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Pioneering Transition Programs; The Establishment of Programs that Span the Ages Served by Child and Adult Mental Health

Maryann Davis
University of Massachusetts Medical School

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Report Prepared by;
Maryann Davis, Ph.D.
Center for Mental Health Services Research
Department of Psychiatry
University of Massachusetts Medical School

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EXECUTIVE SUMMARY

There has been an increasing emphasis on improving supports to help vulnerable youth transition successfully from adolescence to adulthood. One of the major barriers to providing service continuity during this stage of life is the general practice of dividing mental health services into child/adolescent and adult service systems. This division is typically accompanied by age-defined eligibility or target population definitions, funding of programs that are age-defined, and service approaches that are tailored to the age group served. Those age-defined limits typically occur between ages18 and 21. While having age-tailored services for children, adolescents, and adults should improve the quality of care for those age groups, it often results in the unavailability of appropriate services for the "between" age of transition. In particular, these age-dichotomized practices force a disruption of service because as a result of a change in age, a youth who is receiving services through the child mental health system must leave that system and seek an appropriate one in the adult system. This shift from the child mental health system to the adult system is disruptive to existing therapeutic relationships. This can be very stressful and can ultimately result in a loss of service as a result of eligibility-related issues, covered services, and other factors.

The purpose of this project was to provide insight regarding the establishment of pioneering transition programs and to identify processes that others might use to establish pioneering programs in their locales. In this report, *pioneering transition programs* refers to programs that serve youth continuously across the transition age, without disruption due to age changes. Operationally, this means that all of the pioneering programs described in this report, continuously serve a population from an age that *only* child/adolescent systems serve to an age that *only* adult systems serve. All of these programs are at least in part, funded by public mental health budgets. These programs were selected on this basis alone, the quality of the programs was not examined.

For this project, pioneering programs were identified by a review of state-level child and adult mental health system administrator interviews conducted in 2001 and 2003 in which administrators were asked to describe all transition support services in their state. Although by the time this project was conducted in 2005 and 2006, several of these programs had ended, however, some newer ones were identified. In total, seven pioneering programs were identified. In addition, one state pioneering grant program and one federal pioneering grant program were identified and are included in this report.

To perform this effort, program staff and other stakeholders involved in the establishment of the programs were interviewed. Each was asked a standard set of questions aimed at describing the process by which the program became a pioneering transition program.

The following general guidelines regarding the development of pioneering transition programs emerged through the interview process:

1. Recognize the problem and take action.

In all pioneering transition programs, the initial step was recognizing the need to change the service system for the transitioning population. Sometimes the initial problem was recognized

primarily within a program, at other times it occurred primarily among public mental health administrators, and at other times it came about through interagency committees.

2. Become a leader.

In most instances, one or two individuals took it upon themselves to seek a solution and pursued options until a satisfactory situation was achieved.

3. Involve other stakeholders.

Involving multiple stakeholders facilitated the development process, including the identification of funding sources.

4. Capitalize on local expertise and experience in designing the program.

Programs were designed and implemented based on existing local clinical experience and trial and error. Programs were generally not based on evidence-based treatments that were modified for this age group. It appears that current resources to help guide transition programs were unavailable to "older programs" and that "newer programs" were not fully aware of their existence.

5. Seek funding through trusting relationships.

Longstanding and trusting relationships between key players (providers, mental health administrators, public agencies, interagency groups, and others) facilitated the identification and allocation of funds for transition program development.

6. Start small and build funding over time.

Most programs started with a relatively small amount of funding from a variety of sources. In fact, funding did not always originate from mental health agencies or organizations. Program staff indicated that the small amount of their initial funding request facilitated the development process because it was relatively easy to identify and allocate the funds. Then, the programs demonstrated their value and used their success to obtain additional funding.

7. It is easier to obtain funding when local decision makers have autonomy.

The majority of programs were funded through mechanisms that permitted a fair amount of local autonomy in decision making. Statewide funding initiatives that allow for the extension of programs across the transition age appear to be uncommon.

8. Program development is more rapid with state or federal sponsorship.

Maryland's grant program and the Federal Partnerships for Youth Transition grant program demonstrate that decisions to fund pioneering programs at higher levels of government lead to more rapid development of such programs.

9. Seek mental health funding primarily from either the child or the adult system, but not both.

Most of the programs had mixed sources of funding that included: billable Medicaid hours, state or local mental health funds, private foundation grants, funds from other systems, and the like. In examining the funding from public mental health agencies, this source of funding was

dichotomized to child or adult funding in most of these settings, with the program obtaining funding from either, but not both systems.

Conclusions

It is clear from the interviews, that establishing programs that can serve youth continuously across the transition stage is possible. What appears to be unique in the efforts of these pioneering programs as compared with innovative approaches in other age groups, was the lack of an established category of services with an associated funding stream making it challenging to develop, and perhaps to maintain, transition programs. Furthermore, if programs need to request special funding, there is evidence from these programs' experiences to suggest that special funding will be quite limited, and that funders can only support small programs unless they want to change policy. Therefore, funding approaches had to be creative. These forces may contribute to the small number of pioneering programs that were identified. It also appears that many of the mechanisms that support program innovation in general, also support the establishment of pioneering transition programs such as leadership, multiple stakeholder buy-in, and good relationships. It may also be that local autonomy in funding decisions facilitates the development of innovative programs, one at a time. However, it is clear that when the need for age continuity is recognized at the state or federal level, that there is rapid development of pioneering programs.

INTRODUCTION

Service Discontinuity During the Transition to Adulthood

Recently, there has been an increasing emphasis on improving supports to help vulnerable youth transition successfully from adolescence to adulthood. For youth with serious mental health conditions involved with state mental health agencies, one of the challenges they face is loss of service continuity during the vulnerable point at which child services end and adult services begin (typically ages 18-21). There are many forms of discontinuity. For some youth, their condition does not qualify them for access to adult mental health services (Davis & Koroloff, 2006) resulting in loss of services. For others, continuing on in adult services means a change of case manager (child to adult case manager), a change of therapist (their therapist is at a child community mental health center, not at the adult community mental health center), a change of residence (from an adolescent residential setting to an adult group home), a change of treatment culture (from more family and child-focused to more independent adult-focused), a change of daily contact with peers (from "hanging out" with other adolescents in a day treatment program to being surrounded primarily by 35-50 year olds in an employment program), and other types of changes. These types of discontinuities interrupt service and program content, social environments, and attachments. It is likely that this kind of discontinuity leads eligible youth to reject services, or to struggle to adjust to them. This discontinuity is caused in part by the separations between adult and child mental health systems. In most states each system is at least somewhat independent of the other; for example, setting their own eligibility or target population definitions, and having their own policies, administrations, contracting, and funding streams. Child and adult mental health (MH) are typically overseen by the same administrative head (commissioner or director), but in some states, child MH is in a separate administrative arm that is a consolidated child agency.

Reducing Service Discontinuity

Reducing the service discontinuity during the transition years would likely facilitate youth engagement in services, and allow for less impeded therapeutic and rehabilitation progress. One innovative solution to this kind of discontinuity comes in the form of transition programs that can serve youth continuously across the adult age threshold, beginning at a point significantly before "aging out" and continuing into young adulthood. These types of programs are relatively rare. When child and adult MH administrators were queried about the transition support programs in their states, approximately 10 programs were identified in the country that were funded by the state MH authority or child MH that could serve youth continuously prior to aging out until an age that only adult MH served (Davis, 2001; Davis & Hunt, 2005). Researchers from the University of Massachusetts Medical School and Portland State University conducted a detailed study of all the organizations in one county that offered services that an individual with serious mental health conditions might access sometime between the ages of 16 and 25 (including the entire array of human services, public safety, health, and education services). Of the 103 organizations surveyed, only 31 percent could serve both adolescents and adults, and only 22 percent could serve a youth continuously from adolescence to adulthood. Some of these organizations had multiple services within them. Analysis of the proportion of services that allowed for continuity into adult ages revealed that only 13 percent of the services fell into this

category. These findings suggest that it is unusual for programs to serve youth continuously across the transition age.

Pioneering Transition Programs

We refer to programs that serve youth continuously across the transition age as Pioneering Transition Programs in this report. Specifically, each program described in this project is a transition program that serves an age group that spans the child and adult MH system. Transition programs are those that are focused on assisting young people complete the tasks of adolescence and take on the mantle of adulthood. Typical transition services support youths' and young adults' efforts to complete their schooling, obtain rewarding work, contribute to a household, and participate socially in the community. These programs were not selected based on the quality of the program but solely on being programs that spanned child and adult ages and offering transition supports.

Why Examine Pioneering Transition Programs?

The 'age-spanning' approach is an innovative solution to the problem of service discontinuity. Leaving a given adolescent program because a youth has "aged out", and entering a similar adult program can mark a "graduation" that may be a positive event for the youth. However, having to leave an adolescent program only because a new birthday has been reached, when a young person has worked very hard to build trusting relationships with individuals in the program, and there is no clinical value in disrupting those relationships (and potential harm), is not a positive event for a youth. Having to exit multiple programs simultaneously is certainly a challenge. Thus, having programs that allow youth to remain across this vulnerable period of transition, and exit when their needs have been met, rather than upon a particular birthday, is an important dimension for a transition system.

The major puzzle that these programs have solved is how to achieve age flexibility. They have found a way to serve an age group that their funder typically does not support, or they have found a way to combine funding to allow for age spanning. In this way, they have developed specific knowledge that could potentially help other agencies and broader systems think about how they might achieve greater age flexibility. They have also developed more general knowledge about how to successfully introduce innovation into systems.

