CMHS) and the National Technical Assistance Center for State Mental Health Planning (NTAC) of the National Association of State Mental Health Program Directors (NASMHPD) convened a consensus meeting in June 2000 that brought together family members, youth and professionals in the field of transition at the federal, state and local levels (National Association of State Mental Health Program Directors, 2001). Based on testimonials from youth and their families and on findings from studies of the transitioning population, participants concluded that there is great need for concern. There was agreement that youth in transition are at high risk of being unable to function effectively as adults and that appropriate, appealing and coordinated services and supports are generally unavailable to them. A few states reported significant progress in addressing the needs of transitioning youth while acknowledging that they were just at the beginning of this process.

As a result of this meeting, it became clear that the field had no real picture of what child mental health systems across the country were doing to address the transition needs of young people. To remedy this situation, CMHS and NTAC funded an interview survey of members of NASMHPD's Children, Youth and Families Division to identify efforts to address transition needs among the nation's child mental health systems and to obtain their views both about what steps are needed to promote development of more comprehensive transition supports and barriers to improvements. Division members serve as directors of child mental health services in each state mental health agency. This report summarizes the findings of those interviews.

Division members and their designees who participated in the interviews offered to provide information and consultation to state mental health agency officials and other stakeholders who are interested in initiating or improving transition programs. Contact information for members of the NASMHPD Children, Youth and Families Division appears in appendix B of this report.

Between March and June 2001, Maryann Davis, Ph.D., Assistant Professor, Center for Mental Health Services Research, University of Massachusetts Medical School, Worcester, Mass., contacted members of the NASMHPD Child, Youth and Families Division from the 50 states and the District of Columbia to discuss transition issues. Prior to these interviews, division members had received copies of a report on the June 2000 consensus meeting (National Association of State Mental Health Program Directors, 2001) as well as written guidance and information concerning the telephone interviews. (See appendix A.) For purposes of the interviews and this report, transition services were defined as services that focus on assisting young people with serious emotional disturbances to complete the tasks of adolescence and take on the mantle of adulthood.

Typical transition programs offer supports in the following areas:

- completing high school or earning a Graduate Equivalent Diploma (GED);

- entering and completing post-secondary education or training;
- obtaining and maintaining rewarding employment;
- preparing for and achieving independent living;
- developing and maintaining adult social support networks;
- obtaining age-appropriate mental health services and supports; and
- participating in transition planning and coordination of transition services and supports.

The interviews consisted of questions in the following areas:

- transition services and efforts provided by the child mental health system to serve children and youth with serious emotional disturbances;
- interagency efforts that address the transition needs of adolescents in the child mental health system;
- efforts to link child and adult mental health systems for the purpose of transition support;
- members' perspectives on system barriers and aids to transition services;
- requests for written materials on mental health policies, regulations or contract language that address transition;
- state legislation addressing the transition of adolescents in the child mental health system;
- research conducted by the state mental health agency or child mental health system on transition issues;
- eligibility criteria or definitions of target population for child and adult mental health services; and
- organizational charts depicting the position of the child mental health system in relation to the state mental health agency as well as to other key agencies including child welfare, juvenile justice, vocational rehabilitation, education, substance and alcohol abuse, and state housing agencies.

Although division members responded to the interview questions to the best of their knowledge, the information they provided should be regarded as illustrative of the types of services that are available rather than as a comprehensive description of all transition activities taking place within children's mental health systems across the country. Division members from several states with decentralized public mental health administration,

oversight or services provision emphasized that they were unable to report fully on activities and practices in each locality. In addition, several division members reported a significant carve-out of mental health services for Medicaid recipients in their states. Carve-outs generally consisted of a subpopulation of children with serious emotional disturbances who were eligible for Medicaid and whose Medicaid-funded mental health services are the responsibilities of managed care organizations. In these cases, division members were often unfamiliar with the transition supports offered as part of the managed care services. In some states the number of children served through the mental health carve-out was far greater than the population served by the state mental health authority. This report focuses solely on information obtained during the interviews. Division members also provided a variety of written materials that will be the subject of a later report.

Questions for the interviews were developed from topics that both the consensus meeting and the literature suggest are important for youth who are making the transition to adulthood. The overarching concern is that appropriate and appealing services that address transition needs in a comprehensive manner be offered to all young people served by state child mental health systems during the entire transition stage, beginning at age 14 or 16 and continuing until age 25. Thus one of the objectives of this survey was to determine if any states had been able to fully achieve this goal and, if not, to what degree they had moved in that direction.

Innovation in the Field

Numerous state mental health agencies have made or are making concerted efforts to address the transition services and support needs of adolescents they serve. Some of these initiatives are still in the planning stages following significant efforts to assess the availability of transition supports and determine what additional supports may be needed, to enlist the cooperation of important stakeholders and to raise awareness concerning the needs and characteristics of youth in transition. Other state mental health agencies have developed policies that are expected to lead to improved practices such as requiring all providers in the state public mental health system to offer transition planning as part of, or in addition to, regular service planning.

Child mental health systems in some states have collaborated with adult mental health systems to provide better coordination of services for young people moving from the child to the adult mental health systems and to share expertise on transition issues. A few state mental health systems have led interagency efforts to address transition needs. In some cases these efforts have focused on specific populations such as youth involved with both the mental health and juvenile justice systems. The great majority of states have funded at least one categorical program or effort at service coordination to address transition needs.

Programs Initiated by the Child Mental Health System

This report summarizes many notable efforts to improve transition services and supports. Unless noted otherwise, this section addresses initiatives that originated with and that received most of their funding from state child mental health systems, although often in collaboration with other child-serving agencies. Not addressed are efforts that originated in other child-serving agencies and that receive little funding from child mental health systems or that do not focus services and supports on the population of youth with serious emotional disturbances.

Service Coordination

Coordination of the various services needed during the transition period is an essential component of any system of care (Stroul & Friedman, 1986). This section of the report describes efforts that states have made to provide special or appropriate coordination of services during the transition period. Service coordination encompasses needs assessment, plan development, and implementation and monitoring of implementation efforts.

Assertive Community Treatment. Assertive Community Treatment (ACT) (Stein & Santos, 1998) is one of the evidence-based practices for adults with serious mental illness described in the U.S. Surgeon General's report on mental health (1999). A few states including Arizona, Minnesota, Ohio and Wisconsin have used the ACT model to provide transition support. One ACT program that has gained wide attention is the Transitional Community Treatment Team in Columbus, Ohio, which serves youth and young adults, ages 16 through 22. This program focuses on young people who have been diagnosed with mental illnesses

who meet the criteria for receiving adult mental health services and who are thought to be at highest risk for institutional placement, suicide or homelessness (Bridgeo et al., 2000; Davis & Vander Stoep, 1996). The team also operates both supervised and unsupervised housing programs for transition-age young people. The team was established in 1990 when Franklin County (which includes Columbus) adopted the ACT model for its adult mental health system. The county mental health agency director specified that one of the ACT teams focus on the transition-age population.

The Arkansas children's mental health system provides services to young people up to age 21 if they began receiving services prior to age 18. In the past year, the state mental health agency initiated a specialized ACT team for youth ages 18 to 21 in the northwest region of the state.

Wraparound. Wraparound (Van den Berg & Grealish, 1996) is a process of providing service coordination that emphasizes partnering with parents to link the family and child to resources that are individualized to their needs; that build on their strengths; that are offered in the least restrictive, most normalized setting; and that maximize use of the child's and family's natural resources. The wraparound process brings together all involved helpers and the families natural support systems to form a team that is individualized for each child. The team's task is to develop a plan that will link the child and family to the resources that will build on their strengths to address their needs. Wraparound plans are comprehensive and utilize a flexible fund that can pay for resources for which there is no other source of funds. The service coordination efforts are supported by a Community Team, which comprises local representatives of state agencies, school officials, civic leaders, parents and other concerned citizens. One of the Community Team's tasks is to help reduce system barriers that the teams encounter in their efforts.

Many state mental health systems, particularly those that provide child mental health services to youth up to age 21, use the wraparound approach to provide individualized, developmentally appropriate, least restrictive and most normalizing supports to young people during the early and middle stages of their transition into adulthood. Division members from Alaska, Florida, Nebraska, North Dakota, Oklahoma, Vermont, South Carolina, Texas, Washington, Wisconsin and Wyoming reported that wraparound programs address transition needs in at least one site in all of their states. In Alaska and Nebraska, wraparound services are available statewide for at least some youth receiving public mental health services, providing solid transition planning and support during the period of greatest legal and programmatic change (ages 18-21). North Dakota also provides wraparound services statewide to all children and youth up to age 21 who receive public mental health services, although the transition planning component of these services is not yet fully in place, according to the state's division representative. In Greenwood, South Carolina, a grant from the Comprehensive Community Mental Health Services for Children and Their Families Program (Children's Services Grant) from the federal Center for Mental Health Services (CMHS) focuses specifically on transition support.

There are many advantages to using the wraparound approach for transition planning and support. Generally, wraparound services are consistent with the Transition To Independence

Process System (TIPS) developed by Clark and colleagues (2000) to describe the values, philosophy and practices of an age-appropriate system of care for youth in transition. However, two major modifications of traditional wraparound services need to occur for this model to remain developmentally appropriate as youth enter adulthood (Bridgeo, Davis & Florida, 2000). First, there needs to be a shift from partnering with parents to partnering with youth in service planning as young people become increasingly independent and their legal status and rights evolve. The wraparound model is ideally suited for this shift because it emphasizes an individualized approach that enables the wraparound coordinator to make changes in services and strategy at developmentally appropriate points for each individual.

Second, wraparound services should incorporate transition planning and adult functioning skills. The wraparound coordinator, along with the youth's parents and other involved individuals, can help the young person learn the skills he or she needs to plan for the future and to achieve important goals (e.g., how to develop a plan that will help the young person achieve a desired objective, how to make and attend a doctor's appointment, how to prepare a resume and comport oneself during a job interview, how to develop a budget and balance a checkbook). Although skill building is not one of the essential characteristics of the wraparound process (Van den Berg & Grealish, 1996), this area can easily be incorporated into the process. In addition, Community Teams that direct wraparound services should include representatives from programs that adult consumers may utilize including vocational rehabilitation, adult mental health and substance abuse services.

Another advantage of the wraparound approach is that it lends itself to identifying barriers to the provision of individualized services and supports proposed in service plans. When transition coordinators encounter system barriers, they discuss the problem with the Community Team. In this way Community Team members who represent local formal and informal systems and have a significant level of authority to make changes in those systems hear about and grapple with system issues that are specific to transition. Some division members who reported on their states' wraparound services noted several difficulties in using the wraparound approach in the transition planning process. First, it can be difficult to engage the adult mental health system in transition planning. Second, there are still few if any transition-related programs or activities to which young people could be referred.

Thus it is not effective or appropriate to continue standard wraparound procedures with transition–age youth. Transition specialists need to have special training in working with young persons whose relationship to their parents is changing. Adult systems need to be represented on Community Teams. Programs and services that are appropriate and appealing to the transition-age population need to be developed and accessible. Yet because of the many strengths of the wraparound approach, this model may be one of the best platforms from which to develop comprehensive transition supports, especially in states where wraparound services are already in place.

Transition Specialists. A few states have designated transition specialists to aid youth and their families and/or service coordinators in transition planning. In Connecticut, for example, the consolidated child system has entered into a memorandum of understanding with the adult mental health system to create the position of transitional coordinator, a psychiatric

social worker whose job it is to coordinate the application process for young people seeking to receive services from the adult mental health system. The memorandum of understanding describes key steps in the application process and provides mechanisms for informing the coordinator of whether a young person appears to be eligible for adult services. Rhode Island's consolidated child agency has designated an independent living coordinator to serve as a consultant to social workers who help young persons ages 16 to 21 with serious emotional disturbances who receive out-of-home services to prepare for independent living.

Colorado recently used federal block grant funds to establish a pilot transition project in a frontier community, enabling a transition specialist from a community mental health center to provide transition support to persons ages 16 to 21 who have a variety of complex needs including serious emotional disturbances and co-occurring developmental disabilities or substance abuse disorders. The specialist works with schools, interagency teams and directly with youth, serving about 20 youth per year.

Transition Planning. Division members from several states reported that transition planning is mandated by state policy, regulations or provider contract requirements. Alaska's Medicaid regulations require that transition planning begin at age 14 for youth who receive public mental health services, and youth and family involvement is encouraged. In South Dakota community mental health centers are required to provide transition planning for young persons beginning no later than age 17, and youth can continue to receive services through the child mental health system until they reach age 21. System-of-care legislation in California mandates that counties provide transition planning to young people ages 15-21 who receive public mental health services. In Delaware, where the state mental health system utilizes a long-standing managed care model, separate child and adult mental health systems have developed a joint protocol enabling clinical services management teams to identify, on a monthly basis, all clients who have turned 17. The teams work with youth and their families to determine whether the young persons need continuing mental health services and, if so, to develop a plan that focuses on the transition from child to adult services. However, this is not necessarily a holistic transition plan in that it focuses on linking youth with existing mental health services rather than on assessing what transition supports are needed in all domains and planning to access those resources.

Other Service Coordination Efforts. Kentucky has initiated three pilot programs involving the state's child mental health system. The primary impetus for this effort came from the state mental health planning council, which several years ago identified the need for better transition services for the adolescent population. The state used federal mental health block grant funds to provide first-year financing for two sites in urban areas and one in rural Appalachia. Although some block grant funding has continued for these projects, they are now financed primarily by alternative funding sources such as Medicaid reimbursements. The sites provide targeted services coordination for young adults ages 18 to 21. Service coordinators have relatively small caseloads, 10 to 15 clients each, compared with the standard caseload of 20 to 25 clients. The coordinators help young adults to develop long-term mental health service plans and link up with the appropriate services and supports within the adult mental health system and elsewhere. The rural program has been particularly creative in identifying natural resources for transition supports (e.g., an uncle

who teaches a youth to drive, a teacher who helps a youth learn how to develop a budget) in the community since few formal supports are available.