The pioneering programs in the country that have successfully negotiated the system to achieve this status have much to teach those trying to develop better transition support systems. In particular, the history of how the program was established, what it takes to maintain the program, the challenges the programs have faced in providing transition supports and their solutions to these problems can help others, and prevent needless duplication of trial and error. This project provides guidance for those attempting to bridge this important service gap through describing shared and unique approaches to establishing and maintaining pioneering transition programs, and the challenges that they face in providing services to this grossly underserved population.

METHODS

Participating Programs

Twelve programs were identified during surveys of child and adult state-level MH administrators in 2001 and 2003 (respectively). Each program was funded at least in part by the public MH system and was described as serving an age group younger than age 18 up to an age that only adult MH could address. By the time that this effort was conducted in 2005 and 2006, five of the previously identified programs either no longer existed (and former program staff could not be located) or could not be identified by current administrators from the limited information provided in the 2001/03 survey. The remaining seven programs were successfully contacted and participated in the project. These will be referred to as local programs, or simply programs. In addition, one state and one federally-funded MH program were included in the study. In all, the following nine programs were studied:

1. Community Connections, Canton, OH
2. Community Outreach through Resources and Education (CORE), Westmoreland County, PA
3. Jump on Board for Success (JOBS), Barre, VT
4. Program in Assertive Community Treatment (PACT), Madison, WI
5. Successful Employment Program, Quincy, MA
6. Transition Community Treatment Team, Columbus, OH
7. Westchester Youth Forum, Westchester, NY
8. Transition Age Youth Initiative, Maryland Mental Hygiene Administration (state grant program)
9. Partnerships for Youth Transition grant program, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services (Federal program)

Procedures

Information about the programs was collected through a one-hour telephone interview with either the current program director (if they were knowledgeable about the program's development history) or their designee. Interviews were conducted in the fall of 2005 and the spring of 2006. Interviewees were contacted by letter or e-mail to explain the purpose of the study and to elicit their participation. Copies of the interview questions were sent to the interviewees in advance of the scheduled interview. Participants' responses were recorded by two individuals and paraphrased. Notes from both recorders were combined and the answers to each question were then e-mailed to the participant and then coded following interviewee approval. Any stakeholders identified during the initial interview were subsequently contacted for an interview. For most programs, the secondary interview was conducted with a representative of the funding organization. A complete list of the participating programs and interviewees is found in Appendix A.

Coding

Emerging themes were coded by two researchers, using a modified grounded theory approach. In this approach, the first interview was coded simultaneously by the researchers who then

developed a basic list of thematic categories from that interview. Each subsequent interview was coded separately by each researcher, using the existing categories, and then when an existing category did not seem applicable, a new one was described. After independent coding, the two researchers compared coding and came to consensus on each category (new or old). After the final interview was coded, the complete list of thematic categories was used to re-code each previous interview. In this way, each interview was coded by consensus using the themes that emerged from the combined interviews.

Interview Instrument

The interview was semi-structured (see Appendix B: Interview Instrument). The first section requested a basic description of the program, the date the program opened its doors, and the sequence of events that lead to securing MH funding that allowed for continuous service delivery to the age span described. The second section contained specific questions about the basic chronology of program development, including:

1. Any necessary policy changes
2. All funding sources
3. How staff learned to work with transition age youth
4. Role of family or consumer advocacy in establishing the program
5. Role of leadership in establishing the program
6. Barriers encountered during the establishment process
7. Facilitating factors encountered during the establishment process

The third section focused on efforts that were needed to maintain the program once it was established.

Pioneering Programs

In all, seven local programs and two federal programs were studied. Programs had been established for 3-17 years at the time of the interview (See Table 1: Description of Programs Studied). Most of the programs focused on vocational supports, and were located in sites where county or local MH administrators had the authority to make local funding decisions (as compared to state-level authority).

Table 1. Description of Programs Studied

Name	Year Established	Ages Served	Type of Service	Authority Level
Community Connections	2001	12-25	Vocational Plus	Local
CORE	2002	16-24	Vocational Plus	Local
JOBS	1992	16-22	Vocational Plus	State
PACT-Adolescent	1998	15-21	MH Plus	Local
Successful Employment Program	1988	16-22	Vocational Plus	State
Transition Community Treatment Team	1990	16-22	MH plus	Local
Westchester Youth Forum	1993	16-23	Broad Peer-Lead Supports	Local

PIONEERING PROGRAM STORIES

Community Connections
Canton, Ohio

Interviewees: Patrice Fetzer, Program Director
Daniel Fuline, CEO, **Community Services of Stark County, Inc.**

Basic Description: Community Connections of Stark County Community Services is an interdisciplinary community support program and case management team with vocational supports for individuals aged 12-25 in Canton, OH. Public child MH services end and adult services begin at age 18.

ESTABLISHMENT PROCESS

A Good Program is Restricted

Community Connections largely resulted from a grassroots provider movement. The current director of the Community Connections program was previously employed by a transition team funded by a SAMHSA grant. By the end of the grant cycle, the transition program, in its innovative form, had not achieved sustainability and therefore, the Child and Adolescent Service Center discontinued their SAMHSA-funded transition program and resumed their role as a provider of Medicaid-billable services only (as they had done prior to receiving the SAMHSA grant). The county MH board (which oversaw all child and adult MH services) provided Medicaid match funding and oversight of the state match for the SAMHSA-funded transition program. However, the primary focus of the Board when the grant ended was on individuals with chronic serious persistent mental illness and early intervention, and not on transition. Upon completion of the grant, the Board would no longer provide payment for several of the services that the innovative transition program offered The Child and Adolescent Service Center did not want to include the innovative transition program following the grant cycle. Rather, the SAMHSA-funded transition program was being reduced and shifted to a managed care model. For example, the SAMHSA-funded transition program had a dedicated phone line and its own building and under the managed care model, cutbacks were envisioned, and intake procedures and other operations were going to become centralized functions. Providers in the county were aware of the cutbacks and schools expressed concern about the teen dropout rate and the absence of vocational supports as a result of the system changes. Furthermore, there was concern that the reduced managed care model would not appeal to teens. The Family Council (an interagency family advocacy group for children, adolescents, and their families), youth, and young adults all

wrote letters to the Child and Adolescent Service Center seeking action. When it became clear that no changes were going to occur, opportunities to replicate the original transition program were sought by the two program directors.

Advocacy, Leadership and Creativity Produce Funding

The innovative transition program directors described their program vision to the chief executive officer (CEO) of Community Services of Stark County (CCSC), a provider agency. These individuals had worked with the CEO on a variety of advisory groups and the CEO served on the board of a local charity. The CEO helped them prepare a grant application for the local charity's foundation and set up a meeting with the foundation's chair who was also familiar with the previous program. The CEO also encouraged the two directors to apply for a grant from the state's Minority Health Commission. Both grants were for a program that would connect 15-25 year olds with MH conditions to transition services. The grants were to support "connectors" who are quasi-case managers, who build relationships with young adults, identify needs, and connect the young adult to resources to achieve goals. Connectors are not considered to be official case managers, as they do not perform billable mental health services. Connectors work with each young person briefly to connect them with resources and identify gaps. CSSC received both grants and the CEO offered to house the program at CSSC.

While the Community Connections program was being implemented, the two program directors helped CSSC establish formal mental health case management services (which had not been offered previously) and extend their adult psychiatric services for this age group. In addition, because CSSC employed counselors for children, adolescents, and adults, they were available to serve transition-age individuals as well. When grant funds were exhausted, Community Connections was then able to provide their services (which were all Medicaid reimbursable) through CSSC, including case management, counseling, psychiatric and employment support, housing services, among others. Thus, Community Connections services became intertwined with CSSC services. From the outset, if a youth required a particular service, the agency paid for the service, regardless if they could identify a source of funding. This enabled the program to provide continuous and appropriate services.

SPECIFIC DIMENSIONS OF ESTABLISHMENT AND MAINTENANCE

Funding Process

Initial funding was provided by grants from a private foundation and the Minority Health Commission. Subsequently, program funding was obtained primarily from the MH board through the delivery of billable services. The program directors have also pieced together other funding sources to enable them to provide a broader array of services. For example, CSSC has a contract with local schools to provide supports for individual students; United Way funding supports those without Medicaid; and additional funding is provided by the MH board to serve low income, non-Medicaid eligible youth.

Policy Changes

No policy changes were necessary. Overall, the team worked creatively within existing policies.

Leadership and Advocacy

The program directors worked tirelessly with great passion to get the transition program funded. They spoke about it at every possible forum (including many advisory groups and with

providers), and solicited support from many agencies who recognized the need to continue the initial program. The CEO of CSSC recognized the need for the program, the leadership ability and experience of the program directors, and provided valuable resources such as space, grant writing assistance, and facilitating contact with the foundation chair. In addition, recognition of the critical role of the full transition support model by other systems, providers, young adults, and the family advocacy organization contributed to successful grant funding.

Learning to Work with this Population

Because the program directors had previous program supervisory experience, they provided the training and supervision for the current program. They also looked for training from others within CCSC, such as in employment supports, which could be translated into appropriate supports for this age group.

Barriers Encountered

There was a lack of recognition within the county MH board, that the transition population needed services, and other issues had a higher priority at the time. The transition program was viewed as a specialty service and the limited dollars available for all services contributed to the absence of funding to establish the program. Once billable services were established, funding became less of an issue.

No other barriers were encountered, other than the constant struggle to fund services that youth need regardless of eligibility. Three years following transition program development, one of the program directors established the Stark County Interagency Transition Team to address the low priority associated with youth in transition. This interagency group, including providers for all child systems, secondary schools, courts, housing, substance abuse services, and family and youth advocacy, made recommendations to the local child welfare system, and is trying to advocate for changes for this population.

Facilitating Factors

Facilitating factors included support from CCSC, local providers, family and youth advocates, and the “interim” funding provided by the private foundation, and the minority health grant.

Maintenance

Maintenance has consisted of a constant search for funding. The greatest challenge is identifying funding for those who do not qualify for Medicaid, or for those who do not meet adult MH service eligibility criteria. It is also difficult to identify funding for services that are needed but do not qualify for Medicaid reimbursement. The interagency transition team has been helpful in providing direction, support, and advocacy. One of its subcommittees formed the Stark County Mentoring Network, which is housed, staffed, and supervised by Community Connections, which has recently received grant funding.

Community Outreach through Resources and Education (CORE) Westmoreland County, PA

Interviewee: Shannon Fagan, Westmoreland County CASSP Coordinator

Basic Description: The CORE program serves youth in transition, ages 16-24. The program utilizes Person–Centered Planning (PCP). The CORE program provides vocational services including support, counseling, and preparation. It is governed by a multidisciplinary task force representing traditional service providers as well as community groups, and youth, who are committed to supporting this population to ensure that they reach their potential and have access to the services they need. In Westmoreland County, child mental health services end and adult services begin at age 18.

ESTABLISHMENT PROCESS

Task Force Poised to Jump on New Opportunity

The state's MH planning council (an interdisciplinary council mandated to plan for use of federal block grant funds) focused on the transition age population in 1999. Two years later, the county MH system convened an interagency task force to discuss the needs of the transition population. Members included the local Mental Health Association (advocacy organization for children and adults), juvenile probation, child welfare, a provider of child and family services, the local offices of vocational rehabilitation (VR), mental retardation, public welfare, drug and alcohol services, regular and special secondary education, the child and adult county MH board, and the doorway agency for public MH.

The task force had been convening regularly when a request for proposals (RFP) to provide transition age services was released by the State Office of Mental Health and Substance Abuse Services. The RFP served as a catalyst for more focused discussion and fact gathering related to youth in transition. For example, they identified the target population (number of youth needing transition services that would be aging out at age 18) and expressed concern about those who would not qualify for adult MH services, and those who would quality but for whom adult services were not age-appropriate. The task force then developed a recommended service array for this age group; sought fairly open eligibility and continuity of care; and identified the following additional needs: transportation, VR funding and services; working with the education system; and linking youth with appropriate services. Central to their proposal, was a Person-Centered Planning (PCP) approach, using a transition facilitator and peer support.

Task Force Shaped the Program

Upon grant award, the task force proceeded to launch the effort by identifying an area in the county which is geographically large, that had high need, low income, and a vocational technical school. Family Services of Westmoreland County was selected as the provider based upon their experience, size of the program, and their active involvement in writing the grant. Additionally, Family Services of Westmoreland County had many connections in the area. They served both children and adults and had vocational and intensive case management programs. The task force

established guidelines for admission, named the program (CORE), and assisted in selecting program staff.

SPECIFIC DIMENSIONS OF ESTABLISHMENT AND MAINTENANCE

Funding Process
The primary source of funding for the CORE program is provided through a grant from the state Office of Mental Health and Substance Abuse Services.

Policy Changes
There were no policy changes needed to enact the program.

Leadership and Advocacy
The county mental health board provided the impetus for program development by convening the task force to examine transition related issues. The county had a well-established interagency group that embraced family member involvement in its Child and Adolescent Service System Program (CASSP), which provided a strong foundation for addressing transition issues and bringing on relevant adult system partners. The leaders within each of the public systems embraced the issue, came willingly to the table, and sent appropriate representatives to the task force. The Mental Health Association (citizen's advocacy group for children and adults) also played an important role. It had a strong voice in raising the issue of transition at the meeting of the State Mental Health Board in 1999, and had an active advocate on the task force.

Learning to Work with This Population
Formal PCP training was available through local expertise and was provided to the task force members and program staff. The Office of Vocational Rehabilitation provided training on their services, systems, and approach. A great deal of learning also occurred as a result of trial and error. This was particularly true in learning how to engage the population. In addition, the program director and the transition specialist brought their own expertise in working with youth and families and working in different fields.

Facilitating Factors
The previous needs assessment performed by the Mental Health Planning Council helped to set the stage to address transition issues at the local level. In addition, the fact that youth transition related issues had been raised repeatedly across various public agencies helped to engage agency leadership in the formal process of addressing the issues. Having the child and adolescent service system in place (as defined by the CASSP principles; Stroul and Friedman, 1985) provided ready-made system-wide contact and communication within the child system. There was also a strong relationship between the CASSP coordinator and the county adult mental health system. Adult MH also observed a lack of success in the transition age group and felt ineffective in helping this age group.

Barriers to Establishment
There were no major barriers to establishing the program. There was pre-existing recognition of a need and motivation to address it concretely with the issuance of the RFP. There were good

pre-existing relationships among public agencies and advocacy organizations which lead to the development of the proposal.

Maintenance

There has been no difficulty maintaining conceptual support for the program. The task force continued its involvement in the program by meeting every other week to confidentially review cases, solve problems, and provide guidance. However, the main challenge to maintenance was the four-year grant period limitation. While there was a sustainability plan built into the proposal, the funding of the grant was substantially and unexpectedly cut in the third fiscal year as a result of cuts to the federal mental health block grant. At the time of the interview, the county was examining how to support a larger portion of the program budget than anticipated and maintain the unique qualities of the program over time.

Jump on Board for Success (JOBS)
Burlington, VT

Interviewees: Phil Wells, JOBS Program Co-Coordinator
Michael Curtis, Director of Children, Youth, and Family Services, Washington County Mental Health Services
Paul Miller, Co-Coordinator-JOBS
Charles Biss, Director of the Child, Adolescent and Family Unit, Vermont Division of Mental Health

Basic Description; The Jump on Board for Success (JOBS) program in Vermont provides supported employment for youth, ages 16-22, with serious emotional difficulties. Service coordination for this program also focuses on providing educational, mental health, substance abuse, and medical health supports for this population. Youth involved in the JOBS program are eligible to receive these supports and services if they have previously met State of Vermont criteria for serious emotional disturbance (SED) by the age of 18 (public child mental health services end and adult services begin at age 18). JOBS service recipients must be former clients of child MH, special education, child welfare, and/or juvenile justice, or adult corrections. They must also qualify for Vermont vocational rehabilitation services to be eligible for this program.

ESTABLISHMENT PROCESS

Growing Awareness of Dearth of Appropriate Services

In the late winter/early spring of 1992, the first cohort of youth receiving wraparound services from the Washington County Mental Health Agency (WCMH) were approaching age 18 and were poised to enter the adult MH system. These youth previously received services out-of-state and were "brought home" by the State of Vermont to continue their care. The lack of appropriate young adult related services became readily apparent to WCMH. One of the local service providers, Green Mountain Work Force (GMWF), an established employment program for adults with serious mental illness, shared WCMH's concerns about the lack of adult support services for transition age youth. The GMWF program coordinator expressed interest in working with WCMH and other local providers to develop an employment program for transition age youth.

Service Providers Design Program and Seek Funding

The current JOBS program co-coordinator and the Director of Children, Youth, and Family Services, who had been deeply involved in wraparound services, collaborated with the GMWF program coordinator to develop a concept for merging the wraparound approach with the supported employment approach used by GMWF. These individuals approached the state VR office in an effort to seek funding for employment services for transition age youth. They had obtained letters of support from various agencies in this effort, including, in particular, support from the local Division of Child Welfare which strongly advocated the need to provide transition supports and services. Meetings were held with the state's two top VR staff who were already aware of GMWF's excellent work with adults with mental illness as a result of prior meetings.

At this time, the lack of services and supports for the transition age population was also emerging as a major concern for VR.

Convergence of Fortuitous Factors
The timing was additionally fortuitous because the meeting between the interested parties occurred at a time during the fiscal year when VR still had federal funds ($33,000) available. Locally, VR, child welfare, MH, and special education, were aware that some of the wraparound youth would not be receiving Medicaid after age18. They believed that the services that adult MH could offer were inappropriate for this age group and many youth would not qualify for these services.

VR saw this as an opportunity to provide the transition age population with employment support services that they would not be able to receive otherwise. VR provided WCMH with grant funding for one year to initiate the JOBS program which officially opened its doors in the fall of 1992.

Later in the fiscal year, the Director, Children, Youth, and Family Services wrote a letter to the Director of the Child, Adolescent, and Family Unit of the Vermont Division of Mental Health describing the excitement at VR about the program, their success in program initiation, and some initial outcomes. In the letter, he requested program funding in light of the state's official emphasis on developing collaborative agreements. Subsequently, the Vermont Division of Mental Health provided a small amount of funding and allowed WCMH to redirect existing funding to older youth (over age 18).

SPECIFIC DIMENSIONS OF ESTABLISHMENT AND MAINTENANCE

Funding Process
As described above, funding was established through meeting with the top two staff at the state-level VR agency. The concept was proposed at a time when they were aware of the difficulties in serving this population and the need for these types of services during young adult years. In addition, the proposal originated from a program recognized as very successful in serving older individuals with serious mental health conditions. This experience coupled with the knowledge about how to provide wraparound services to adolescents provided an excellent foundation to serve this age group. The proposal also came at a time when the state VR agency still had federal funds available. As a result, the state VR agency provided a one-year grant that has been renewed each year. Funding was requested in writing to state child MH services and subsequently received by obtaining permission to divert existing WCMH funds to older youth (over age 18).