New Mexico has established numerous Adolescent Transition Groups (ATGs) since 1994, when the first group began in Albuquerque. Today groups operate in four other regions of the state. Ranging in size from 5 to 50 members, the groups typically include representatives from agencies involved with the public child and adult mental health systems (any interested party can attend group meetings). Adolescent Transition Groups have three primary goals: to help young people make the transition to the services they will need as adults; to identify barriers to services and service gaps and to develop strategies to address these problems; and to offer professional support to persons involved in the adult and child mental health services systems**.** The groups exemplify a systems management approach that utilizes the experiences of individuals to identify systemic barriers to successful transition to adult services.

Adolescent Transition Groups hold monthly half-day meetings, during which mental health professionals, family members and young persons themselves present information about transition-related issues and problems that they encounter. After the group hears about a young person's difficulties, members discuss possible responses and solutions. Most youth who are referred to this program have dual or multiple diagnoses including a mental health condition with substance abuse and/or developmental disorders. The groups regularly provide reports to mental health agency personnel regarding their findings. Adolescent Transition Groups are currently an unfunded initiative that provides informal problem-solving assistance.

One community mental health center in Utah has developed its own procedures and strategies for working with transition-age youth in addition to its other services. The site has developed a policy manual on transition issues and collaborates with other agencies including the adult mental health system.

Building System Capacity

System of Care Initiatives. Stroul and Friedman (1986) described an ideal system of care for serving children with serious emotional disturbances that includes "a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of severely emotionally disturbed children and adolescents." Several states have made attempts to enhance their systems of care to provide better supports to youth in transition.

Advocates from the Michigan Association for Children's Mental Health (state affiliate of the national Federation for Children's Mental Health) brought their concerns about the need for better transition support to state child mental health system staff, who raised the issue with adult mental health services. Both systems agreed that this was an important matter. As a result, beginning two years ago, the Michigan mental health agency used block grant funds that were targeted for adult services to establish pilot projects based in three community mental health centers. These centers are working to develop systems of care for youth ages 16 to 21, even though children's mental health services usually end at age 18. Each site

provides service coordination and has an advisory transition council that includes family members and representatives from the school system as well as the local human services and housing agencies. The systems being developed at each site are consistent with the values and practices of the TIPS model (Clark et al., 2000).

One site coordinates its efforts with the local wraparound project. At another site, two half-time transition facilitators based in children's mental health services collaborate with two case managers in the adult system to assist young adults (up to age 21) in making the transition to the adult system. These adult case managers can continue to work with those individuals after age 21. The sites have reported several key concerns. The transition councils report that they have difficulty engaging and maintaining young members. In addition, they report that the sites have trouble finding appropriate services with which to link participating youth. They also emphasize the challenges of implementing effective service coordination with services that are not designed for the transition-age population.

Division members from Idaho and Virginia reported that sites in each of their states are developing systems of care for children and adolescents with serious emotional disturbances that are addressing transition issues. The Center for Mental Health Services funds some of these sites, and others receive financial support from their respective state mental health agencies.

Other System-Building Efforts. Those in Maryland's child mental health system have long recognized the need for better transition support services. A task force composed primarily of advocates for individuals with developmental disabilities launched a successful effort in 1996 to enact legislation requiring the Maryland Education Department and the Department of Health and Mental Hygiene to develop a statewide plan to improve services for children and youth in each system. The resulting state plan called for development of a comprehensive strategy to address the needs of transitioning youth and resulted in the appropriation of new funds to serve transition-age youth with mental illness. In 1999 the Maryland Department of Health and Mental Hygiene initiated funding for a range of programs for transition-age youth offered by a number of local mental health authorities. The goal was to create a diverse range of programs that would provide a statewide foundation of local expertise that other local mental health authorities could draw on to develop or expand their own transition programs. These included a program for transition-age mothers, an Outward Bound program, a supported education initiative at a community college and a specialized case management program that provided mentoring and supported employment.

Maryland is one of a relatively small number of states in which there is little demarcation between adult and child mental health services. In all but a few areas, such as residential services, eligibility requirements are the same for youth and adults. Thus service coordination can continue uninterrupted for young adults during the transition period. This system-building capability focuses directly on developing capacity for services that address transition needs into adulthood. Among the challenges Maryland has faced are the difficulties in identifying providers who are willing to work with transition-age youth and who also have the expertise, experience and flexibility to do so effectively.

Vocational Efforts

When state mental health agencies provide vocational supports to transitioning youth, they often do so in collaboration with their state's vocational rehabilitation and education agencies. One of the most innovative examples of this approach is Vermont's JOBS (Jump On Board for Success) program, which is now offered in half of the state's cross-agency human service areas. The program seeks to help young adults adjust to community living by coupling employment support activities with comprehensive service coordination so that youth receive help in several major domains of life including employment, mental health, education, substance use treatment and medical health. The only major life domain not addressed is housing.

The JOBS program works with employers, helping to reduce common barriers to employment that youth with serious emotional disturbances often encounter. The program serves youth ages 16-22, although eligibility for public child mental health services officially ends at 18. To participate in these services, young persons must meet the state's criteria for having a serious emotional disturbance by age 18 and have been involved with child mental health services, special education, child welfare, juvenile justice or adult corrections prior to reaching that age. The youth must also qualify for vocational rehabilitation services. JOBS is supported by an interagency agreement that sets aside 20 percent of openings for youth who are involved in either the juvenile or adult corrections systems. The agreement also specifies the funding responsibilities of each participating state agency. The Department of Vocational Rehabilitation contributes the largest share, with additional support coming from the departments of Corrections, Social and Rehabilitative Services, and Developmental and Mental Health Services.

The JOBS program is based on a highly effective model of supported employment for adults with serious mental illness. Recognizing that children's mental health services might be more effective for transition-age youth if supportive counseling were linked with the motivator of employment, one community mental health center with a reputation for providing both leadership and effective wraparound services collaborated with the Vermont Department of Vocational Rehabilitation to develop the JOBS model. Although comparison or control group data are not available, initial findings from the first site include high rates of employment and high school or GED completion, increases in stable housing, and reduced use of mental health services and corrections and juvenile justice involvement. With these impressive results, Vermont's Department of Vocational Rehabilitation took the lead at the state level to engage the adult corrections, juvenile justice and child mental health agencies as funding partners with the goal of expanding JOBS statewide over a period of several years.

One of the things that make the JOBS program stand out is that in the sites where the program operates, funding has been obtained to provide consistent support for most youth with serious emotional disturbances in the child mental health system beyond the age that the system typically provides services. This is due in part to Vermont's Medicaid waiver, which makes it possible to extend targeted case management services to young adults through age 21. Strong advocacy by the Department of Vocational Rehabilitation has also been a key factor, along with a willingness by the adult corrections system to embrace a prevention

model. Both of these systems, which primarily serve adults, have taken a measure of responsibility for the transition-age population, something that is comparatively rare to date.

In Maine, representatives of the state mental health and vocational rehabilitation systems meet monthly to discuss the vocational rehabilitation needs of persons receiving public mental health services and to identify any barriers within the systems that might interfere with provision of services. The two systems are also developing a curriculum to train employment specialists to work with youth who have serious emotional disturbances.

Nebraska has funded a small pilot program at a single site in which the school system and the mental health and vocational rehabilitation agencies collaborate to help youth with serious emotional disturbances prepare to find and maintain employment.

San Francisco's child mental health division entered into a contract with a public vocational rehabilitation agency to hire two vocational counselors who specialize in pre-vocational counseling, job coaching, job development and employment support. The agency also has purchased a business specializing in second-hand clothing that is operated by transition-age youth. More than 40 persons have participated in these programs during the past year.

Independent Living

Education. Massachusetts' Department of Mental Health has introduced the Preparing Adolescents for Young Adulthood (PAYA**)** independent living curriculum, used widely by child welfare systems across the country, as a required element in all state mental health agency residential programs for adolescents ages 16 through 19. In Arizona, where public mental health services are offered through regional behavioral health authorities, young consumers ages 16 and 17 can receive tutoring in independent living skills from behavioral health technicians. Many Arizona residential and outpatient programs offer Independent Living/Life Skills services and programs for adolescents. However, children's services end at age 18.

Supervised or Supported Housing. Division members from Utah and Wisconsin reported that each of their states has at least one supported or supervised housing program for adolescents who receive services from the state mental health system. San Mateo County, California, surveyed young adults, family members and providers to assess the community's housing and related needs. Based on the survey findings, the San Mateo County Mental Health Services Division provided funds, matched by the local housing division with federal Community Development Block Grant funding, to purchase housing for young adults. This initiative, known as the Young Adult Independent Living Program, provides affordable rental units in a part of the state where rental costs have become prohibitive. The program also provides a variety of related supports based on needs suggested by the survey. For example, many survey respondents emphasized that staff members who work with transition-age youth must be extremely flexible in their approach to providing services. Another finding was that youth who receive public mental health services experiment with drugs, alcohol and sex at about the same rate as other youth their age. These findings have guided service provision, for example, by highlighting the importance of ensuring that program staff members are

available for youth in the program beyond the regular 9 to 5 hours to discuss their concerns about a range of issues. In addition, programs have developed clear, age-appropriate rules of behavior.

West Virginia has used federal mental health block grant funds to complement state mental health and child welfare resources in establishing a pilot program that serves youth ages 17 to 20 in the Wheeling area who are at risk of being placed in out-of-state care, who are leaving child mental health services to live on their own, or who are at risk of court involvement or residential treatment placement. This program is geared primarily toward youth without stable homes who are considered too old for foster care. Services include assessment of transition needs, provision of independent living readiness classes, assistance in obtaining a GED and employment, and provision of supervised living opportunities as a transition to independent living.

Supporting Homeless Youth. King County, Washington, operates a program that provides transition supports to homeless youth or youth at risk of homelessness ages 17 to 22. The program, which seeks to maintain or move youth into community-based housing, follows a well-developed intensive case management model for youth who are homeless and runaways described by Ana Maria Cauce and colleagues (1998). Similarly, Tacoma, Washington, has focused its efforts on youth ages 17 to 22 who are homeless or at-risk of homelessness, providing a drop-in center, vocational rehabilitation services, educational opportunities and housing services.

Coordination with Child Welfare. Several states including Nevada operate programs such as supported and supervised housing through the state child welfare system to prepare youth in foster care for independent living. The programs usually set aside a small number of places for youth who are not in foster care. New Jersey has used public mental health resources to support housing, independent living and wraparound programs that are funded primarily by the federal John H. Chaffee Foster Care Independent Living Program. Only youth receiving public mental health services who are also in foster care may participate in these programs.

Educational Support and School-Based Transition Planning

Working with School Transition Planning. Nebraska uses school-based wraparound services to implement transition planning within Individualized Education Plans in three sites. Two sites were funded with Children's Services Grants from the federal Center for Mental Health Services. Federal block grant funds were used to finance the third site. In Massachusetts every area office of the state Department of Mental Health employs a coordinator whose job it is to ensure that transition planning—required by state law for special education students expected to need adult services—is provided to eligible mental health consumers. Similarly, the Utah Department of Education has appointed a special education liaison to the state mental health system to help address areas of potential overlap between the two agencies, including provision of transition services. At one California site, a school-based transition team comprising representatives of a number of public and private agencies meets on a monthly basis to review all requests by special education students for transition services.

In Hawaii, both the state mental health and special education agencies were the subjects of a class action lawsuit that is shaping many of the state's efforts in children's services. In October 1994, the United States District Court in the District of Hawaii approved a settlement of the class action lawsuit in the case of *Felix v. Waihee, Civil No. 93-00367-DAE*, (known as *Felix v. Cayetano*) and entered a federal consent decree. In accordance with the consent decree, the state has agreed to provide all necessary services for youth certified as eligible under the Individuals with Disabilities Education Act (IDEA) or certified disabled under Section 504-Subpart D of the Rehabilitation Act of 1973 (as amended in 1974) to benefit from their education. The consent decree requires the development of a system of care that follows the guidelines set forth by Stroul & Friedman (1986) and compliance with the IDEA mandate for transition planning. The ruling affects youth in the mental health system who are also involved in special education. In fall 2000, Hawaii established the position of a transition specialist as part of its response to the consent decree. The specialist serves as a mentor to case managers and helps them understand how to develop an effective transition plan that emphasizes life and community supports.

In Pennsylvania's Columbia, Montour, and Northumberland counties, transition teams made up of professionals who are knowledgeable about the school-based transition process and about resources, including mental health supports, are available to provide information and assistance to youth and their families, often helping them to start the transition planning process. Special days are designated for the teams to hold in-depth meetings with families in each school district. Teams also meet periodically to discuss systemwide needs for improving transition services.

Virginia's Mental Health, Mental Retardation and Substance Abuse Services Board requires local mental health authorities, known as community services boards, to work with local school districts to ensure that the Individualized Education Plans (IEPs) of mental health consumers include an Individualized Transition Plan by the time they reach age 15.

One of the top priorities of Nancy Marz, M.S.S.W., clinical consultant to the child/adolescent section of Wisconsin's Bureau of Community Mental Health, is to improve transition services for youth. As one of her initial actions, Ms. Marz convened a Transition Advisory Council that includes representatives of advocacy groups and the state's vocational rehabilitation, education and child mental health systems. One of the council's first recommendations was to propose that every county in the state establish a transition committee to review transition plans for students in special education programs. Ms. Marz is collaborating with state education agency staff to bring this goal to fruition The group also encourages functional testing of special education students with serious emotional disturbances to help guide their transition plans.

Educational Support. Through a program based at Louisiana State University, staff on campus provide assessment and counseling services to help students with mental health needs make the transition from high school to college. The mental health center at Grady Hospital in Atlanta, Georgia, operates the Excell program at Washington High School to help students in this inner-city school complete their secondary education and prepare for independent living after graduation.