Policy Changes
Policy changes were not necessary to serve youth over age 18 with child MH funding or to obtain Medicaid reimbursement. Although child MH provides services up to age 18, there were no specific stipulations regarding the age groups eligible for services. A Medicaid waiver (which applied to most of those with serious emotional disturbance (SED) until their 22nd birthday) permitted fee-for-service billing for JOBS services. In addition, WCMH (the mother agency)

provided services for all age groups, therefore, JOBS services could be billed as an adult or child client, depending upon their age.

Leadership and Advocacy

Critical to the success of this initiative was the ability of program leaders to envision a goal and achieve it. WCMH was willing to take risks and creative collaboration between individuals from different WCMH programs was central to the success of JOBS. Although there was no direct consumer advocacy involved in establishing the program, wraparound principles were embedded in the JOBS approach, which reflects extensive youth input.

Learning to Work with This Population

One new JOBS staff member had experience providing employment supports to the adult developmental disabilities population, and the other was an energetic young person. Both had a willingness and ability to be creative and establish relationships with employers and clients. They learned through clinical supervision provided by an individual with experience in wraparound approaches and another individual who is knowledgeable about employment approaches. Staff expertise was developed by applying knowledge from these two fields, using a positive mindset about problem solving and creativity, and then learning through trial and error.

Facilitating Factors

At least one facilitating factor occurred by chance—the availability of unspent federal VR funds. In addition, there was a convergence of awareness across a variety of programs and agencies (i.e. local special education and child welfare, state child MH, and VR at every level) around the need to provide appropriate services to the transition age population particularly for youth, ages 18-21; the absence of appropriate programs for them; and the difficulty accessing adult services due to eligibility criteria. The commitment of state child MH at the time, to working collaboratively with other agencies to address the needs of children facilitated their added support of the program. In addition, the adult MH system originally provided the staff expertise for the vocational component for JOBS and enough flexibility to allow this experiment to take place.

Barriers to Program Establishment

There were no barriers to establishing the program (i.e. obtaining funding and opening the doors). However, there were barriers to overcome program operation. Within WCMH and state adult MH, there was concern that the co-coordinator (who was also the program coordinator for GMWF) was not able to devote adequate time to both positions. By showing that GMWF's good outcomes were maintained and JOBS' outcomes were positive, these concerns were diminished. It quickly became apparent that the employment work they were doing at JOBS was hindered by a lack of support in other transition related areas of need. JOBS was the *only* support these youth received, and more time was needed to address corollary needs (such as MH treatment, housing, recreation/socialization activities, non-job skill development etc). To address this, WCMH sought state child MH funding for a transition specialist who could provide that support. They proposed that child MH stop providing the $15,000 in state child mental health funds, and instead, provide $50,000 in Medicaid funding (controlled by child MH). With this funding, they provided a transition specialist to help address corollary needs for Medicaid eligible JOBS clients (the majority).

Maintenance

The JOBS program uses data to show how service utilization drops precipitously at age 18, rising slowly until age 26, and their own positive employment related data to help maintain their funding.

For the past nine years, the major challenge to program maintenance has been trying to provide the same service capacity while receiving level funding. Ironically, the reason for level funding in part, stems from the success of JOBS. VR priority at the state level, has been to expand JOBS across the state, therefore, funding has been applied to establishing new sites rather than increasing JOBS funding to keep pace with inflation. Also, their pioneering status may actually hinder their opportunities with VR. According to the interviewees, there appears to be some conflict at the state level regarding the "ownership" of JOBS. Although the state perceives that VR now "owns" the program, in reality, the concept was developed at WCMH which is where the original program currently resides. New JOBS sites may be unaware of this. There are concerns that this issue may interfere with efforts within VR to increase program funding. In addition, the program is currently funded by a capitation of $1,500 per youth/per year, which is insufficient.

JOBS has addressed these maintenance barriers by seeking additional sources of revenue. They are starting to raise awareness about the program by participating in local conversations and partnerships around transition supports and services which hopefully, will result in additional funding. For example, JOBS can provide transition training, a billable service. They are also trying to refocus the original purpose of JOBS, which was to divert youth from needing services from the adult MH system. JOBS currently serves youth at the very high end of need, who were exiting the child welfare and MH system, and helps them achieve stability through JOBS and a transition specialist.

Program in Assertive Community Treatment (PACT)-Adolescent Madison, WI

Interviewees: Suzanne Senn Burke, Community Treatment Specialist, PACT
David LeCount, former County Director of Adult Mental Health

Basic Description: The Program in Assertive Community Treatment (PACT) adolescent program is part of the original PACT model that was first researched (for 18-35 year olds). The PACT adolescent program provides similar services for 15-21 year olds. The program shares the same staff and location as the program that serves individuals up to age 70. Individuals have either schizophrenia or a major mood disorder, and qualify for Community Support Program (CSP) MH services. Public child MH services end and adult services begin at age 18.

ESTABLISHMENT PROCESS

Multiple Stakeholders Recognize a Problem.
The Adolescent PACT program grew out of several factors in 1996. PACT, which served 21-70 year olds, had a contract with the county (in WI, the county is responsible for all MH services) and a long and trusting relationship with the county adult MH system. When a referral was made for PACT, case reviews were performed jointly by staff from PACT, the referral source, and the county director of adult MH services. They recognized that many 21-30 year old new referrals to PACT had well-established patterns of MH problems and functional deficits. Youth were falling through the system cracks as they reached age 18 and not receiving needed services. Many had already received costly services in the child system and would likely continue to need similar services in the adult system. The PACT program had already helped reduce costs of expensive mental health treatments in adults over age 18, and these stakeholders felt it could be used as a model for transition age youth. Primarily as a result of the case review process, those involved concluded that PACT was needed at a younger age.

The Program Drew on Existing, Trusting Relationships
With support from adult county MH and child/adolescent MH, the PACT program embarked upon an expansion to serve 15-18 year olds. PACT staff began to meet with youth crisis services and established screening procedures to identify PACT appropriate clients. In 1998, they began to admit 15-18 year olds to the program and obtained limited additional funding from the county.

Stretching Funds through Creativity
Due to the limited amount of funding provided by the county, the PACT program had to rely on attrition in the older client program to provide opportunities for existing staff to serve the younger population. In addition, PACT's parent agency, the state psychiatric hospital, provided funding to support a staff increase of two members—one immediately, and another, 2-3 years later. Two factors were critical in PACT program expansion. First, the state psychiatric hospital is a state institution, and PACT is part of the state hospital. The hospital has been supportive of PACT programming and has provided financial support as well. The other factor was the philosophy that PACT needed to provide long-term treatment, resulting in infrequent discharges.

Infrequent discharges restricted the number of new openings. Openings came from infrequent attrition and addition of staff. The approach to add an adolescent component was to restrict all new admissions to the PACT program to adolescents (an average of six adolescent admissions per year). No new adult admissions were accepted, but previously discharged PACT clients could be readmitted.

SPECIFIC DIMENSIONS OF ESTABLISHMENT AND MAINTENANCE

Funding Process

The funding stream did not change substantially to establish the program. The change was accomplished with a minor amount of additional funding from county adult MH and later from the county child/adolescent program. Both new staff positions were supported through hospital funding. The biggest issue was maximizing existing sources of revenue (insurance reimbursement and Medicaid). The state Medicaid program set the stage for adult and child services to be reimbursed, and state insurance law supported private insurance payment for "transitional" mental health services (intensive community-based services such as Community Support Program services). These features allowed programs like PACT to seek reimbursement for their services.

Policy Changes

The PACT contract with adult county MH was amended to allow them to serve the first cohort of adolescents. Within 2-3 years, county MH started to contribute funding under a new contract.

Leadership and Advocacy

Leadership was provided by existing program staff. The PACT director and psychiatrist were instrumental in identifying the need to provide PACT at an earlier age and pursuing what was needed to make it happen. Senior leadership of child and adult MH in the county supported the program. Leadership within the state hospital was critical, since they recognized the value of community support programs and specifically, PACT.

Learning to Work with This Population

Since PACT served 18-70 year olds (and the original program focused on serving 18-35 year olds) they were already familiar with the "older" end of the transition-age population—ages18-21. Therefore, they had already worked with some child systems in serving these clients. The most significant learning curve or adjustment occurred regarding the interface with the juvenile justice system and the state requirements for educational services. The adolescent program also provided more intensive family services by utilizing a supportive psychoeducational approach. They also added a teacher to the PACT team (half-time) to provide alternative education programming which was partially funded by the local school system for two students. PACT bore the remaining costs of the teacher position. Both clinical treatment staff and the teacher are actively involved in the Individualized Education Plan (IEP) process and with ensuring that the local school system provides state mandated educational services.

Facilitating Factors
The longstanding relationship between PACT staff and the county adult MH director was essential in establishing the PACT adolescent program. In addition, these key players had the authority to make the decision to serve this younger group.

Barriers to Program Establishment
The biggest barrier to program establishment was stretching the program's existing funding streams to accommodate the costs of serving new clients. Although the county contributed some funding, it was insufficient to support program expansion without making the changes to existing operations (as described earlier).

Maintenance
There has been no specific effort to maintain the adolescent program. The PACT adolescent program is an integral part of adult PACT (shared staff, shared administration). In some ways, because it is not a separate program, it benefits from PACT's strong relationship to the county, to the state hospital, advocacy groups, and parents.

The maintenance challenges faced by the adolescent program mirrors those of the PACT program in general. These challenges are largely comprised of limited state resources, which have resulted in increasing pressure on all state agencies to maximize other sources of revenue. PACT has improved third-party collections as part of this revenue maximization effort.

Successful Employment Program
Quincy, MA

Interviewees: Rebecca Walters, Program Director
Deborah Jean Parsons, former Program Director
Linda Stanton, Director, Child Case Management, Department of Mental Health (local)

Basic Description: The Successful Employment Program helps young adults ages 16 to 21 years (who have been diagnosed with mental illness) make a successful transition into the work force, by supporting skill development, peer support, and social activities. New members of the program participate in a six-week orientation program in which they are introduced to the skills they will need to successfully find and maintain employment. Following graduation from the orientation program, members are welcome to participate in a variety of services including job coaching, peer support, social activities, and their drop-in center. All participants have been involved in MH treatment. Public child mental health services end at age 19 and adult MH services begin at age18.

ESTABLISHMENT PROCESS

A Need Became Apparent

New state MH funds became available for child/adolescent services which permitted the local Department of Mental Health (DMH) office to develop resources within child/adolescent mental health. This included the hiring of the local DMH office's first child case manager. At that time, MH services for adolescents were limited to one residential treatment program and DMH was seeking ways to engage 15-18 year olds in "normal" activities and skills to move into young adulthood. Local schools did not have a vocational component, yet youth were in need of employment and were not engaged in after school activities. DMH wanted to link youth with peers and older role models to provide employment related support and teach mutual support skills and social skills.

When new funding became available, the local DMH child/adolescent office started talking more intensely with the regional DMH office about the needs of youth, and assessing the relative value of different approaches. They agreed on the need for vocational and social supports and prepared a Request for Proposal (RFP) for a vocational/social support program.

South Shore Mental Health Center was a main provider of services for the DMH. They responded to the RFP with an application for a program entitled "Super Employable People" and were awarded the contract to serve 16-18 year olds. Super Employable People was recently renamed Successful Employment Program at the request of program clients.

South Shore Mental Health Center was awarded the contract for approximately $50,000 which provided support for a full-time program director and a half-time job coach. South Shore Mental Health Center contributed an administrative supervisor and program

supervisor at no additional cost. The program opened its doors in September, 1988. The program was contracted to serve youth referred from DMH, schools, and any young person with a MH condition seeking employment. The local DMH child/adolescent office reviewed all applicants, but never denied them services as there was no specific eligibility requirement. The contract stipulated that the Successful Employment Program (SEP) received a set amount of money per year regardless of how many clients they served

Seeing the Need in Young Adults

The decision to extend services to 19-21 year olds was initiated by the SEP program supervisor in consultation with the state's VR agency's area office in Quincy regarding their clients with MH conditions. The SEP supervisor worked with case managers at the state office, two of whom had 19-25 year old clients. At that time, case managers indicated that the adult work programs were not well-suited for younger adults with MH conditions.

The program supervisor and program director identified two of the VR agency's clients (a 19 and 20 year old) who would be appropriate for the SEP program. They approached the local VR agency office to obtain funding for these individuals to enter the program. SEP then received a monthly capitation to provide services. Subsequently, SEP provided services to 16-18 year olds through the DMH contract and the 19-21 year olds were served through the VR contract.

Extending the Program by Building on Trust

SEP sought approval from DMH to extend the DMH portion of the program to 21 year olds. As a result, approximately one year after SEP opened its doors, SEP convened a meeting of key stakeholders, many of whom were trusted colleagues with established working relationships. Meeting attendees included the regional DMH director, the CEO of South Shore Mental Health Center, the regional director of the VR agency, the DMH case manager, and the program supervisor and director.

SEP presented a proposal providing the rationale for DMH support for serving 19-21 year olds. SEP demonstrated how funding from the VR contract allowed them to expand the job coach's position to full-time, which provided greater capacity than was needed by the two VR slots. SEP wanted to use this excess capacity to serve youth up to age 21. Other than SEP, DMH-funded vocational programs in the area served adults ages 18 and older. Although 18 year old clients could enter these programs, DMH believed they would be better served in SEP than in an adult program and a major system change, such as eligibility changes, would not be necessary.

Retaining the Age Group in the Face of Change

One of the reasons eligibility did not need to be changed to use adolescent funding for SEP clients over age 17, was that, at the time of this age extension within SEP, child MH services covered individuals up to their 21st birthday. Adult MH served individuals ages 18 and older. Child services for those over age 17 were only available for youth whose eligibility for child services was established prior to their 18th birthday. Shortly after SEP began serving 19-21 year olds, the age requirements for child DMH services became restricted to individuals under age 19. Because of the strong relationship between SEP and DMH; the ongoing involvement and support

of the child case management director; and the belief that a specific program was necessary for the 16-21 year old group, upon the restriction of child services to those under age 19, SEP was permitted to continue serving 16-21 year olds with child DMH funding .

SPECIFIC DIMENSIONS OF ESTABLISHMENT AND MAINTENANCE

Funding Process

As a result of the increasing awareness of the special needs of youth in transition, DMH decided to use additional state DMH funds to support the development of a vocational and social program for 16-18 year olds. DMH issued a RFP and an award was made to the South Shore Mental Health Center. South Shore Mental Health Center further expanded its funding base by obtaining a contract from the VR agency to provide 2-3 vocational rehabilitation slots for clients 18-21 years of age with psychiatric conditions who were in need of a work related program. The additional funding enabled the program to expand its capacity to serve a broader age group from DMH at no additional cost. Program funding remained intact even when child DMH funds were limited statewide to those under age 19.

Policy Changes

No specific policy changes were necessary, given that the target population was already incorporated into the SEP program at the time that DMH funding restrictions were imposed.

Leadership and Advocacy

Pointed leadership was evident from three individuals. Foremost was a child community psychiatrist, who consulted with both DMH and the VR agency, served as a mental health provider at South Shore Community Mental Health Center and served as SEP's program supervisor. At every opportunity, this individual emphasized to DMH, the importance of transitioning the adolescent population into employment related skills and providing assistance in normalizing processes. In fact, much of the SEP proposal and current SEP operations reflects this perspective.

The Child Case Management Director at the local DMH also played a leadership role in establishing the program. Child case management had only been in place in the state for two years prior to the development of SEP. As the first child case manager and the only child-related staff member at DMH, this individual and her supervisor played a pivotal role in identifying unmet needs and system gaps. It was through their impetus, that the RFP was initiated and that program funds were used to expand coverage to young adults. The DMH child case management director was also instrumental in maintaining the ages served after the state limited child funding to those up to age 19.

In addition, the original program director infused a great deal of positive energy into the program development process as evidenced by strong leadership, a dynamic personality, and a high energy level. These personal qualities also helped garner program support at DMH.

Initially, parents were concerned that the proposed program was not sufficiently MH treatment focused and therefore, they did not ardently support the effort. To obtain parental support, DMH solicited direct parent involvement in the RFP development process, thereby providing an ongoing opportunity to emphasize the importance of the vocational/social program elements and

to allay their concerns that MH treatment would be adversely impacted by the development of the new program.

Learning to Work with This Population

The overarching goal of the program was to provide participants with the skills and necessary experience to function as adults. The child case manager, at DMH, the original project coordinator, and the job coach worked closely together. They used a developmental perspective in dealing with the population; relied upon common sense; and the variety of expertise they brought to the program. The child case manager and the original program director provided child system experience. In particular, the child case manager previously worked in residential treatment settings with 18-19 year olds and in recreational programs prior to that. The job coach offered experience in managing a consumer-run coffee shop for inpatient and day treatment adult psychiatric hospital clients.

A clear program philosophy was evident at the outset. First, the primary focus of the program was on the work environment. Second, the purpose of the program was to provide a vehicle for youth to achieve what *they* were seeking; and third, to partner *with* employers to develop work situations that were advantageous for both the employer and the young adult. Through informed trial and error coupled with a clear guiding philosophy, service providers learned how to work with this particular population. For example, SEP staff learned about employment opportunities for this age group by becoming more involved in the local community, canvassing for jobs, and listening to employers to identify mutually beneficial opportunities.

Facilitating Factors

The initial funding of SEP was possible because there was a pre-existing awareness of the importance of social and vocational supports for older adolescents and younger adults, and a concern about the lack of appropriate services for adolescents and young adults over age 18. When new funding became available, DMH was well-poised to carve out a piece of funding for this purpose. The development of the SEP proposal was grounded in the SEP supervisor's existing vision of recovery and normalizing situations. Good relationships between South Shore Community Mental Health Center and the local and regional DMH offices helped secure the initial contract and extend the age groups served. Allowing child funds to be used for those up to age 22 was critical to the initial work with the 18-21 year old population. This set the stage to continue services for that age group despite the fact that child funding became restricted to those under age 19.

Barriers to Program Establishment

There were no major barriers to program establishment. The initial limitation of the program to 16-18 year olds arose out of a lack of recognition of the needs of 19-21 year old clients. Once the need became apparent, and additional funding or policy changes were unnecessary, expanding the capacity to 19-21 year olds was relatively easy to accomplish. In addition, there were no major barriers to maintaining the age groups served when the child age limits changed for the state.

Maintenance

The major program stakeholders are DMH and South Shore Mental Health Center (the mother agency). Given the small size of the program, minor problems experienced in the SEP program can be easily overlooked. To ensure that the SEP program remains a priority for South Shore Mental Health Center, SEP program representatives routinely discuss client outcomes, highlight

key events, and conduct presentations for supervisors, administrators, and other program staff within the Center and in DMH. The DMH child case manager indicated that this process provides the opportunity to shape the program and contributes to DMH ongoing support. The SEP staff and DMH work as a team which provides continuity and helps ensure a steady program funding stream. In addition, SEP monitors employment progress and outcomes for their clients, and shares those findings with DMH.

Transition Community Treatment Team
Columbus, OH

Interviewees: Dan Bridgeo, original Program Director
Beth Ullery Maxwell, former Director County Child Mental Health

Basic Description; The Transitional Community Treatment Team (TCTT), serving young adults aged 16-22, focuses on individuals diagnosed with mental illnesses who are at highest risk for institutional placement, suicide, or homelessness. TCTT is based on the Program in Assertive Community Treatment (PACT). Public child MH services in Columbus, OH end and adult services begin at age 18.