In New Hampshire, Joe Perry, Administrator of Children's Mental Health Services, has an ambitious plan to improve transition supports through statewide expansion of the RENEW program (Cheney et al., 1998), an educational and vocational support program focusing on IDEA planning offered in conjunction with the New Hampshire Department of Education. Implementing the plan will require interagency cooperation and, in all likelihood, additional funding. Mr. Perry has used resources from the state's Children's Services Grant from the Center for Mental Health Services to arrange for a curriculum on system-of-care principles and components to be included in the teacher-training curriculum at a pilot site for teacher training through Plymouth State College and the College for Lifelong Learning, an adult learning program within the state university system that offers courses in communities across the state. Ultimately, Mr. Perry plans to combine the CMHS Children's Services Grant with a New Hampshire Department of Education State Improvement Grant to bring comprehensive transition planning to youth with serious emotional disturbances throughout the state. In addition to ensuring that teachers receive training in systems of care, Mr. Perry envisions collaborating with the school system to incorporate transition planning in the IEP development process.

Committees That Focus on Transition

Specialty Committees Headed by Mental Health Agency. Mental health agencies in several states have recently taken the lead in establishing committees to examine transition issues. Interagency committees focusing on transition have been established in Arkansas, New Mexico, South Carolina and Wyoming. Mississippi has established a transition committee within its state mental health agency. Most of these committees include youth with serious emotional disturbances and parents of young people with serious emotional disturbances. Arkansas' child and adolescent service system program's (CASSP) state-level coordinating agency has designated a transition subcommittee whose members include the CASSP coordinator; family members; representatives of community mental health centers; and representatives of the state's education, health, child welfare, developmental disabilities and substance abuse agencies.

As of September 2000, 17 community mental health centers in South Carolina had established interagency transition task forces whose members include representatives of key state agencies, family members, and members of mental health advocacy groups. The state mental health agency asked each task force to identify service needs and discuss how member agencies could work together to address transition issues. The state also asked the task forces to develop specific plans to serve transition-age youth. The task forces are evaluating these plans in an effort to identify strategies that can be implemented statewide. An anticipated deficit in the state budget has made it unlikely that there will be state financial support for this effort. However, state mental health officials have encouraged the task forces to implement their plans at the local level.

A year and a half ago, Mississippi's state mental health planning council created a transition task force comprising child and adult system representatives from the state mental health agency, and consumers and community members from the planning council. This group examines state mental health procedures, policies and services as they relate to transition

needs. Division members from Idaho, North Carolina and South Dakota noted that their state mental health planning councils have also provided leadership on transition issues.

Interagency Committees Headed by Other Agencies. Many division members reported that their states have established state-level transition councils as mandated by the IDEA legislation to address transition issues for youth who receive special education services. The councils are usually headed by the state education agency. Mental health representatives participate in the councils in several states including New Mexico, Oklahoma, Rhode Island, South Dakota and Utah. However, a number of division members reported that although the councils focus valuable attention on transition issues, they rarely address the specific needs of students with serious emotional disturbances.

State child welfare agencies in North Carolina and Pennsylvania have established committees that include state mental health agency representatives to address systemwide issues regarding independent living for youth in the child welfare system. North Carolina's committee has developed a plan to address transition issues and obtained a grant for personnel development; however, at the time of the interviews for this report, the committee had not yet discussed specific transition issues related to mental health.

Virginia's Intercommunity Transition Council (VITC) was established through an interagency agreement among 10 state agencies including the departments of education; rehabilitative services; blind and visually impaired; and mental health, mental retardation and substance abuse services. The purpose of the agreement is to establish VITC as an interagency initiative that "ensures effective coordination of transition services for youth and young adults with disabilities, thereby increasing the accessibility, availability, and quality of transition services for youth and young adults with disabilities across the Commonwealth of Virginia." The agreement covers youth in special education as well as other youth with disabilities as defined by section 504 of the federal Rehabilitation Act of 1973, which requires that any program or activity receiving federal financial assistance (including public schools) make their programs or activities accessible to individuals with disabilities (34 C.F.R. Part 104). The departments of education and rehabilitative services jointly head the council, and its members include parent advocates as well as agency representatives.

Maine has recently established an interdepartmental planning committee focusing on family involvement and transition whose members include representatives of the state mental health (adult and child), child welfare, juvenile justice, substance abuse and education agencies as well as parents and youth. Eighteen counties in Northern California convene an annual children's summit meeting that brings together representatives from mental health, public health, education, social services, probation and the juvenile court to discuss common concerns and develop plans for improving services in a number of areas including transition. Hawaii's state-level children's council includes representatives of Hawaii's child-serving agencies and the adult mental health and substance abuse systems. The council views transition as one of its major concerns. Similarly, Ohio has established the Community Support Planning Council whose members include representatives of agencies that serve children and adults, consumers and family members. The council's subcommittee on children has identified transition as an issue requiring systemwide improvements, particularly in the

area of mental health services. Oregon has created a statewide supported-education task force that includes university faculty and representatives from the state developmental disabilities, mental health and vocational rehabilitation agencies. This is the only committee mentioned by any division member that specifically focuses on supported education.

Information Dissemination. In Alaska, a task force that focuses on the transition of youth with serious emotional disturbances in mental health and special education programs is developing informational materials for parents and youth on transition issues (drafts must still be approved by the state mental health agency commissioner). One document explains differences between the terms serious emotional disturbance, which is used to assess eligibility for services by child mental health systems and special education programs, and serious mental illness, which is used by the adult mental health system. Another document addresses a young person's rights to confidentiality concerning mental health services they receive, how these rights change when a youth reaches 18, and how those changes may affect parental involvement in service and support decisions.

This task force includes representatives of a number of state agencies including vocational rehabilitation, child welfare, juvenile justice, education, and mental health and developmental disabilities; a representative of the governor's board; young adults; parents of transition-age youth with serious emotional disturbances; providers; the Alaska NAMI affiliate; and Parents, Inc., a private, not-for-profit family advocacy organization. The task force has also developed a draft memorandum of understanding that calls for the state education agency to designate a contact person to respond to questions concerning transition issues and seeks cooperation between the mental health system and special education programs. In Pennsylvania a parent advocate has written a resource book on transition for families that the state mental health agency makes available to families and other stakeholders.

Linkages to the Adult Mental Health System

Linking Youth in Child Mental Health. Division members from Connecticut, Nevada and Rhode Island, all of which have consolidated children's agencies, have developed memorandums of understanding that describe the process of linking young people receiving services in the children's system to adult mental health services. Delaware, which also has a consolidated children's agency, includes transition planning in its contracts with child mental health providers. (For more information on transition planning, see page 24.) Nevada and Rhode Island have developed memorandums of understanding between their child and adult mental health systems designed to facilitate continuity of care and to ensure that youth who reach the age limit for receiving child mental health services can gain access to the adult system if they qualify. The memorandum requires the adult system to provide intake and assessment for youth leaving children's services.

Connecticut's memorandum of understanding is broader, defining the application process that young people must follow to request adult mental health services, designating financial responsibilities for services identified in the transition plan, requiring the children's system to designate a transition coordinator and identifying special populations of children who do not

meet adult services criteria but who may still receive special transition services funded by the adult system.

Connecticut has developed specific programs for two groups of youth who are too old to receive services from the child system. One group encompasses youth designated as special populations, including young people with serious emotional disturbances who also have a history of perpetrating sexual crimes and youth who have pervasive developmental disorders. The second group includes youth who do not meet the eligibility criteria for receiving adult mental health services at the time but whose conditions are expected to develop to the point that the youth will become eligible for adult services.

These youth are eligible to participate in the state's Transitioning Youth Programs (TYP), which provide supported housing and related services and were developed through a planning and consensus-building process initiated by Connecticut's North Central Regional Mental Health Board with funding from the federal Center for Mental Health Services. The process included convening a one-day statewide conference on youth in transition. The TYP model grew out of a subsequent series of focus groups involving young people, families, providers and agency representatives. The state legislature provided funds to establish supported housing programs in connection with the four community mental health centers that provide both adolescent and adult services. The programs serve 18-23 year olds.

All four programs offer supported housing, yet each is different in the specific nature of the supported housing and related services provided. Differences include types of housing (e.g., living alone in scattered sites or with roommates in a shared building) and the degree to which case management, independent living skill preparation and mental health services are integrated. Each program serves a small number of youth (4 to13 at any given time). All program staff have received training in the TIPS model (Clark et al., 2000), which proposes a developmentally appropriate system of care for youth in transition, and in the therapeutic stance described by Bruculerri and colleagues (2000), which emphasizes the importance of family systems and a developmentally-appropriate therapeutic approach.

Several other states including Arizona, Massachusetts and Illinois require children's mental health services to screen some or all of their clients during the 6-to-12-month period before they are scheduled to leave the children's mental health system to determine whether the young people need continuing mental health services and supports and to assist those who do need continuing assistance to apply for them through the adult mental health system. New Jersey has established a protocol for transferring eligible youth from adolescent Case Assessment Resource Teams (CARTs) to adult CARTs during the period around their 18th birthday. The procedure allows youth to be clients of both CARTs for two to three months during the transfer.

Virginia's policy on transition services (see Education Supports above) calls for local mental health authorities to include in their "annual written interagency agreements, procedures for planning and implementing transitional services for adolescent clients of the community services board who are not in a special education program but who will require a transitional

plan to prepare them to enter the adult service system." Thus the procedures are mandated throughout the state but defined locally.

Some states that utilize the wraparound process for transition planning report success in engaging the adult mental health system in the process at a relatively early stage. However, others note that this is an area of concern. One reason for this concern is that Medicaid does not provide reimbursement for dual case management services, nor do many state mental health agencies.

Linking Youth with Serious Emotional Disturbances in Other Systems with Adult Mental Health Systems. Massachusetts' mental health and juvenile justice systems developed an interagency agreement through which a forensic coordinating team assesses the needs of youth in juvenile justice custody who are about to turn 18 to determine if they need mental health services. If so there is a protocol for applying for adult services and linking the youth with an adult case manager. Similarly, Colorado operates two pilot programs at juvenile detention centers through which mental health services staff collaborate on transition planning with youth who are about to leave the facility. The staff can also provide limited continued services to youths once they return to the community.

New York provides some funding for youth who have been placed in out-of-state educational facilities by the public education system. The funds enable out-of-state placements to continue after the young person reaches age 21 until a plan is developed for the person to receive adult mental health services.

In North Carolina a program funded by the state health agency provides mental health services to pregnant and parenting teens. The program utilizes both the child and adult mental health systems to coordinate a plan for services that are needed as young persons enter adulthood. The focus, in part, is on preventing a second pregnancy. The program also coordinates maternity and child care services.

Programs or Services for Both Adolescents and Adults. There are programs in some states that serve both adolescents and adults, either by allowing transitioning clients to participate in adult programs or accepting older clients in programs primarily for adolescents. Most of these programs, as with Connecticut's TYPs, offer services only to youth receiving child mental health services who meet or are expected to meet adult mental health eligibility criteria. However, some innovative sites have been able to extend services to youth who do not meet adult criteria. In one suburban Boston community, for example, several of the programs that serve adolescents also serve young adults ages 18 through 21 even though eligibility for children's services typically ends at age 19. Services include residential treatment and educational/vocational support activities. After the state changed the upper age limit for eligibility for children's mental health services from 21 to 19, the child mental health division in this suburban area decided to continue the programs that had been serving youth up to age 21. However, no state funds for new children's services can be spent on any person over age 19, restricting the transition supports that this area can offer youth to these pre-existing programs.

In New Hampshire, the age of eligibility for children's mental health services recently has been shifted from 18 to 21 in certain cases. Community mental health centers can apply for a waiver to continue serving youth up to age 21 as long as they remain in school. The Crossroads program in Westchester County, New York, serves young adults ages 17-1/2 to 21, providing mobile crisis, case management and clinical services. The Westchester County Youth Forum receives county funding to provide peer support for youth and young adults ages 14 through 25.

Vermont's JOBS programs (see Vocational Efforts section above) appears to be the only program described in these interviews that offers relatively comprehensive services and supports to any young person who meets the eligibility criteria for child mental health services and that continues services beyond the upper age limit for child mental health programs.

Illinois' statewide Individual Care Grant Program, which serves 375 to 400 youth annually, assists parents to obtain residential placements or intensive community-based services for their children. The program includes a specific provision for transition services that enables persons ages 17 to 22 who are returning to the community after an out-of-home placement to obtain up to 12 months of support to maintain them in a less restrictive setting and link them with appropriate long-term supports including adult mental health services.

The Transition Community Treatment Team in Columbus, Ohio, is an example of a program that works with older adolescents who generally meet adult mental health systems eligibility criteria and that can continue to serve them into young adulthood. Similarly, several of Wisconsin's Program of Assertive Community Treatment (PACT) teams have begun to serve adolescents who later will move into adult services (ages 15 to 21). Although the PACT teams do not specialize in transition, they attempt to provide continuity for youth moving from adolescence into adulthood. (See page 5 for more information on assertive community treatment.)

Oregon recently used federal block grant funds to initiate two pilot programs, one rural and one urban, that focus on youth and young adults ages 16-24 who are making the transition to the adult mental health system. The rural site utilizes a wraparound approach for youth who are being discharged from hospital programs. The urban site provides a day treatment program with supported housing and education components. Interagency committees oversee both of the pilot programs, which have a capacity to serve about 20 youth each year. The goal of the programs is to develop experience and expertise in combining child and adult mental health services for the transition-age population and share that expertise with other mental health programs to expand system capacity.

Cross Training. Division members from 36 percent of states reported that child and adult case managers or providers received some cross training in transition issues. California recently held a one-day conference on transition that was attended by staff from both the child and adult mental health systems. The conference focused on programs throughout the state that provide transition services and supports and encouraged those in attendance to consider what they could do to initiate or expand transition services in their own programs

and communities. Based upon this successful conference, county mental health directors and the state Department of Mental Health are organizing five regional forums on transition age youth. The forums will focus on coordination between the child and adult mental health systems as well as on ensuring collaboration with the housing, education and employment agencies. Kansas held a similar one-day statewide conference for staff from the adult and child mental health systems and for families that addressed the needs and characteristics of the transition-age population as well as system capabilities to address these needs. The conference also provided information about a variety of local transition initiatives and included workshops on specific transition concerns.