ESTABLISHMENT PROCESS

Confluence of Developments

Since the MH system is strongly county-based, each county in Ohio has an alcohol, drug, and MH board which is responsible for state funds, Medicaid funds, and some local levy funds. In the early 1980s, interagency "clusters" were formed that served multi-system intensive-needs children. The clusters had pooled funds from the major child systems they administered. As a result of the cluster relationships, a growing inter-system awareness of the presence of children with severe needs emerged and in 1986, the counties formed emergency crisis teams for children.

As a result of the closure of the adolescent psychiatric hospital in 1988, the state ADAMH boards formed a consortium as a conduit for adolescents needing psychiatric hospitalization. The consortium hired an executive director to screen referrals for publicly-funded private psychiatric hospitals. The consortium also tried to link adolescents with other services and supports; however, the main focus was on youth who needed hospitalization.

Between the consortium and crisis teams, there was a perception that MH had important pieces in place to help youth with intensive needs. Subsequently, the Franklin County cluster (Columbus is in Franklin County) reviewed 25 youth who in the past year had accessed the hospitals through the consortium. Review findings indicated that youth bounced from one system and placement to the next prior to entering hospital care at ages17-18, and that they needed much more intensive supports for aging out. Findings indicated a clear need for some type of targeted initiative to transition youth more successfully to the next system. Concurrently, the consortium director had become alarmed about the lack of options for the aging-out population.

In addition, Child Welfare had a program for transition-aged youth that provided services up to age 21, but a subgroup of these individuals needed more intensive services than were available through their program. Thus, several forces were converging on a need for greater transition support.

The Availability of New Funds and Team Work
Simultaneously, Franklin County had received a large grant from the Robert Wood Johnson Foundation in the mid-1980s to shift their traditional case management approach to intensive case management teams, such as the Program in Assertive Community Treatment (PACT) model. Since funding, 22 PACT Teams had been started. The PACT teams generally served clients ages 18-60. Some had begun to specialize, such as those with co-occurring substance abuse or dependence. Similarly, the child system started developing intensive community treatment teams for children. These were not PACT models; they were more home-based. This produced a teamwork mind-set in both child and adult MH in the county. The ADAMH was then planning how to use the increase in local levy funds that supported ADAMH services and was examining service gaps.

Bringing Child and Adult Mental Health Resources Together
The lead administrator for child county MH, negotiated with adult MH to set aside $150,000 of levy funding for a transition community treatment team, with child MH setting aside the same amount. They also negotiated with the cluster to allow access to the local $380,000 flex fund, for youths up to age 25 (the flex fund had been limited to those under age18). With these funding options in place, they issued a Request for Proposals (RFP). The RFP was to develop a PACT-like model for 16-22 year olds, with flexibility to extend services after age 22. The target population was similar to the hospitalized aging-out population who struggled to connect to adult services. The RFP was to support a team that was comprised equally of adult and child staff.

North Central Mental Health was the successful bidder and received the contract at the end of 1989. North Central Mental Health already had an adolescent crisis mobile team and provided outpatient counseling for children/families. They also had community treatment teams and an adult aftercare department. It was viewed as the best candidate because it was the only comprehensive center (community mental health center) that offered both child and adult programs, and the proposal was considered outstanding by MH. Eventually the county's grant funding (Robert Wood Johnson Foundation) was absorbed into county ADAMH funding through local levy and state MH funds.

SPECIFIC DIMENSIONS OF ESTABLISHMENT AND MAINTENANCE

Funding Process
The child MH administrator and the adult MH administrator, used $150,000 of their local levy funding to support the team. This was enhanced by access to the $380,000 flexible fund, which was for the child MH population but was extended to youth in this program up to age 25. The program was also asked to access Medicaid reimbursement and only use the local funds as a last resort.

Policy Changes
No policy changes were necessary. Local ADAMH boards have considerable autonomy in how they use their funding and even more so with local levy funds, which largely funded the TCTT.

Leadership and Advocacy

The program was largely set in motion by the child MH administrator who recognized the specific need; was willing to talk to a variety of individuals about solutions; had a clear vision of concrete goals; met with a serendipitous opportunity for funding; and was in a position to make crucial decisions. Additional leadership was provided by the CEO of ADAMH who was very attuned and supportive of the age group. The executive director and clinical directors of child agencies; colleagues at child welfare; and directors of special education were all aware of aging-out issues and the lack of placement stability for the target population. They were anxious to address these issues and willing to collaborate on a solution. Although the adult MH system was responsible for young adults, they were unable to provide the type of assistance they needed. According to the child MH administrator, the ability to move forward was derived from the quality of stakeholder relationships and reliance upon a problem solving approach. Having an understanding of what was available in the community, what was lacking, and how to make things work better, contributed greatly to incremental goal attainment. Thus, a solid foundation was built even before the RFP was issued.

Learning to Work with This Population

The TCTT psychiatrist was adult and child–certified and the original program director had prior experience working with older adolescents, ages 16-20 in Massachusetts. Staff with adolescent experience were hired and trained by the TCTT psychiatrist and the original program director. Most of the staff had to learn more about the adult MH system. Daily team meetings were held (with youth involvement) with frequent communication among all parties involved. Trial and error learning coupled with creativity and experimentation was encouraged. The original program director suggested that their willingness to experiment was an outgrowth of the fact that child and adult teams were tight-knit groups. To prevent alliance or the perception of alliance with either the adult or child teams, TCTT team members worked independently. They deliberately sought ways to distinguish themselves from the adult or child teams, using creative solutions in charting their own course.

Facilitating Factors

Having a child MH cluster (a regular meeting of child agencies and the clinical arm of ADAMH) allowed for ready cross-agency discussion and intersystem collaboration. The flexible fund provided an alternative source of funding for efforts that had no other source of financing. Having case management teams in both child and adult MH provided a firm foundation for team-based approaches in working with youth with intensive needs. As a result of the Robert Wood Johnson grant, there was a great deal of system building on the adult side, which was based on addressing client needs and increasing accountability for outcomes. Also, there was a good network of transition services in the community in other child serving agencies. For example, there was a local emancipation unit for runaway youth, and child welfare had their own emancipation program serving those up to age 22. In combination with the cluster, these programs added to the pre-existing recognition of many transition issues in the county.

Barriers to Program Establishment

Because of the confluence of factors described above, there were no significant barriers to obtaining funding for and designing a RFP. There was some lack of understanding of the needs of this population and how the existing service system fell short of addressing their needs. In addition, the child system did not understand the adult system. Furthermore, adult

MH had a more narrow eligibility definition than child MH. The adult system focused on poor, under-educated individuals with serious mental illness (SMI). There was little understanding of diagnoses that were outside their definition of SMI, or of other systems, such as education, mental retardation, or child welfare. The agreement to use adult and child funding overcame the eligibility issue, and the program was intended to help educate child and adult systems about each other through interactions with the TCTT. These were not significant barriers to establishing the program.

Maintenance

There have been several maintenance issues (primarily in the early years) such as the challenges of establishing their reputation; familiarizing the community and the service delivery system about the kind of work they did; and fostering system change to provide improved client service. According to the county child MH director, two factors contributed to the maintenance of the program over the years. First, the original program director was respected in both the child and adult systems. The program rapidly reached capacity, but due to the small size of the program, there were no significant challenges to their funding stream. The program worked as a pressure valve. The TCTT demonstrated outcomes that were meaningful such as in the areas of client education, vocation, symptom management, stability of residence, family support, and "staying out of trouble". The program functioned within the adult system, but was considered part of both the child and adult system with respect to accountability. Eventually, program funding was provided directly from the ADAMH board rather than through child or adult MH funding.

The original program director described a series of program operational challenges such as lack of acceptance from the child and adult system; attempts to cost shift to the TCTT that was not in the best interest of the client; and the absence of appropriate services that were needed in addition to the TCTT. Each of these were addressed through a consistent perspective of what was in the best interest of the client, education about what this population needed, building on additional capacity when the system could not be changed, and support from the county's child and adult MH directors.

An inter-system transition group was formed to address selected system-related issues. Membership in the group consisted of the county child MH director; the original program director, representatives from major child and adult MH providers, representatives from mental retardation (MR)/developmental disabilities (DD) agencies, child Welfare, juvenile justice, VR, the school system, the adult court system, and two young adults. The purpose of the group was to problem solve, and provide guidance. The TCTT presented specific cases to the group. Barriers were identified and discussed and system changes were suggested and implemented. The inter-system transition group kept the TCTT positively in the spotlight and served as a powerful advocate. Within a relatively short time frame, TCTT was viewed as a valuable service. It achieved excellent outcomes, and therefore, was considered to be worth the investment. Thus, after 2-3 years, it was no longer necessary to maintain the group.

In addition, the former program director's doctoral dissertation focused on the program and the outcomes of the first 100 clients, which helped to promote effectiveness of the service. The TCTT was frequently asked to present their program and their outcomes locally and at the state level. County stakeholders are very proud of it and it enjoys an excellent state and national reputation.

Westchester Youth Forum
Westchester, NY

Interviewees: Myra Alfreds, Director of Children's Mental Health Services, Westchester County Department of Community Mental Health
Carol Hardesty, Executive Director of Family Ties (family organization)
Michael Friedman, Former Child Director, Regional Office of Mental Health

Basic Description: The Westchester Youth Forum (WYF) is an integral part of the system of care in Westchester County. It is a consumer-lead program, which offers peer support, recreation activities, advocacy for youth in child and family team meetings, leadership for youth in the system, advocacy at the state and national level, and training to various groups. WYF helps set the agenda for the system regarding transition age issues. Currently WYF serves 16-23 year olds. Public child MH services end, and adult services begin at age 18 in New York.

ESTABLISHMENT PROCESS

Inspiration and a Concrete Task

Staff members from county child MH, and members of Family Ties (a family advocacy organization) attended an inspiring youth presentation at a national Federation of Families for Children's Mental Health meeting. The presentation included a discussion of their experiences during the transition process and recommendations for change. Immediately following the meeting, attendees discussed the pros and cons of undertaking a similar effort. They wanted to have a group of young people develop a document for submission to the Commissioner of the New York Office of Mental Health and the Director of Family Ties about what worked and what was harmful as youth transitioned from childhood through adolescence. Transition age children of Family Ties' members volunteered to take on the task. Young social workers volunteered to help as well. Family Ties provided funding to support regular meetings at a restaurant for the youth to discuss their ideas. In six weeks, after a two-day retreat with the social workers, they produced a document.

Using an Effective Forum

The document produced was excellent and was perceived by the agency director, Childrens' Mental Health Services and the Executive Director of Family Ties as having broad ramifications for the entire health care system—not just for MH. Therefore, they sought a venue for presentation. The authors were youth who were "well-known" to the system, and had received extensive support; therefore, the description of their experiences was significant. The heads of each county agency (social services, developmental disabilities, substance abuse, and probation), the superintendents of schools, and others were invited to attend. Approximately 125 people attended the presentation, including many individuals in powerful planning positions, including the Commissioner of Mental Health as well as other important colleagues. The youth presenters

were articulate, thoughtful, and provided meaningful insight into the care system. The striking contrast between who these youth "were" in the past versus their current contributions and insights made a significant impact upon how this population was perceived by the attendees.

Youths Successfully Press for More
As an outgrowth of this successful experience, the youth expressed an interest in continuing their efforts to dialogue and improve the system. They sought funding from county child MH and Family Ties to continue to meet. They wanted to have support groups, with a social worker, and as well as a variety of recreational and social activities.

Support without Additional Funding
Funding for recreational and social activities came from youth-run fundraisers (such as car washes and bake sales). Family Ties funded a peer leader and a professional coordinator. Peer leader supervision was provided by the County Department of Community MH and Family Ties provided coordinator supervision. After approximately 1.5 years, they contacted Family Services of Westchester, a mental health services provider, and requested that they oversee the Youth Forum to provide independence from Family Ties. Family Services of Westchester then housed the program, provided conference rooms for their meetings, and provided coordinator supervision. Family Ties continued to provide some supervision to the coordinator, and also provided funding for the peer leader and coordinator.

Additional, Reliable Funding Secured
Subsequently, county child MH applied for a $10,000 grant from the regional child office of mental health. The agency director, Children's Mental Health Services and the executive director of Family Ties met with the regional child MH director to advocate for program support, emphasizing that support of the youth movement was consistent with the goals of family support—a major goal at the time with available funding attached. Family support funding was provided to the Westchester Youth Forum from the child MH budget. Family Services of Westchester received administrative overhead to provide activities and continued support, including the coordinator and peer leader.

SPECIFIC DIMENSIONS OF ESTABLISHMENT AND MAINTENANCE

Funding Process
Initial funding was provided by Family Ties, bolstered by in-kind support and youth fundraising efforts. Youth Forum funding ($10,000) was provided by the regional child MH Office of Mental Health in response to discussion with agency leadership indicating that the youth program was consistent with family support goals. Additional funding was subsequently received through the county.

Policy Changes
No policy changes were needed. The director, Regional Child Office of Mental Health had sufficient autonomy and a desire to permit child MH funding to be applied to youths who were over age 18.

Leadership and Advocacy
Attendance at the Federation of Families for Children's Mental Health provided the initial impetus for program development. Program development was initiated through a strong partnership between the family advocacy organization and county child MH agency. The directors of these two entities were instrumental in establishing the program which included providing funding out of existing budgets, and in-kind support.

Youth and peer leaders received leadership training which contributed to the success and continuity of the program. The county child MH agency and Family Ties is also credited with the incorporation of youth into the program which has been a key element of its success. The former director, Office of Regional Mental Health acknowledged the difficulty that some administrators, in positions such as his, experience in trying to obtain funding for useful programs because of the way in which funds are categorized and allocated. The former director indicated that he viewed his role as being able to provide funding for good programs without being constrained by funding categories.

Learning to Work With This Population
Because this is a consumer-lead program in which youth determine program goals and objectives, learning to "work with this population" was not much of an issue. The only "staff" member is the coordinator. The first coordinator had a unique background. She was a student working on two Masters degrees (MSW, MSpED); she was a former high school teacher and she had previous work experience in a psychiatric hospital. She had excellent writing skills and was young herself and therefore, could relate very well to program participants. She was already well-versed in system of care concepts and the development of the family and youth movement. She learned how to be helpful through firsthand experience in working with youth in the program. She helped them take on a leadership role and then listened to their input. She was also involved with other transition-age projects which provided her with a professional peer group with whom she could share ideas and obtain important feedback and insights into her client base.

Facilitating Factors
Critical to the formation of the Youth Forum was the partnership between the Westchester County Office of Mental Health and Family Ties, and the belief that youth should be full partners in shaping system reform.

Barriers to Program Establishment
The biggest barrier to program establishment was that there was no discreet funding available for this effort. It was not a "program" in the typical sense of the word, and therefore, it was not funded as such. It took the accumulation of investment by the county, Family Ties, and Family Services of Westchester, to produce a track record that could be used to obtain additional program funding. Given that there was no specific funding category that applied to this type of program, obtaining the funding meant that there would have to be a cut from another family support program. Therefore, this was viewed as a type of barrier. Although adult MH had funding, their principal focus is on other issues such as housing and case management. Furthermore, since adult MH viewed this group as largely consisting of individuals they do not serve (because more than half would not meet their very narrow eligibility criteria) it was apparent that funding would have to be provided by the child MH system instead.

Maintenance

Additional funding was necessary to keep the program running. There has been no discreet funding for this program provided by either child or adult MH. There have also been numerous changes in state government over time, with a great deal of fluctuation in beliefs regarding family/youth support. Also, the system has converted to one that is more Medicaid dominated, and Medicaid does not cover family or youth support. In addition, the child MH budget in the county has dropped 12 percent.

Fortunately, involving the Youth Forum in so many aspects of the system of care has given it a high profile, and lead to the understanding that it was integral to the system of care. When more funding was available from one agency (the Youth Bureau, which is for delinquency prevention) the Youth Forum was easily funded, and the budget increased from approximately $10,000 to $60,000, and then again by an additional $25,000. As a result, the Forum now has an annual budget of $85,000. Youth Bureau staff visit the Youth Forum, and through attendance at forums, they have obtained valuable insight regarding what works and what does not on a variety of topics, such as housing and education, for example. Also, county MH received a Federal System of Care Grant from the Center for Mental Health Services in 1999, which included the transitioning population. Therefore funds from the grant supported the professional coordinator.

Transition Age Youth Initiative
Maryland

Interviewees: Steven Reeder, Program Administrator for Vocational Services, Adult Service Unit, Maryland Mental Hygiene Administration

Basic Description: The Transition Age Youth Grant Initiative funds 12 separate programs out of 23 regions across the state (one for each of 12 regions). Each program provides innovative services for those individuals transitioning from the child to the adult MH system. The goal of the grant program is to create a set of services for transition age youth that promote innovations and allow for testing of models and approaches. A second goal of the grant is to develop expertise in various approaches to working with this population that can then be shared statewide. The program is administratively housed within the adult MH administration. It is conceptualized as a program to provide youth with sufficient skills and supports during the transition period to minimize or prevent further involvement in the adult MH system, and as such is a diversion program. Initiatives are varied in their focus and approach within the broad aims of supporting and diverting the population. Youth in the various programs can be as young as age 13 or as old as age 25. Each program has defined its age range, which for some includes the entire spectrum, and for others includes only a portion. The initiatives can have latitude in serving individuals who do not meet target population definitions, provided they have a primary condition that is a MH condition diagnosable with the DSM-IV and significant functional impairment that is defined in a developmentally appropriate manner. The MH system largely funds services through fee-for-service mechanisms, and the grant provides flexibility to use grant funds to fill gaps not addressed through fee-for-service. The program was initiated in Fiscal Year 2000 and was current at the time of the interview. Public child MH services end, and adult services begin at age 18 in Maryland.

ESTABLISHMENT PROCESS

Within the Maryland MH system, the need for better transition support has long been recognized. Advocates for individuals with developmental disabilities identified the need for additional funding for supports and services. This group introduced legislation that required the Departments of Education and Health and Mental Hygiene to develop a state plan. The Maryland legislature passed the statute in 1996. As a result, Maryland's Department of Education convened a task force that developed a plan for transition-age youth, including services for children and adolescents with mental illness. Family advocacy at the state level ultimately lead to an Executive Order to create the Interagency Transition Council in 2000 by Governor Paris Glendening. The purpose of the Council was to coordinate transition services across agencies for youth with disabilities. The Council is responsible for annually reviewing and updating the Interagency State Plan for Transitioning Students with Disabilities. Some funding was attached to the Council and those funds were sent in part, to the three state agencies to improve the transition age youth they served. MH used the funds to develop the grant program. The Transition Age Youth Initiative was strongly shaped by the input obtained through family focus groups that were conducted by the state's branch of the Federation of Families for Children's Mental Health. The proposals were reviewed by a

panel, which included family advocates and child and adult MH administrators. There was a balance between the quality of the proposed approach and the size of the budget, as well as balancing between various focal points, so that numerous and diverse approaches were funded. This was a strategy to develop expertise across different approaches and evaluate what worked and did not. The range of funded programs included one for transition-age mothers, an Outward Bound program, education at a community college, and specialized case management that focused on mentoring and supported employment. They successfully obtained funds from their federal mental health block grant to fund the grant. The block grant was sufficiently robust and therefore, it was not difficult to obtain a portion for this program.