Cross Dialogue. Division members from Connecticut, Florida, Illinois, Maine and Texas said that there have been discussions between the adult and child mental health systems in their states to develop a consensus about what types of services are needed for transition-age youth. In these discussions child mental health system representatives made the argument that adult mental health services are geared toward older clients and thus are often unappealing to the transition-age population. Among their concerns are that many adult mental health services do not appear to recognize the need for young adult consumers to develop adult living and working skills for the first time, that they are not as flexible or individualized as child mental health services and that group settings are often dominated by older clients. For their part, adult services staff often contend that child mental health systems do not pay enough attention to the development of clients' skills for daily living and adult functioning and that as a result, young consumers often enter the adult system less prepared than they should be for many aspects of adult life. Division members point out that these types of exchanges have been very productive and should lead to better coordination between the child and adult systems and better preparation for adult living among youth.

Young Adult Programming in Adult Mental Health Services. Since the transition from adolescence to adulthood does not necessarily end at 18 or 21, or whenever youth are no longer eligible for children's services, it was important to assess whether youth who do gain access to the adult mental health system encounter age-appropriate services there. Since this report is based on interviews with child mental health administrators, information about the degree to which adult mental health systems provide appropriate services to their young adult population is somewhat limited. However, division members from several states reported that the adult mental health system was making concerted efforts to address the needs of their young adult population with developmentally appropriate programming and supports.

A number of division members described efforts in their states to provide appropriate housing for young adult consumers. North Carolina's Mental Health Association (an affiliate of the National Mental Health Association) has facilitated the development of homes for adults in the mental health system with funding from the U.S. Department of Housing and Urban Development (HUD). The program promotes the development of reasonably priced, appropriate, supervised and assisted housing. Some group houses and shared apartments are designated specifically for young adults ages 18 to 23 or, in some cases, to 25. The program has also begun reaching out to youth and young adults in the corrections system to help them make a successful return to the community. In Alaska the adult mental health system has been examining the needs of consumers ages 18-27 in an effort to adapt its programs to meet

those needs. The adult system has identified the development of supported or supervised housing as a consistent area of need and has requested additional funding for housing. In Delaware transitional housing residences are being developed specifically for young adults.

ACT teams in Delaware are becoming increasingly aware of young adult issues. This development may result in part from young adults who are more typical of adolescents with serious emotional disturbances who do not meet adult eligibility criteria gaining access to ACT teams as a result of strong advocacy by child mental health professionals or family members. The presence of these young adults has raised awareness about this population and the challenges it faces. In Alabama, where there has been a growing awareness about the needs of young adult consumers, the state mental health agency has adapted a psychosocial rehabilitation model for day programs that enables clients to design their own rehabilitation program. The agency finds that young adults often select similar types of services and supports, resulting in group activities that are filled largely by young adults rather than older adults. The agency feels that this approach has greatly improved the appeal of its services to the transition-age population.

Reducing "Cultural Barriers" Between Child and Adult Mental Health. Although many of the interactions between adult and child mental health systems described so far in this report have represented preliminary discussions about reducing barriers between the two systems, California has taken some concrete steps to reduce the disparities between the two systems. The state legislature recently enacted legislation and refined existing statutes (AB 34 [99-00 session]) and (AB 2034 [00-01 session]) which resulted in the adult mental health system becoming more like children's mental health services in many California counties, thus reducing the culture shock and disengagement that many young people experience as they move into the adult mental health system. Similarly, Los Angeles has recently crafted a document on its children's system of care that is intended to form a basis for adding an adult system of care and a senior system of care, with the aim of having one system of care that is always developmentally appropriate.

Other Transition Initiatives

Youth Involvement. Involving youth at every level of public mental health services, from planning their own services to contributing to policy development, results in better transition services. The California Youth Connection (CYC), which advocates for youth who are or were in foster care, has received funding from the state mental health system to participate in an evaluation of the public mental health system, make presentations at statewide training conferences for mental health professionals and participate in site visits to county-managed mental health programs. As part of these activities, CYC youth managed a statewide focus group project examining adolescent consumers' perspectives on mental health care and seeking recommendations for improving youth involvement in mental health services. The California Youth Connection has an active legislative agenda and successfully promotes improved transition services at the county and state levels.

For the past two years, New York's Youth Advisory Council, whose members include a dozen or so young people ages 14 through 21, has advised the state's child mental health

system concerning publicly funded mental health services with which young persons may have had experience. The council has a small budget that helps pay for travel and meeting expenses.

State and Federal Policy Issues

Single Plan of Care or Coordination with Schools. Even when state mental health systems require transition planning, there can be too many, uncoordinated plans. The federal IDEA legislation (PL 101-476) and its 1997 amendments (PL 105-17) require that youth enrolled in special education programs have transition plans beginning at age 14. With the doubling of the federal budget and broadening of supports in the John H. Chaffee Foster Care Independence Act of 1999 (PL 106-169), youth with serious emotional disturbances in foster care may increasingly have plans focusing on the transition to independent living. Minnesota's Community Mental Health Act requires development of a unified plan of care for any youth up to age 21 who receives special education services along with services from another agency such as mental health. In Oregon a statewide effort to integrate public services includes specific mandates to establish provider teams. Serious consideration is also being given to requiring the development of a single plan of care covering all public services that a person receives.

Michigan requires community mental health centers to collaborate with schools on school-to-work transition efforts utilizing individualized, interdisciplinary, person-centered planning that focuses on each youth's goals and hopes (Kincaid, 1996). Tennessee's interagency agreement to implement IDEA includes a provision identifying Medicaid as the payor of first resort for needed services, thus establishing funding sources for transition plans. A memorandum of understanding initiated by the Texas education agency calls for annual, local community transition planning that addresses system-level issues. However, no funds had been provided to implement the memorandum of understanding at the time of these interviews.

Overlapping Responsibilities for 18-21 Year Olds. In Maine, Montana, Nebraska and South Dakota, young adults ages 18 to 21 may receive services from either the adult or child mental health systems. In Texas, this overlap exists for persons ages 18 to19. In order to continue receiving children's mental health services after age 18, youth in these states must, in most cases, have been receiving these services prior to that age. In some states including Maine and Nebraska, the young person, his or her family and public mental health officials jointly make the decision about whether a person between the ages of 18 and 21 receives services in the child or adult mental health system. In other states, a young person must have met the criteria for having a serious emotional disturbance, or otherwise have been eligible for child mental health services, prior to age 18 to continue receiving those services through age 21. If not, the person would receive services in the adult system.

Division members from several states said that the decision about which system provides transition services depends, in part, on which system has greater financial resources. The system with the most funding is likely to provide services to the majority of transition-age youth. Other division members viewed the overlap period as a way to continue services for

youth who are not expected to be eligible for adult services. Persons who qualify for adult services usually make the transition at 18, while those who are not expected to do so would continue to receive services through the child mental health system through age 21.

Extension of Services into Adulthood. Although a few states including Florida, Georgia and Massachusetts have child mental health programs that serve youth from adolescence into the age typically served by the adult mental health system, only two states report having legislation or policies that make it possible to provide services beyond the ages typically served by the child mental health system. The California legislation [AB 2034 (00-01 session)] that established the adult system of care extends mental health services to age 25 for any individual who is "at risk of becoming homeless." Although it is not yet clear how the law will be interpreted, it appears to allow either for extended services through the child mental health system or for the adult mental health system to provide services to an individual who has received children's services but would not normally qualify for the adult system to prevent homelessness. In Oklahoma an individual who is eligible to receive public mental health services can continue to receive services until they are no longer needed. Thus adolescents who continue to need services are allowed to move into the adult mental health system, regardless of whether they meet the adult criteria for receiving services.

Requirement for Transition Planning or Services. California's child mental health legislation requires counties to offer several transition-related services "to the extent possible" to persons ages 15 through 21 who receive public mental health services. These include transition planning that identifies a youth's needs and the resources required to help the person make a successful transition to adult independent living. Collaborative teams that include the youth and representatives of two or more agencies participate in the planning process. The law requires planning as necessary in the areas of employment, job training, health care, education, counseling, socialization, housing and independent living skills. In addition, county mental health agencies are required to provide assistance to young consumers over age 18 in obtaining health insurance and educational opportunities; to ensure that goals for young adults are individualized, identified by the youth and developmentally appropriate; and to develop plans for young adults to identify individuals and community services that can provide transition support for persons ages 18 through 21.

Florida law (Florida Mental Health Act, Chapter 394, Part III, Comprehensive Child and Adolescent Mental Health Services [ss. 394.490-394.495]) establishes comprehensive child and adolescent mental health services including transition services. For example, Section 394.491 (12 &13) states that an "older adolescent should be provided with the necessary supports and skills in preparation for coping with life as a young adult" and that an "adolescent should be assured a smooth transition to the adult mental health system for continuing age-appropriate treatment services."

Interagency Policies for Transition Services. Unlike many states in which transition services are required only for youth in special education programs, New Jersey mandates transition services for all youth who receive services through the state child welfare, mental health or developmental disabilities agencies. This policy, developed in 1996 by a joint work group on transition involving the mental health and child welfare systems, addresses both the need for

transition services and their delivery. Most aspects of the policy have been implemented with funds from the Chaffee Foster Care Independent Living Program, which can only be applied to youth in foster care. However some funding is also available for young people who do not receive child welfare services and for some services that are not available through the child welfare agency. Although New Jersey's policy serves as a statement of priorities, it is not accompanied by a specific funding commitment.

The interagency agreement that established the Virginia Intercommunity Transition Council calls for transition planning for all youth with disabilities. Virginia's Comprehensive Services Act, which focuses on "troubled and at-risk youth," requires representatives from a range of agencies to meet when needed regarding an individual's transition services. Funds provided by this law may be used to support transition services for persons up to age 21.

Status of the Field

The following material summarizes some of the general patterns of progress toward improved transition services reported during the interviews. This section provides an aggregate picture of areas where progress has been made as well as those where barriers to effective transition services still exist.

Child Mental Health Programs. This section addresses programs that primarily serve children and adolescents with mental health needs or that receive funding from the state child mental health agency. Although child welfare and special education programs provide services that are available to adolescents in the mental health system, this section addresses only those programs that are provided by the child mental health system. For example, it does not cover programs that are funded by child welfare, often through the Chaffee Foster Care Independent Living Program, or that provide independent living supports for youth in the child welfare system who may also be mental health consumers. However, if the mental health system provides substantial funding for such a program, we would include it.

Division members from the majority of states (78%) reported that their states' child mental health systems provide at least one transition service in at least one site, and more than a third (37%) provide at least two types of transition support. However, with the exception of Nebraska, no division member reported that a state provides a comprehensive set of transition services and supports to persons everywhere in the state. Nebraska uses a wraparound approach for youth up to age 21, and transition supports are addressed in service plans. It is not clear whether wraparound teams have more difficulty finding appropriate resources for the older population of young adults.

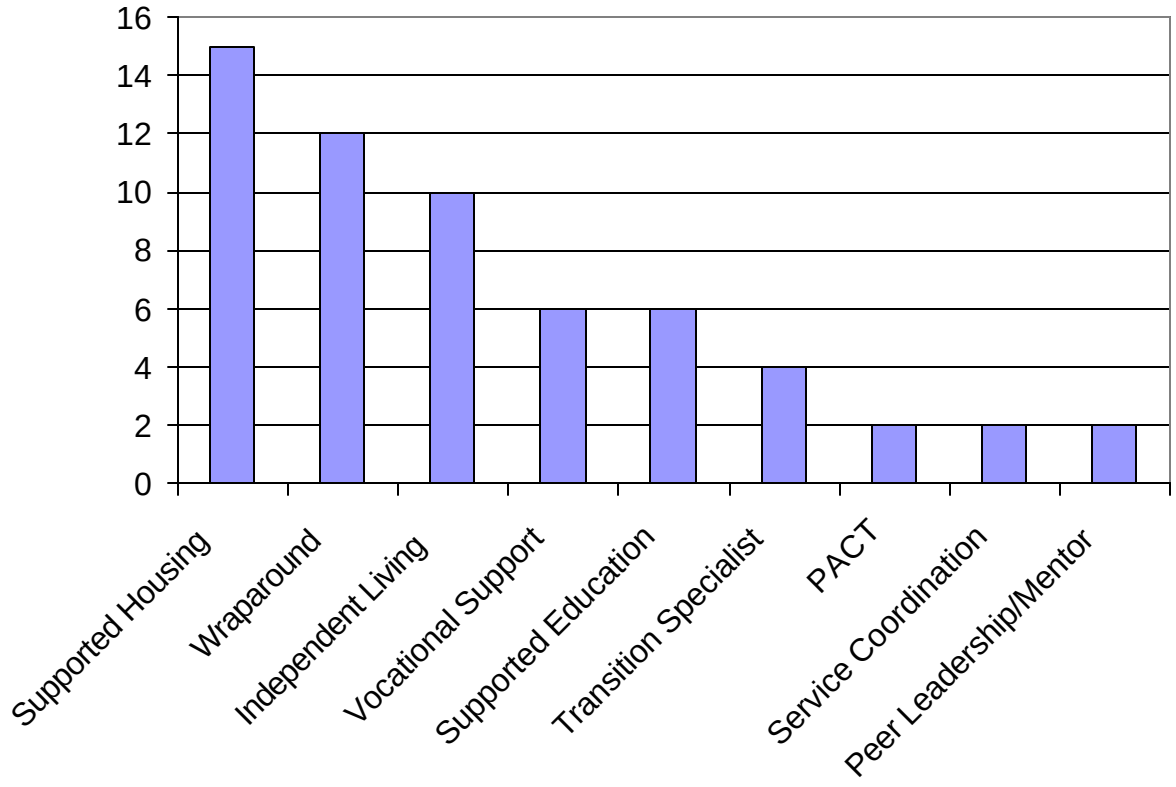
The most common transition assistance provided by state child mental health systems is supported or supervised housing (30%). Expanding the use of children's wraparound services to older youth and young adults or implementing wraparound services developed specifically for older adolescents were also common strategies (24%). Supported employment, independent living preparation and supported education were offered by no more than 16 percent of states. (See figure 1.)

Coordination with Schools on Transition Planning. Division members from nearly half of all states (24) reported a special effort by the child mental health system to collaborate with schools on transition planning. This special effort went beyond participating in states' school-focused transition councils and often took the form of a liaison or transition specialist who helped to bridge gaps between the mental health and education systems at the state or local level.

System Needs Assessment on Transition Supports. A surprisingly large number of states (19) had conducted a needs assessment in at least one site to determine the demand for transition services and supports. The vast majority of these assessments were accomplished through formal or informal focus groups in which participants, who may or may not have included young persons with serious emotional disturbances or family members, expressed their ideas about what types of transition programs existed and what additional initiatives were needed.

Figure 1.

Number of states that offer each type of transition support service through child mental health services.



Several states that have received CMHS system of care grants, which include a transition component, reported that the grant sites have conducted a needs assessment for transition services. Numerous states reported that the inter- or intra-agency committees that focus on transition had also polled their members to ascertain needs and resources.

Transition Planning. Division members from 19 states reported that their state mental health systems provide transition planning for adolescents who participate in children's mental health services. This group of states does not include those that took part in either special education or child welfare transition planning but rather those that have developed their own transition planning process. These state mental health systems developed plans to chart the steps a client would take to proceed either toward independent adult functioning or entering the adult mental health system. Some state mental health agencies incorporate transition planning into their written policies, while others establish this expectation by contract. Still others identify transition services as activities that can be reimbursed or funded.

It was more common for transition plans to focus on helping young persons enter the adult mental health system than on the broader goal of helping them to prepare for adulthood. Several states have specific procedures for moving youth from child to adult mental health services that include identifying the steps that are part of this process and that may also include recommendations concerning the type of supports that may be needed after a young persons moves to adult services. States were less likely to require the development of general transition plans that encompass a young person's goals for adulthood (e.g., finishing school, getting a good job, living on his or her own, building friendships) and the short- and long-term means to achieve those goals.

Interagency Efforts

This section focuses on collaborative efforts such as interagency agreements about transition services, planning or procedures, or about interagency committees that focus on transition issues that either are headed by the state mental health agency or in which the mental health agency participates.

Interagency Agreements. Seventeen division members reported that either the adult or child mental health system in their state had entered into an interagency agreement outlining areas of consensus about transitioning youth. Some of these agreements were quite broad, for example, stating a willingness to work together to improve transition supports. Others were linked to a specific process, such as participating in wraparound services, and include stipulations about how transition activities will be accomplished within the wraparound planning process. Some division members reported specific agreements with other child-serving agencies, including juvenile justice, to help youth with mental illness obtain services through the adult system when they are no longer eligible for children's services. Three of the four states with consolidated children's agencies have entered into agreements with the adult mental health system regarding transfer of youth who continue to need services and supports. Connecticut's more elaborate interagency agreements, described earlier in this report, designates which agency is responsible for financing particular services and establishes a liaison between the adult and child mental health systems.

Interagency Committees. As noted earlier, public mental health systems often participate in statewide transition councils initiated by state education agencies to fulfill the transition-planning mandate of the federal IDEA legislation. Some states also have established interagency committees that address transition issues, often at the urging of the public mental health system. State mental health planning councils, which are interagency in nature and involve consumers and family advocates, have also addressed transition in some states. Division members from 32 states reported that the child mental health system in their states led or participated in interagency committees or subcommittees that address transition issues.

Linkages with Adult Mental Health

Child administrators were asked specifically about the availability of cross training (agencies and providers that serve adolescents or adults receiving joint training on transition-related issues), shared case management and joint participation in transition planning procedures.

Questions also focused on whether there were differences in eligibility criteria for child and adult mental health services and whether the administrators believed that adult mental health staff were aware of the unique transition needs of the young adult population.

Shared Case Management. Clark and colleagues (2000) have suggested that one relatively inexpensive way to provide specialized supports to transitioning youth is for some case managers to develop expertise in the unique service needs of this population and to serve young adult consumers throughout the transition period from adolescence to early adulthood. To assess whether this approach may be feasible and how much informal connection between the two systems may be achieved through shared case management, we asked whether there are separate case management services for the child and adult mental health systems or whether individual case managers can serve both populations. Forty-two states reported that case management services for children and adults were either completely separate (19 states) or were separate with a few exceptions (23 states). In nearly every case, states that reported exceptions to separate case management explained that in rural or frontier regions, resources were too scarce to allow for specialization, resulting in service providers wearing multiple hats. The division member from Kansas, one of the nine states that reported commonly shared child and adult case management, indicated that this approach involved a conscious strategy to aid in the transition process. North Carolina's division member reported that the state mental health system provides one case manager for each family to help coordinate services for the entire family. Presumably, as a youth from the family enters adulthood, he or she can continue to work with the same case manager, providing an element of continuity. Division members from the remaining states with shared case management indicated that this approach was taken because local mental health authorities or community mental health centers have had the freedom to choose this strategy.

Cross Training. Division members from quite a few states (19) said that their states offered some form of cross training on transition-related topics to adult and child staff, case managers and providers. The majority of them reported that when adult and child case managers received training, they usually participated in the training together and that transition-related issues were covered. A handful of states, as noted in the "Innovation in the Field" section, had provided full- or half-day conferences and workshops focusing specifically on the transitioning population.

Participation of Adult Mental Health in Transition Planning Process. Division members from 22 states reported that the adult mental health systems participated to some degree in the transition planning process. In six of these states, participation occurred only at some sites. With one exception, adult mental health systems in these states became involved only with youth who were expected to require adult mental health services. The exception was Kansas, where youth ages 18 to 21 can receive services either through adult or child mental health. The state offers many transition programs that are managed by adult community-based services, thus bringing the adult system more fully into transition planning.

For many states, participation by the adult mental health system was mandated by specific procedures established for helping youth move from the child mental health system to the adult system. One barrier reported by respondents is that case managers from the two

systems usually cannot both receive reimbursement for services from either Medicaid or state general funds. For example, if a case manager from adolescent services were involved, case management services provided by the adult system were not reimbursed.

Different Eligibility Criteria. As noted elsewhere in this report, one of the major barriers to the provision of appropriate transition supports for adolescents is that many youth who receive child mental health services do not qualify for adult services. Those who are not eligible for adult services have few options for transition supports once they leave the child system. Division members from only two states reported that there were no differences in eligibility criteria between the adult and child mental health systems. In a few states eligibility differences affected only some services, often including case management.

Differences in eligibility requirements usually revolve around the distinction between serious emotional disturbances for youth and serious and persistent mental illness for adults. The former has a broader definition than the latter, including a wider range of diagnoses and conditions. Quite a few states included at-risk populations or youth who have attempted suicide in their child services population. The serious and persistent mental illness criteria are usually narrower both in terms of diagnoses and severity of functional impairment. A few states indicated that although the diagnostic and functional criteria were similar for child and adult mental health services, financial requirements were quite different. For example a child might be eligible for services if his or her family income was as high as 200 percent of the federally designated poverty level, while eligibility for adult services might reach a cutoff at 125 percent of the poverty level. Thus some youth were not able to continue services because their family income was too high.

Only Oklahoma ensures that youth who receive child mental health services and who need continuing services can receive them from the adult mental health system. However, there is no requirement that services offered by the adult mental health system be developmentally appropriate and appealing to youth in transition. Thus youth may qualify for adult services but find that those services available to them are not appealing.

Age at Which Child Mental Health Services End. The majority of states (31) end child mental health services when a young person reaches 18. Some division members reported that the child mental health system in their states would continue involvement with youth who receive services from multiple agencies until their eligibility in all child-serving systems ends. Thus child mental health systems in a few states may serve youth who are also involved in the child welfare system through age 21 and those in special education through age 22. However, services end at age 18 for youth who are involved only with the public mental health system. Three states end child mental health services at age 19, and two of those states extend child services to age 19 only for those who began receiving services prior to 18 and who continue to need services. In these two states, a youth who enters the public mental health system at 18 would receive services through the adult mental health system. This phenomenon is known as child-adult overlap. Of the 15 states that serve youth up to age 21, twelve have an overlap between the child and adult systems for persons ages 18 to 21. One state has an overlap for persons ages 18 to 22.

Awareness of the Needs of Young Adults. Child mental health administrators were asked whether they believe that staff of the adult mental health system are aware of the unique needs of the young adult population and whether the adult system provides age-appropriate programming for transitional youth. Only 14 division members reported that there appeared to be an awareness of these needs that had resulted in action. Another 14 reported that they did not think there was any awareness of this need; 8 reported that there was some awareness, 6 that there was awareness that had not resulted in systems change, and 9 that they were not sufficiently familiar with the adult mental health system to make a judgment. (For information about efforts by adult mental health systems to address transition issues, see "Linkages to the Adult Mental Health System" on page 17.)

Programs that Serve Adolescents and Adults. One way to ensure a smoother transition from adolescence to adulthood for young consumers is to offer programs that serve youth throughout the entire transition period. The difficulty in doing so is that it requires securing funding from both the child and adult mental health systems, obtaining permission from the two systems to use these funds for persons who are either too old to receive child services or too young to receive adult services, or to secure funds from other sources that can be used to serve youth who do not meet one or the other system's eligibility criteria. Division members from 14 states reported that there was at least one child mental health program at one site in their states that could serve adolescents into the age range usually covered by adult services. The majority of these programs serve youth who already meet the criteria for receiving adult mental health services or who are expected to do so in the future. A few extend the age range of youth they serve with child mental health funds, allowing those who do not meet adult criteria to continue to receive services. However, most of these states extend services in just one or two programs. At the time of the survey and interviews, only Vermont appeared to be making a systematic effort to establish this option throughout the state mental health system, having already implemented it in four regions.

Taken together the survey and interview findings provide evidence that although many places around the country are engaging in impressive and innovative transition programming, comprehensive, appropriate services and supports are largely unavailable to youth in transition.

Factors that Facilitate or Hinder Efforts To Improve Transition Services

Division members were asked to identify the characteristics of public mental health systems that help or hinder efforts to improve transition services and supports for transition-age youth with emotional or behavioral difficulties. The survey and interview questions purposefully focused on characteristics of the public mental health system that support or hinder the development of effective and appealing services for transition-age youth rather than on the characteristics of this population that make it difficult to provide such services. For most factors that were described as either facilitating or hindering improvements in transition services, the absence of the factor was generally viewed as having the opposite effect even though this was not always specifically stated. For example, many division members said that the presence of forums for discussion among relevant agencies was an asset; thus it would follow that the absence of such forums would be viewed as a hindrance.

Characteristics that Facilitate Efforts To Improve Services

One common theme that ran through division members' comments concerning characteristics of public mental health systems that facilitate transition efforts is that the agencies must make transition a priority for effective services to be provided. Most division members said that dogged advocacy and leadership also are necessary to bring the issue to the forefront and keep it there.

It is important to recognize that improving transition services will require addressing problems in both the child and adult mental health systems. The more effective these systems are at the outset, and the more closely they adhere to models of coordinated systems of care that seek to address the comprehensive needs of clients in a coordinated fashion, the more successful they are likely to be in providing comprehensive and coordinated transition support services. For example, it is generally acknowledged that early identification and prevention reduce the severity of problems experienced by children coping with mental health needs and young adults facing their first episode of serious mental illness. By extension early identification and prevention also make the transition to adulthood easier than if the mental health problems are left to fester.

The goal of this report is to address views and concerns that are broadly shared by division members. Issues that appeared to be of concern to only one or two states are not covered here. For example at the time of the interviews, both Arkansas and the District of Columbia were in the process of establishing child mental health systems that are overseen by a separate child administrative structure rather than by the adult system. Because the absence of a child mental health administrative structure within a state mental health agency was such a rare occurrence, this issue was not addressed in the report.

Advocacy and Leadership. One of the most frequently mentioned factors that led to success in improving transition services was the presence of strong, active advocacy voices. The combination of robust advocacy and a willingness by public mental health systems to be

open to and, in fact, embrace advocates' perspectives and leadership resulted in many of the successful transition efforts that have occurred to date. Sometimes efforts at change that originated outside the mental health agency (e.g., with advocacy organizations) were successful without the support of the state mental health system; however, partnerships between advocates and state mental health agencies appeared to produce the best results. Several division members said that internal and external advocates must be as tenacious as a "dog with a bone" in seeking improved transition services because there are so many barriers to change.

Ownership. Several division members said that when both child and adult mental health systems feel a sense of ownership for the transitioning population, action and funding are likely to follow. If that joint sense of ownership does not materialize, transition-age youth can become an unclaimed population, no longer part of the child mental health system once they reach a certain age yet unable to access the adult mental health system by virtue of not meeting its eligibility criteria.

To date child mental health systems have shouldered most of the responsibility for meeting the transition needs of young persons with mental health issues because child systems are already serving many of these young people and have a sense of accountability for them. Yet several division members noted the limitations of the status quo. Although nearly all of the successful transition efforts identified by division members originated in child mental health systems (or with advocates for children), there appeared to be general agreement that transition efforts are likely to fall short if adult mental health does not do its part. The rarity of transition services that continue from adolescence through age 25 appears to support this view. Youths' needs for transition support do not necessarily end when child mental health services do, many division members pointed out.

Division members also addressed the importance of community support for transition efforts. Many respondents mentioned that members of the public often appear to be even more wary of transition-age youth with mental health problems than they are of younger or older groups of mental health consumers. Many division members emphasize that public mental health systems need to develop strategies to promote public awareness and concern about these young people. However, division members indicated that using scare tactics, such as emphasizing the possibility of crime and violence among youth who do not receive effective services, is likely to be counterproductive and cause more fear than support. Instead they recommended emphasizing the tremendously positive results that can occur when young people with emotional difficulties receive effective services and supports that help them prepare to take on productive roles in society.

Awareness and Attention. Several division members pointed out that for transition services to improve, there must be a greater understanding of the needs and characteristics of the transition-age population. Some respondents focused on the importance of effective advocacy efforts, including the need to point out to adult mental health officials that their systems will eventually be providing services to many transition-age youth if their untreated or inadequately treated conditions progress sufficiently for them to qualify for adult services. It can also be pointed out that the eventual cost to society, in the form of crime, homelessness

and other problems, for not providing adequate mental health services would eventually put pressure on human service agencies to respond. Other division members emphasized the need to make public mental health officials aware of the characteristics and needs of the transition-age population and to provide them with examples of effective programs and strategies for this population. Similarly, some respondents suggested that public mental health systems that develop data on unmet needs are more likely to address transition issues because of the dramatic results they would obtain concerning the high percentage of transition-age youth with unmet mental health needs.

Some division members mentioned that media accounts of transition-age youth could shine a light on this population and put pressure on public mental health systems and other youth-serving agencies to improve services. Generally, however, there was concern that media attention might instill fear rather than concern by highlighting the crime, homelessness or violence that can occur without effective services. Unfortunately, many said, positive stories that demonstrate the tremendous benefits of effective transition programs rarely make the news.

Interagency Involvement. One of the issues raised most often by division members was the importance of collaboration and cooperation between the child and adult mental health systems. The presence of inter-system dialogue was the most common factor described by division members in states that had made significant strides in addressing transition. In particular, several respondents emphasized the importance of developing effective, ongoing relationships between the two systems if they are to be able to address such difficult issues as improving transition services. Division members from states in which there were wraparound community teams and state-level interagency teams emphasized the importance of these forums for initiating and sustaining improvements in transition services. Division members also emphasized the interagency nature of transition and the need to have other child and adult systems working together. Conversely, many members emphasized that system fragmentation was a major hindrance to providing comprehensive transition supports. Numerous respondents said that their states have instituted a Medicaid mental health carve-out over which the public mental health system had little or no control. No transition supports were provided within the carve-out, according to many respondents. Yet several division members reported that many more young consumers were served through Medicaid carve-outs than through the public mental health system. Clearly skilled outreach is required to bring all partners to the table in such fragmented service systems.

Including Youths' Voices. Since no state mental health system has implemented a fully coordinated continuum of transition support services that continue into adulthood, several division members, particularly those from states that had made progress in the area of transition services, emphasized that ensuring that young people's opinions are heard and considered is essential to developing appropriate and appealing transition services. Many states have found that having a youth advisory group or enabling youth to participate in existing mental health advisory groups had a positive impact on service provision.

Emphasis on Functioning. The importance of focusing on functioning was expressed in two ways. First, many division members pointed out that placing an emphasis on adolescent

functioning leads naturally to conclusions about the need to prepare young people for adult functioning. In addition, a number of respondents said that focusing too much on symptom reduction and crisis management leaves little room for planning for the future or addressing long-term functional needs. Several members said that the emphasis on improved functioning is a strength of the adult public mental health system.

Emphasis on Responding to Individuals' Needs. Several division members felt that better transition services emerge when public mental health systems focus on the needs and wishes of individual consumers rather than employing a one-size-fits-all approach. They pointed out that focusing on an individual is good practice for any age group but that child mental health systems had embraced this approach much more than adults systems and that this difference was one of the barriers to coordination with adult systems.

Practices that Reward Creativity. Several respondents emphasized that tremendous creativity is needed to maximize current system capacity and to develop both a vision and a plan for future transition services. Public mental health systems can promote this type of creativity, they said, by rewarding innovative approaches with increased funding, developing contracts with providers that require them to come up with improved strategies for transitions services, by establishing policies and regulations that promote innovation and by establishing a relationship between funders and providers that encourages creativity.

Developing a Vision and a Strategic Plan. Several division members felt that one of the necessary consequences of making transition a high priority is the need to develop a strategic plan that establishes a vision of transition, defines goals and identifies the steps needed to build system capacity.

Information. Numerous respondents acknowledged the importance of information in efforts to open doors for transitioning youth. Several had employed service utilization data to demonstrate that youth who left children's mental health services at one point often sought adult mental health services several years later with much more serious mental health disorders and related problems. This type of information has helped to convince adult mental health systems that it is worthwhile to provide services to young people before their problems worsen. In Vermont, for example, child mental health officials used data on the corrections involvement of youth after they had left child mental health services to support the need to extend services to young people with emotional difficulties who do not qualify for adult mental health services.

Federal Leadership. A number of respondents emphasized the value of federal leadership in improving transition services. Several division members praised the federal Center for Mental Health Services for funding a series of policy academies on children's mental health services offered by the National Technical Assistance Center for Children's Mental Health at Georgetown University's Child Development Center and noted that this would be a good way for the federal government to provide leadership on transition issues.

Accountability. One way to focus attention on transition issues is to emphasize their role in ensuring accountability of public mental health systems. Division members noted that when

client outcomes are used to evaluate the performance of mental health systems, transition takes on greater importance because of the key milestones that society expects young adults to achieve and the difficulty that many in this population have in achieving them.

The Need for Clarity in Policy, Regulations and Contractual Provisions. Members also noted that contract language, policies and regulations are important ways to shape practice and facilitate change. Numerous state mental health agencies require transition planning in contracts or regulations governing public mental health providers. Other states encourage transition planning simply by identifying such services as a reimbursable activity. On the other hand, employing a general endorsement of such approaches as the Child and Adolescent Service System Program (CASSP) values of ensuring smooth transitions to the adult system did not seem to translate into programmatic change.

Fund Sources. Division members from states that had made significant progress in improving transition services uniformly emphasized the importance of making additional funding available for these services. While noting that reallocating funds from other parts of the mental health system to transition services can lead to some improvements in transition, they felt that only limited progress could occur using this strategy. Some state mental health systems had successfully sought new sources of funding for transition initiatives. Most had used federal mental health block grant resources to establish pilot projects. Connecticut and Vermont, the states that appeared to have made the broadest inroads in reaching previously unserved transition-age youth, had done so by obtaining additional state funding. However, Vermont's efforts began with the vocational rehabilitation, child mental health and corrections systems contributing small amounts of their existing budgets for this purpose. Division members also identified the importance of maintaining funding sources, once acquired, as a critical concern. Maintaining funding required efforts similar to obtaining the funding, advocacy and leadership, with the addition of outcome data they gather from the programs.

Many division members believe that funds must be dedicated to specific transition programs or staff to avoid having the money redirected to other needs. Some respondents said that it is important to designate programs and staff to activities that have a clear overlap between adult and child mental health services, with funding dedicated to the clients in those programs. States that had achieved such joint transition efforts had usually begun by obtaining funds from a single source, such as the mental health block grant or from child or adult mental health services. The programs or positions were generally assigned to either the adult or child mental health system rather than having both systems share administrative responsibilities. Vermont's JOBS program is an exception to this pattern because of its interagency funding and administration.

Similarly, many division members felt that funding should be used to promote the development of new technologies, encourage interagency collaboration and reward agencies and programs that emphasize transition preparation and support.

Some children's mental health services administrators also noted that allowing local mental health authorities some flexibility in using state mental health funds on services leads to an

increase in transition support services. For example, when state mental health agencies identify transition services as one of the types of services for which local mental health systems can be reimbursed with state funds, some regions begin developing or improving transition services (while other regions may choose not to do so).

Finally, several division members noted that Medicaid funding for the Early and Periodic Screening and Diagnostic Testing (EPSDT) program could be used for young people up to age 21. Some states have used these funds to extend eligibility for children's public mental health services from age 18 to 21 for those youth who qualify for the EPSDT program.

Publicity. Several persons noted that efforts to improve transition services often followed media reports of upsetting events involving youth in this population.

Lawsuits. Several persons reported that lawsuits have sometimes had a direct or indirect impact on improving transition services.

Characteristics that Hinder Efforts To Improve Services

Conflicting Eligibility Criteria. Many respondents noted that differences in eligibility criteria for child and adult public mental health services produced barriers to the provision of effective transition services. Because many adult and child mental health services have separate funding, youth who do not meet adult criteria cannot access adult services. Child services administrators said they often had difficulty engaging the adult system in dialogue unless the focus was on adolescents who would or did meet the criteria for receiving adult services. Several division members said that some adult public mental health system officials feel that many youth receiving services in the child mental health system did not have a mental illness as defined by the adult mental health system and thus would not benefit from or were not as in need of these services as adults with serious and persistent mental illness.

Several respondents also point out that youth who receive services from other systems, such as juvenile justice or welfare, may have mental health problems that are as serious or more serious than youth in the mental health system. Yet these youth are even less likely to gain access to adult mental health services. This is true in part because there is little dialogue among these systems and in part because young people involved with these other systems may not have developed a mental health "resume" of diagnoses and treatments that would qualify them for public adult mental health services.

Conflicting eligibility criteria are not limited to state mental health agencies. Numerous child mental health administrators pointed to the differing criteria between children and adults for receiving Supplemental Security Income (SSI) from the Social Security Administration and the burden placed on human services agencies when youth lose SSI income upon reaching adulthood. Division members from states whose child mental health systems primarily serve the Medicaid population frequently pointed to the different ages at which Medicaid eligibility ends depending on which Medicaid program youth are enrolled in and to the different poverty criteria that are used by states for adults and children that can lead to a loss of eligibility upon entering adulthood.

Conflicting Cultures. Respondents acknowledged that differences in eligibility criteria for child and adult mental health services as well as the difference in age groups served have led the child and adult mental health systems to develop differing approaches that often do not serve youth well during the transition period. The positive side of these differences is that each system has developed areas of expertise that could be shared to help address transition issues. For example, the adult public mental health system has developed expertise in housing and vocational supports that the children's system does not have. The child mental health system, for its part, incorporates the larger context of family and community in its work with children in a way that the adult mental health system typically has not. The negative side of these differences is that they can lead each system to blame the other for failure to provide adequate services, create discontinuity in services for transition-age youth and pose difficulties in creating bridges between the two systems that young adults can use to access services.

Respondents consistently pointed out that child mental health services are usually community focused, emphasizing normalized environments and interaction with youth people who do not have serious emotional disturbances. However, adult services are often offered in more isolating settings, away from the wider community. Thus there was great concern that young consumers who receive services from the adult public mental health system may not have the opportunity to enter into adulthood within their own communities or to maximize their families as resources, all of which can result in unnecessarily restrictive adult settings.

One of barriers to effective transition services mentioned most consistently was that many adult mental health programs and services are not tailored to the needs and goals of the young adult population. However, child mental health officials and staff also acknowledged that they often receive complaints from their adult mental health counterparts that child services do not sufficiently prepare youth for the responsibilities of adulthood. Several respondents felt that their own awareness of the need to prepare adolescents for adult functioning while still in the child system made it easier for them to collaborate with adult mental health staff. Clearly each system could benefit from listening to and learning from the other.

Several respondents noted that clinicians working with children are often hesitant to apply the most serious diagnostic labels to young people for fear of the stigma and other consequences that such diagnoses might bring. However, they noted that reluctance to use those diagnoses, even when they are applicable, can make it difficult for a young person to gain access to needed adult services.

Lack of Dialogue. Some respondents reported that operating child and adult mental health systems as separate entities reduces opportunities for increased awareness of transition issues and useful interactions between the two systems. When there is no collaborative planning and no forum for raising issues, these respondents said, the adult mental health system is likely to remain unengaged in transition initiatives. It is interesting to note, however, that in many of the states where child mental health services are provided by a separate, consolidated agency, interagency agreements have developed between the child and adult mental health systems to help bridge this gap.

Differences between the two mental health systems have also resulted in a lack of understanding about the mission and activities of each system and how they might play a role in transition. Several respondents pointed out that the quality of transition planning performed by child providers suffers from a lack of understanding of the adult mental health system. Ignorance about each other's mission and functions can also lead to misunderstandings that may create a barrier to dialogue.

Lack of Expertise. Several child services administrators who had obtained funds to support transition programming noted that providers are often reticent to apply for funding themselves or did not demonstrate the appropriate expertise when they sought funding because of their lack of experience in working with transition-age youth. Connecticut has developed extensive training activities for its supported housing program for the transition-age population. This type of training also requires significant funding. It is also possible to gain expertise by combining the knowledge and experience of the adult and child mental health systems, and other systems, then tailoring it to the mental health population. Schools and child welfare systems have fairly lengthy histories of providing transition supports to the broader groups of youth that they serve. Thus states could broaden their knowledge base about working with transition-age youth who have serious emotional disturbances if each agency shared its area of expertise and then integrated those different areas into its own activities. For example, if the mental health system shares what it knows about working with youth with serious emotional disturbances and the child welfare and school systems share their expertise on transition, the combined expertise gained by all systems may result in better transition services for youth with serious emotional disturbances in all three systems.

Another consequence of the lack of expertise in working with youth in transition is the natural anxiety raised by the unknown. Several respondents noted that clinicians and others who work in the children's mental health system may not be comfortable providing services to adults, even young adults, and that those in the adult mental health system may not be prepared for the energy and natural rebelliousness of the young adult population.

Several division members also pointed out that the types of nontraditional services that often work well with transition-age youth are not routinely included in the curriculums of training programs for clinicians and other mental health professionals. These gaps in training not only leave future mental health professionals unprepared for the requirements of their jobs but also with a reticence to utilize practices that have not been endorsed by the authorities at these training grounds.

A few respondents said that there has been a lack of federal leadership in synthesizing the latest knowledge and practices concerning transition-age youth. In the absence of this knowledge, state mental health systems may feel hesitant to move ahead on their own.

Overemphasis on Out-of-Home Treatment. Division members noted that transition planning, including preparations for independent living, is more difficult when youth have few ties to their home communities and little positive experience in functioning in less structured, community-based settings. Thus it appears that child mental health systems that emphasize

out-of-home services will face greater difficulties in successfully integrating youth into communities and fostering successful independent living.

Housing and Employment Shortages. Several respondents commented on the severe shortage of affordable housing and, in some cases, of housing stock in general. The lack of affordable housing appeared to be a greater problem in urban areas, whereas the shortage of housing seemed more characteristic of rural areas. In either case landlords can be highly selective in choosing tenants, which may pose a significant barrier to youth in transition who are trying to obtain housing. More commonly, even if agencies find funds for housing programs, providers have difficulties findings sites for these programs because of resistance from the communities or neighborhoods in which they want to place the programs. Several division members also mentioned that the availability of jobs has a direct impact on the success of vocational programs for transitioning youth.

Hopelessness. Several respondents mentioned that children's mental health system staff can become so disheartened by the lack of progress in young consumers that by the time youth reach the upper age limit, they may feel a great sense of relief that their work with the youth is over. For those who question the potential for positive change offered through the transition process, there may be a reticence to embrace a longer and continuously discouraging involvement, as they perceive it.

Broader Societal Issues. Several respondents suggested that society's negative views about youth were a major hindrance to garnering legislative and public support for transition services. One person said that the NIMBY (not-in-my-backyard) syndrome discourages development of supported and supervised housing options for transitioning youth. Others pointed out that the majority culture expects these youth to pull themselves up by their bootstraps and that it is difficult to provide a sympathetic picture of them for many legislators and policymakers.

Lack of Connection to Primary Care. One division member made the observation that primary care physicians can provide a link to mental health services for many youth. When youth reach middle adolescence, they often stop seeing a pediatrician and largely forego annual physical examinations (except for those participating in school sports). These young people are more likely to seek care from emergency rooms. Thus a stronger linkage between mental health and emergency rooms may build bridges to needed services for these youth.

Fund Resources. Just as the availability of funds facilitates transition system improvement, the lack of funds inhibits it. Numerous division members reported that their state mental health systems appeared to be chronically underfunded, making it difficult for them to provide specialized services such as transition programs when there are barely enough funds to provide basic services. Several members added that funding shortages often result in large caseloads, which make it difficult to provide effective transition planning. Others pointed out that funding shortages often lead to turf wars in which agencies seek to limit access to services. A more subtle issue was described as funding "jealousy." Several division members reported that it was hard to engage the adult system because there was resentment over the greater level of funding in children's services in those states. However, division members

from some states said that children's services were greatly underfunded in relation to adult services. The resentment this might cause was not described as a barrier. Instead the lack of adequate funding was said to prevent the children's system from providing effective transition supports while youth were still receiving their services.

Several division members felt that categorical funding streams often inhibit the development of coordinated transition supports, which in turn is linked to the issue of eligibility: Because categorical funds are linked to services rather than individuals, those who do not meet the eligibility criteria cannot access services. Several division members pointed out that age limits for federal programs are not consistent. Although eligibility for some programs ends at age 18, eligibility for others continues through age 21, and these types of inconsistencies add to fragmentation during transition. There was also a feeling that child mental health services officials might be unaware of funding resources outside the children's mental health arena that could be used for transition services.

Gaps in Professional Training. Several division members made the point that shortcomings in professional training programs increased the difficulties of initiating systems change. In particular these members believed that traditional clinical and teacher training emphasizes one-dimensional thinking. For clinicians, they said, training that focuses primarily on diagnosis and treatment makes it difficult for clinicians to view consumers in a holistic manner and to place adequate emphasis on functioning, as opposed to symptom management. For educators, teacher training does little to expose teachers to the other systems in which students may be involved and roles that they might play in coordinating efforts among these system to improve student functioning. Differences in training also result in major differences in perspectives among different groups of professionals that can result in barriers to the effective interagency communication and collaboration that is necessary for the development of comprehensive transition supports. Failing to take a holistic approach to the transition process can also result in incomplete or no transition planning based on the view that transition planning is someone else's responsibility.

Impact of Lawsuits. Numerous division members reported that their states were so focused on carrying out court-ordered activities resulting from a variety of lawsuits that there was no funding or staff to address anything else, including transition needs. There seemed to be general agreement that although legal action often leads to improved services in a particular area, these advances often occur at the expense of other services and issues.

Conclusions

Taken together the comments of division members indicate that although those in child mental health systems are concerned about transition issues and have made important efforts to improve transition services, public mental health systems across the country have yet to develop a comprehensive approach to transition. Child mental health agencies have generally recognized the need to prepare adolescents for adulthood and to provide them with ongoing services and supports. With rare exceptions states are embarking on discussions about the need to improve transition services. It is also clear that most states provide at least some preparation for adulthood for a portion of adolescents receiving child mental health services. Thus states have a base of local expertise on which they can build.

It is important to point out that the experiences of child mental health systems across the country in developing transition services provide an extraordinary knowledge base that could be shared throughout the public mental health system. However, it is equally important to note that child mental health systems provide few across-the-board transition support services, have had limited success in engaging other child-serving agencies concerning transition and generally have been unsuccessful in gaining the support of adult mental health systems to provide transition services to young adults who are leaving the child system.

It is clear that one key to improving transition services is for state mental health systems to identify these services as a high priority. Unless this happens, children's mental health systems and staff can become so focused on day-to-day challenges that they may loose sight of the need to help young people prepare for adulthood. By the same token, adult mental health staff can become so focused on their traditional clients (adults ages 30 and older with long histories of chronic and serious mental illness) that they lose sight of the very different and challenging needs of young adult consumers.

Making transition a priority is also critical to obtaining funding for new efforts. Most states that have made notable progress in transition services did so by securing new funds rather than shifting resources from other mental health services. Child mental health services administrators raised concerns about the barriers imposed by federal funding policies that are tied to specific age groups. Eligibility for many federally funded mental health services either ends somewhere between the ages of 18 and 21 or begins at age 18. This can lead to piecemeal funding and fragmented services.

Many child mental health administrators expressed a high degree of frustration, recognizing the importance of transition services but having been unable to make much headway in expanding services. Only a few administrators reported little effort in their states to address transition issues, reflecting little interest in this area among family members, administrators or providers.

Overall, child mental health administrators expressed a sense of frustration about transition issues. Although several expressed understandable pride in their states' accomplishments, none were complacent about the status quo. They uniformly recognized the need to expand on their successes.

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Appendices

Appendix A: Guidelines for Telephone Interview of Children, Youth and Family Division Members of the National Association of State Mental Health Program Directors

For purposes of this interview transition services are defined as those services that are *focused* on assisting young people complete the tasks of adolescence and take on the mantle of adulthood.

Typical transition services offer the following supports:

1. completing high school
2. entering and completing post-secondary education or training
3. obtaining vocational support/training
4. independent living preparation and support
5. assistance in developing and maintaining adult social support networks
6. continuation of mental health services through the transition (beyond age 21)
7. transition planning and coordination of transition services and supports

Items 1-6, below, are the focus of the telephone interview. At the end of the interview Dr. Davis will ask you about documentation that would address items 7-11.

1. Are there any special efforts that children's mental health is involved with in providing or improving transition services?

    - Do individual case managers serve adolescent and adult clients, or do case managers serve only one or the other? ____ both _____one or the other

    - Are there any specific adolescent programs focused on preparation for adult functioning (either vocational, educational or housing/independent living)? What are the ages of those served in the programs?

    - Are there any special efforts to coordinate with schools' transition planning mandates?

    - Has a system needs assessment been done for transition services? Statewide or locally?

    - Other efforts.

2. Is transition planning formally done for adolescents in care? If so, who is involved, and what is the process?

3. What efforts, such as interagency agreements, interagency committees, or system of care approaches, are children's mental health or the state mental health agency making to

coordinate transition services across other systems (schools, vocational rehabilitation, housing, child welfare, juvenile justice, etc.)?

4. What efforts are being made to coordinate transition services across the state's child and adult mental health agency (i.e., shared case managers, cross training, joint participation in transition planning)?

5. What are your perceptions of what works, and what are the challenges and needs to providing good transition services for adolescents in care?

6. What are the budgetary and fiscal considerations that aid or limit transition services?

The following items are likely to exist in written form. Please send copies of these to Dr. Davis. When we conduct the phone interview we will ask about what you have or will send us.

7. Are there any mental health policies that directly address transition issues (i.e., mandating transition planning, requiring the preparation for independent living of adolescents in care who are ages 16 and older, etc.)?

    - Transition planning while in adolescent care
    - Grandfathering of eligibility, or any extension of 'children's' services beyond upper age limit
    - Any interagency agreements that involve sharing responsibility about youth in transition
    - Policies requiring preparation of adolescents in care for independent living
    - Any policies around youth in care who will not meet adult eligibility requirements
    - In your state MH plan, is there any endorsement of the system of care principle that call for assurance of smooth transitions to the adult system
    - Other

8. Are there any state laws that directly address transition issues that affect adolescents in the care of the state's child mental health agency (i.e., mandated coordination with transition planning for students in special education)?

9. Has there been any research that the state mental health agency or children's mental health have conducted or contracted for that examines transition issues; for example - utilization of transition services, description of transition services, patterns of general MH service utilization from adolescence into adulthood, adult outcomes of adolescents that were served, rates of school completion among those served and the like.

10. What are the eligibility requirements to obtain state child mental health services and state adult mental health services (i.e., target populations for child and adult MH)?

11. Please provide an organizational chart that shows where child and adult services are located within the state mental health agency, or where child mental health is in relation to the state mental health agency if in different agency. Also provide an organizational chart that shows where child and adult mental health are located in relation to education, child welfare, juvenile justice, vocational rehabilitation, health, substance and/or alcohol abuse, and housing agencies.

Appendix B: Active Members Roster: NASMHPD's Children, Youth and Families Division

Active Members Roster:

NASMHPD'S
Children, Youth and Families Division

October 2001

Note: Each member has been designated by the State Mental Health Commissioner to represent his or her respective state in NASMHPD's Children, Youth and Families Division.

National Association of State Mental Health Program Directors
66 Canal Center Plaza, Suite 302, Alexandria, VA 22314
(703)739-9333 Fax: (703)548-9517 www.nasmhpd.org

NASMHPD'S
Children, Youth and Families Division Roster

EXECUTIVE COMMITTEE

Chairperson (2000-2002) . . . . . Sherida Falvay (Michigan)

Vice-Chairperson (2000-2002) . . . . . Larry Thompson, Ph.D. (Tennessee)

Secretary (2001-2003) . . . . . Joseph Perry (New Hampshire)

Member-At-Large (2001-2003) . . . . . Lucy Keating (New Jersey)

Regional Coordinators:

(2000-2002) (Western States) . . . . . Kenneth J. Martinez, Psy.D. (New Mexico)

(2001-2003) (Mid-Western States) . . . . . Ed Morris (Missouri)

(2001-2003) (North-Eastern States) . . . . . Albert A. Zachik, M.D. (Maryland)

(2000-2002) (Southern States) . . . . . Susan Robinson (North Carolina)

Past Chairperson (2000-2002) . . . . . .Gary Blau, Ph.D. (Connecticut)

NASMHPD BOARD LIAISON

Marylou Sudders, Commissioner
Department of Mental Health
25 Staniford Street, Boston, MA 02114
(617)626-8123 Fax: (617)626-8131
marylou.sudders@dmh.state.ma.us

NASMHPD COMMISSIONER ADVISOR

Vacant

NASMHPD DIVISION ADMINISTRATOR

Roy E. Praschil, Director of Operations
National Association of State Mental Health Program Directors
(703)739-9333, ext. 20
roy.praschil@nasmhpd.org

ALABAMA

Charles L. Day, J.D.

Director
Office of Child & Adolescent Services
Division of Mental Illness
Department of Mental Health and
Mental Retardation
100 N. Union St., P.O. Box 301410
Montgomery, AL 36130-1410
Ph. 334/242-3643
Fax 334/242-3025
mailto:cday@mail.state.al.uscday@mail.state.al.us

ALASKA

Kathy Craft, DMHDD & AMHB

Children's Mental Health Coordinator
751 Old Richardson Highway
Suite 123
Fairbanks, AK 99701-7802
Ph 907/451-2017
Fax 907/451-5047
kathryn_craft@health.state.ak.us

AMERICAN SAMOA

Fuala'au Hanipale

Social Services Division
Department of Human Resources
American Samoa Government
Pago Pago, American Samoa 96799
Ph. 684/633-4485, ext. 2696
Fax 684/633-7449

ARIZONA

Robin Trush

Chief
Division of Behavioral Health Services
Department of Health Services
2122 East Highland, Suite 100
Phoenix, AZ 85016
Ph. 602/381-8999
Fax 602/553-9043
rtrush@hs.state.az.us

ARKANSAS

Ann Wells

Assistant Director for Children Services
Division of Mental Health
Department of Human Services
4313 West Markham St.
Little Rock, AR 72205
Ph. 501/686-9489
Fax 501/686-9182
ann.wells@mail.state.ar.us

CALIFORNIA

Stephen W. Mayberg, Ph.D.*

Director
Department of Mental Health
1600 9th Street
Sacramento, CA 95814
Ph. 916/654-2309
Fax 916/654-3198
mailto:
dmh.smayberg@hul.cahwnet.gov

COLORADO

William Bane, MSW

Program Administrator
Child and Family Services
Colorado Mental Health Services
3824 W. Princeton Circle
Denver, CO 80236
Ph. 303/866-7406
Fax 303/866-7428
bill.bane@state.co.us

CONNECTICUT

Gary M. Blau, Ph.D.

Bureau Chief
Bureau of Quality Management
Department of Children & Families
505 Hudson St.
Hartford, CT 06106
Ph. 860/550-6421
Fax 860/550-6541
gary.blau@po.state.ct.us

DELAWARE

Nancy Widdoes

Director, Administration
Division of Child Mental Health Services
Department of Services for Children, Youth & Their Families
1825 Faulkland Road
Wilmington, DE 19805-1195
Ph. 302/633-2603
Fax 302/633-2614
nwiddoes@state.de.us

DISTRICT OF COLUMBIA

Louis E. Woolard, Jr.

Director
Child & Youth Services Administration
Commission on Mental Health Services
4301 Connecticut Ave., NW, Suite 240
Washington, DC 20008
Ph. 202/282-0300
Fax 202/282-0343

FLORIDA

Sue Ross

Chief of Children's Mental Health
Division of Mental Health Services
Department of Children & Families
1317 Winewood Blvd., Bldg. 6, Rm. 290
Tallahassee, FL 32399-0700
Ph. 850/410-1177
Fax 850/413-6886
Sue_Ross@dcf.state.fl.us

GEORGIA

Dawne R. Morgan

Child & Adolescent MH Program Chief
Division of Mental Health, Mental Retardation and Substance Abuse
Department of Human Resources
2 Peachtree St., Rm. 23-403
Atlanta, GA 30309-3999
Ph. 404/657-2157
Fax 404/657-2160
dmorgan@dhr.state.ga.us

GUAM

Vacant

Child & Adolescent Services Division
Department of Mental Health
and Substance Abuse
790 Governor Carlos G. Camacho Rd.
Tamuning, Guam 96911
Ph. 671/647-5410
Fax 671/649-6948

HAWAII

Christina M. Donkervoet

Division Chief
Child & Adolescent Mental Health
Division
Department of Health
3627 Kilauea Ave., Room 101
Honolulu, HI 96816
Ph. 808/733-9339
Fax 808/733-9357
cmdonker@camhmis.health.state.hi.us

IDAHO

Ross Edmunds

Child Mental Health Program
Specialist
Division of Family and Community
Services
Bureau of Family & Children's
Services
Department of Health & Welfare
450 West State Street, Statehouse Mail
Boise, ID 83720
Ph. 208/334-5726
Fax 208/334-6664
edmundsr@idhw.id.us

ILLINOIS

Sharon Marie Quintenz

Director, Children's Mental Health
Office of Mental Health
Department of Human Services
160 N. LaSalle St., Suite 1000
Chicago, IL 60601
Ph. 312/814-5138
Fax 312/814-4832
DHSDDFK@dhs.state.il.us

INDIANA

Jim Phillips
Chief
Bureau of Children's Services
Division of Mental Health
Family & Social Services
Administration
402 West Washington St., W353
Indianapolis, IN 46204-2739
Ph. 317/232-7934
Fax 317/233-3472
jimphillips@fssa.state.in.us

IOWA

Denise Lange

Child & Adolescent MH Specialist
Division of Mental Health, Mental Retardation
& Developmental Disabilities
Department of Human Services
Hoover State Office Building
Des Moines, IA 50319-0114
Ph. 515/281-8222
Fax 515/281-8512
dlange@dhs.state.ia.us

KANSAS

Pam Alger

Team Leader for Children's Mental Health
Social & Rehabilitation Services
Division of Health Care Policy
Department of Mental Health, Substance Abuse Treatment & Recovery
Docking State Office Bldg., 5th Fl. North
915 S.W. Harrison
Topeka, KS 66612
Ph. 785/296-7272
Fax 785/296-6142
pra@srskansas.org

KENTUCKY

Randy Oliver

Manager
Children & Youth Services Branch
Division of Mental Health
Department for Mental Health and Mental Retardation Services
100 Fair Oaks 4 W-C
Frankfort, KY 40621-0001
Ph. 502/564-7610
Fax 502/564-9010
randy.oliver@mail.state.ky.us

LOUISIANA

Cheryll Bowers-Stephen, M.D., M.B.A.

Director of Child & Adolescent Services
Office of Mental Health
Department of Health & Hospitals
P.O. Box 4049, Bin #12
Baton Rouge, LA 70821-4049
Ph. 225/342-2540
Fax 225/342-5066
cstephen@dhh.state.la.us

MAINE

Joan Smyrski

Children's Systems Manager
Division of Children's Services
Department of Mental Health and Mental Retardation
#40 State House Station
Augusta, ME 04333
Ph. 207/287-4264
Fax 207/287-9915
joan.smyrski@state.me.us

MARYLAND

Albert A. Zachik, M.D.

Director
Office of Child and Adolescent Services
Mental Hygiene Administration
Department of Health & Mental Hygiene
201 W. Preston St.
Baltimore, MD 21201
Ph. 410/767-6649
Fax 410/333-5402
azachik@dhmh.state.md.us

MASSACHUSETTS

Joan Mikula

Assistant Commissioner for Child-Adolescent Services
Department of Mental Health
25 Staniford St., Central Office
Boston, MA 02114
Ph. 617/626-8086
Fax 617/626-8058
mailto:joan.mikula@state.ma.us joan.mikula@dmh.state.ma.us

MICHIGAN

Sherida Falvay

Director
Mental Health Services to Children and Families
Department of Community Health
3423 N. Martin Luther King, Jr. Blvd.
P.O. Box 30195
Lansing, MI 48909
Ph. 517/335-9261
Fax 517/335-9341
falvay@state.mi.us

MINNESOTA

Glenace Edwall, Ph.D., Psy.D.

Director
Children's Mental Health Division
Department of Human Services
444 Lafayette Rd.
St. Paul, MN 55155-3860
Ph. 651/215-1382
Fax 651/296-7731
glenace.edwall@state.mn.us

MISSISSIPPI

Brenda B. Scafidi, Ed.D.

Director
Division of Children & Youth Services
Department of Mental Health
1101 Robert E. Lee Bldg.
239 North Lamar St.
Jackson, MI 39201
Ph. 601/359-1288
Fax 601/359-6295

MISSOURI

Ed Morris, Ed.D.

Director of Children & Youth Services
Department of Mental Health
1706 East Elm Street
P.O. Box 687
Jefferson City, MO 65102
Ph. 573/751-8028
Fax 573/751-7815
mzmorre@dmh.mail.state.mo.us

MONTANA

Diane White, L.C.P.C.

Child & Adolescent Services Specialist
Mental Health Services Bureau
Addictive & Mental Disorders Division
Department of Public Health & Human Services
1400 Broadway Rm C118
P.O. Box 202951
Helena, MT 59620-2951
Ph. 406/444-7064
Fax 406/444-4435
dwhite@state.mt.us

NEBRASKA

Mark DeKraai, J.D., Ph.D.

Child & Adolescent Mental Health Administrator
Division of Mental Health, Alcohol, Drug Abuse and Addiction Services
Department of Health & Human Services
P.O. Box 94728
Lincoln, NE 68509-4728
Ph. 402/479-5512
Fax 402/479-5162
mark.dekraai@hhss.state.ne.us

NEVADA

Christa Peterson, Ph.D.

Deputy Administrator
Department of Human Resources
Division of Child & Family Services
6171 W. Charleston Blvd.
Las Vegas, NV 89158
Ph. 702/486-6190
Fax 702/486-7627
drcrp@aol.com

NEW HAMPSHIRE

Joe Perry

Administrator
Children's Mental Health Services
Division of Behavioral Health
Department of Health & Human Services
105 Pleasant St.
Concord, NH 03301
Ph. 603/271-5095
Fax 603/271-5040
joeperry@dhhs.state.nh.us

NEW JERSEY

Lucy C. Keating

Assistant Director
Division of Mental Health Services
Office of Children's Services
P.O. Box 727
Trenton, NJ 08625
Ph. 609/777-0740
Fax 609/777-0767
lkeating@dhs.state.nj.us

NEW MEXICO

Kenneth J. Martinez, Psy.D.

Deputy Director
Prevention & Intervention Division
Children, Youth and Families Dept.
P.O. Box 5160
Santa Fe, NM 87502-5160
Ph. 505/827-7659
Fax 505/827-9978
pera.kjmartinez@cyfd.state.nm.us

NEW YORK

Michael Zuber
Associate Commisioner
Bureau of Children and Families
Office of Mental Health
44 Holland Ave.
Albany, NY 12229
Ph. 518/473-6902
Fax 518/473-7926
cocompz@omh.state.ny.us

NORTH CAROLINA

Susan Robinson

Head of Program Policies and Services Branch
Division of Mental Health, Developmental Disabilities & Substance Abuse Services
Department of Health and Human Services
3015 Mail Service Center
Raliegh, NC 27699-3015
Ph. 919/571-4894
Fax 919/571-4878
susan.robinson@ncmail.net

NORTH DAKOTA

JoAnne Hoesel

Administrator, Children's Mental Health
Division of Mental Health and Substance Abuse Services
Department of Human Services
600 E. Boulevard, Rm. 302
Bismarck, ND 58505
Ph. 701/328-2335
Fax 701/328-3538
sohoej@state.nd.us

OHIO

Sharon Aungst

Assistant Deputy Director
Office of Children's Services
and Prevention
Department of Mental Health
30 East Broad St., 8th Floor
Columbus, OH 43215-3430
Ph. 614/466-1984
Fax 614/466-1571
aungst@mhmail.mh.state.oh.us

Kay Rietz

Assistant Deputy Director
Family and Children First
Office of Children's Services
and Prevention
Department of Mental Health
30 East Broad St., 8th Floor
Columbus, OH 43215-3430
Ph. 614/466-1984
Fax 614/466-1571
rietzk@mhmail.mh.state.oh.us

OKLAHOMA

Beverly Smallwood

Coordinator of Children's Services
Department of Mental Health
P.O. Box 53277, Capitol Station
Oklahoma City, OK 73152
Ph. 405/522-3908
Fax 405/522-3650
bsmallwood@odmhsas.org

OREGON

Diane E. Ponder

Child & Adolescent Services
Specialist
Mental Health & Developmental
Disability Services Division
Office of Mental Health Services
2575 Bittern St., NE, P.O. Box 14250
Salem, OR 97309-0740
Ph. 503/945-9739
Fax 503/947-1023
diane.e.ponder@state.or.us

PENNSYLVANIA

Terry Moloney

Special Assistant for Cross-System
Issues
Office of Mental Health and
Substance
Abuse Services
Pennsylvania Department of Public
Welfare
P.O. Box 2675
502 Health & Welfare Building
Harrisburg, PA 17105-2675
Ph. 717/787-6443
Fax 717/787-5394
tmolomey@state.pa.us

PUERTO RICO

***Carmen Capella, M.D.* ***

Clinical Director of Mental Health Services
Department of Mental Health and Anti-Addiction Services Administration
G.P.O. Box 21414
San Juan, Puerto Rico 00928-1414
Ph. 787/758-0241
Fax 787/765-7104

RHODE ISLAND

Janet Anderson, Ed.D.

Assistant Director
Children's Behavioral Health
Department of Children, Youth, and Families
101 Friendship Street
Providence, RI 02903
Ph. 401/528-3756
Fax 401/528-3760
andersj@dcyf.state.ri.us

SOUTH CAROLINA

Louise Johnson

Acting Director
Division of Children, Adolescents and Their Families
Department of Mental Health
2414 Bull St., P.O. Box 485
Columbia, SC 29202
Ph. 803/898-8346
Fax 803/898-8335
lkj40@co.dmh.state.sc.us

SOUTH DAKOTA

Amy Pollreisz

Child & Adolescent Program Specialist
Division of Mental Health
Dept. of Human Services
East Highway 34
c/o 500 E.Capitol
Pierre, SD 57501-5070
Ph. 605/773-5991
Fax 605/773-7076mailto:e:kent.huckins@state.sd.us.amy.pollreisz@state.sd.us

TENNESSEE

Larry Thompson, Ph.D.

Director
Office of Child & Youth Services
Department of Mental Health and Developmental Disabilities
Cordell Hull Building - 3rd Floor
425 Fifth Ave, North
Nashville, TN 37247
Ph. 615/532-6767
Fax 615/532-6719
lthompson@mail.state.tn.us

TEXAS

Deborah Berndt

Director of Children's Services
Division of Children's Services
Department of Mental Health
and Mental Retardation
P.O. Box 12668, Capitol Station
Austin, TX 78711
Ph. 512/206-4722
Fax 512/206-4775
debbie.berndt@mhmr.state.tx.us

UTAH

Stan Fillmore

Children's Program Coordinator
Division of Mental Health
Department of Social Services
120 North, 200 West, 4th Floor
Salt Lake City, UT 84103
Ph. 801/538-4270
Fax 801/538-9892
sfillmore@email.state.ut.us

VERMONT

Charles Biss

Director
Child, Adolescent & Family Unit
Division of Mental Health
Department of Developmental
and Mental Health Services
103 South Main St.
Waterbury, VT 05671-1601
Ph. 802/241-2650
Fax 802/241-3052
cbiss@ddmhs.state.vt.us

VIRGINIA

Pamela Fitzgerald Cooper

Director of Child & Adolescent
Services
Department of Mental Health,
Mental Retardation and Substance
Abuse Services
P.O. Box 1797
Richmond, VA 23214
Ph. 804/371-2183
Fax 804/786-0918
pcooper@dmhmrsas.state.va.us

VIRGIN ISLANDS

Jaslene Williams*

Assistant Director
Division of Mental Health,
Alcoholism
& Drug Dependency Services
Department of Health
3500 Richmond Christianstead
St. Croix, USVI 00820
Ph. 809/773-1311 x3011
Fax 809/773-7900

WASHINGTON

Mary Sarno

Administrator
Child & Adolescent Services
Mental Health Division
P.O. Box 45320
Olympia, WA 98504
Ph. 360/902-0796
Fax 360/902-7691

WEST VIRGINIA

Helen Snyder

Director
Division of Children's Mental Health Services
Office of Behavioral Health Services
Department of Health & Human Resources
1900 Kanawha Blvd., Bldg. 6, Room 7173
Charleston, WV 25305
Ph. 304/558-0627
Fax 304/558-1008
hsnyder@obhs.state.wv.us

WISCONSIN

Chris Hendrickson *

Director
Bureau of Community Mental Health
Department of Health & Family Services
P.O. Box 7851
Madison, WI 53707-7851
Ph. 608/266-6838
Fax 608/261-6748
hendrch@dhfs.state.wi.us

WYOMING

Lisa Brockman, R.N.

Child/Adolescent Liaison
Medicaid Program Consultant
Division of Mental Health
Department of Health
6101 Yellowstone Rd., Rm. 259 B
Cheyenne, WY 82002-0480
Ph. 307/777-7326
Fax 307/777-5580
lbrock@state.wy.us

*State Mental Health Agency Director