SPECIFIC DIMENSIONS OF ESTABLISHMENT AND MAINTENANCE

Funding Process

The Governor formed (by Executive Order) an Interagency Transition Council that focused on the transition to adulthood in all individuals with disabilities. The legislature provided funds to the Council, which in turn provided the bulk of their one-year funding for initiatives in the state's developmental disabilities, MH, and VR agencies. The MH agency used the one year of funding to develop the grant program design, develop the RFP, and review the submissions. The grant was funded from their federal mental health block grant. Funding was restricted to youth transitioning from the child to the adult state MH system, but broadly included ages 13-25. The grant was intended to provide ongoing funding to maximize fee-for-service funding by wrapping the funding around what could be paid for through fee-for-service. For example, there was a small grant for mentoring. The grant paid for recruiting and training mentors and paying them, which is not reimbursable. This service is offered as part of a psychosocial rehabilitation program in which other services are reimbursable.

Policy Changes

A definition of the transition population was developed at the state level. This definition was deliberately broad so that diagnostic categories would not pose a barrier to these services at any age. In general, the diagnostic requirement was having a DSM-IV MH diagnosis coupled with a functional impairment.

Leadership and Advocacy

There has been a strong consumer and family focus in Maryland. Family advocacy at the state level ultimately lead to the Executive Order that established the Interagency Transition Council. (The director of the Interagency Transition Council is a parent of a disabled youth.) The Transition Age Youth Initiative was strongly shaped by the input obtained through family focus groups that were conducted by the state's branch of the Federation of Families for Children's Mental Health. There was no organized youth voice at the time, but there was strong family advocacy input in to both shaping the request for applications and evaluating the proposals. In addition, the Director, Adult Services, Mental Hygiene Administration, played a leadership role within MH by identifying the adult MH system as the administrative home of the grant, and taking on the transition issue as a means by which to divert youth from chronic dependency.

Facilitating Factors

Family advocacy was central to the establishment of this grant program, as was the existence of the Interagency Transition Council. Also critical to its success was the leadership of the Director, Adult Services, Mental Hygiene Administration in embracing the transition issue within the adult MH system.

Barriers to Program Establishment

There were a number of turf issues that posed barriers to program establishment. Within MH there was a schism between the child and adult systems. Collaboration was not yet an active effort. Child and adult MH had separate reporting structures and separate administrations. There was limited cross-fertilization of ideas. The grant program was administratively housed within adult services and was viewed as an adult initiative by the child system. Furthermore, child MH had a flexible fund that allowed for purchase of services they could not fund otherwise, and to which adult MH did not have access. Some of the child MH concerns were eased by having child MH representation on the reviewing panel for the grant.

Maintenance

Internal advocacy has been the key to the maintenance of this grant program. The Mental Hygiene Administration collected quarterly data on these programs since their outset, and have primarily presented those findings, particularly related to diversion from the adult MH system, and affiliated costs, and the positive impact of the program. The Mental Hygiene Administration demonstrated that nearly 80 percent of the transition program graduates never accessed additional services. On average, youth spend approximately two years in the programs. Family advocacy still plays a role, as they constantly keep the programs and the transition issue on the legislators' radar screens. In addition, the Interagency Transition Council keeps a public focus on the transition issue for all youth with disabilities. The new Governor (in 2003) formed a Department of Disabilities in the cabinet under which the Interagency Transition Council is housed, and provides direct access to the Governor.

Partnerships for Youth Transition
Center for Mental Health Services,
Federal Substance Abuse and Mental Health Services Administration

Interviewee: Diane Sondheimer, MSN, MPH, CPNP; Deputy Chief, Child Adolescent and Family Branch, Center for Mental Health Services (CMHS)

Basic Description; The Partnership for Youth Transition (PYT) was a federally-funded discretionary grant program through the Center for Mental Health Services in partnership with the Department of Education's Office of Special Education Programs, in 2002. The purpose was to develop, implement, stabilize, and document models of comprehensive transition support programs. The target population was youth aged 14-25. Funds were limited to youth with a serious emotional disturbance or young adults with an emerging serious mental illness as defined in the Federal Register, Vol. 58, No.96, Thursday, May 20, l993. Five grants were awarded to public MH agencies (in Utah, Washington, Minnesota, Maine, and Pennsylvania) at approximately $500,000 per year for four years. Grant funding was intended to provide sites with the time to evaluate their programs and put them in a position whereby they could sustain the program without the grant funds and apply to other agencies to obtain funding for rigorous evaluations. Grant work was supported by a technical assistance center and the final year of the program was completed in 2006.

Grantees were responsible for completing the following activities for each of the four grant years:
Year 1: Engage in a strategic planning process with all relevant organizations, yielding a written action plan, a theory-based logic model, and a process evaluation.
***Year 2*:** Implement the program model, including training staff, aligning resources, coordinating services, enhancing existing programming to fill the gaps in the Comprehensive Youth Transition Program, renewing interagency partnerships, and collecting quality assurance data. By the end of Year 2, grantees were to have a final operational model described in a program manual, and enrolled and served youth participants. Data collection was required that measured participant characteristics, and amount and type of services. Grantees had to document the processes through which the Comprehensive Youth Transition Program was implemented and the specific services implemented and/or coordinated.
***By Years 3 and 4*:** Have a stabilized program, a routine service delivery process, and have made any needed adjustments in programming and underlying program theory. The goals for this final period were to fully operationalize the program model and document short-term outcomes.

Applicants were required to describe and develop plans to sustain the program after federal funds expire.

ESTABLISHMENT PROCESS

Persistence and Relationships

Multiple sources of information revealed the lack of appropriate services for youth in transition in the U.S. As a result, the Deputy Chief, Child Adolescent and Family Branch, CMHS

spearheaded an effort to highlight the needs of this population by preparing a concept paper that outlined the issue; provided recommendations about how to address it; identified potential partners; and presented a budget. The concept paper was submitted first to the Child, Adolescent, and Family Branch Chief and ultimately, it was submitted to the Division Chief for final review, approval, and funding. Although the initiative was not funded at the outset, the Deputy Chief served a persistent advocate for this population (with support provided by national experts) and continued to re-submit the concept paper, until it was eventually approved and funding was allocated in the CMHS budget. Following approval, CMHS proceeded to prepare the Request for Applications (RFAs), which involved all branches of CMHS. This facilitated broad support of the program. A funders'meeting was held to describe the grant program, review the need for the program, and solicit financial support from other federal agencies and private foundations. Despite the effort to conduct follow up phone calls to attendees, only one agency contributed (Department of Education/Office of Special Education Programs), and the RFA was prepared and released, resulting in the funding of the five sites.

SPECIFIC DIMENSIONS OF ESTABLISHMENT AND MAINTENANCE

Funding Process

Funding resulted from "pure tenacity". The Deputy Chief submitted the concept paper for the program for approximately four consecutive years until it was accepted. Program funding was provided through the Special Projects of Regional and National Significance (SPRANS) budget which typically funds discretionary grant programs. One additional grant was obtained through a funders' meeting process. Additionally, private foundation money was sought to support a technical assistance center for the awardees. CMHS funded four applications for all four years from the Child, Adolescent, and Family Division. The Department of Education/Office of Special Education Programs funded one application for all four years. The Annie E. Casey/Jim Casey Youth Opportunities Initiative provided $250,000 per year for the National Technical Assistance Center (at the Florida Mental Health Institute, University of South Florida).

Policy Changes

No policy changes were needed.

Leadership and Advocacy

According to the Deputy Chief, leadership and persistence were the reasons that this program was funded. Dogged advocacy with key players was essential. Thus, knowing who the individuals were who formally and informally influenced funding and decisions, was critical. Highlighting the issues through those relationships contributed to developing consensus about the need for the program. External experts kept leadership apprised of what was really happening with the target population in the community. As a result of CMHS' constant inquires to identify service and funding gaps coupled with the availability of supporting data, ultimately, it was identified as a critical system gap. At that point, it was a matter of seizing a funding opportunity and taking action. Family members and representatives from consumer advocacy groups also played a leadership throughout the development process.

Facilitating Factors

The Child, Adolescent, and Family Branch members were aware of the transition issues before the concept paper was written, and were supportive of the project throughout. The adult division was receptive to hearing about issues that they had not identified, and came to understand quickly the need for this grant program. In addition, once permission to write the RFA was obtained, it was structured to involve all divisions. This facilitated their support of the program. In addition, the Office of Special Education Program's pre-existing awareness of transition issues (likely stemming from legislatively mandated transition planning for all special education students) most likely increased their receptivity to program funding.

Barriers to Program Establishment

The most significant barrier to program establishment was the lack of awareness of transition issues in other federal agencies and private foundations. For example, only the Department of Education was represented at potential funder's meetings convened by CMHS. Had other agencies contributed, many more sites could have been funded as there were many excellent, but unfunded applications.

Maintenance

The grant program was funded as a four-year program, and therefore, all funding was dedicated at the outset. However, efforts to extend or continue the program beyond its four years were unsuccessful. There was a change in leadership at the agency during the tenure of the grant program, and a concomitant change of priorities, as is typical with leadership change. There has not been a good way to fit such a grant program into the new priorities. The criteria for extending or maintaining existing programs were unclear, making it difficult to advocate for continuation. Funds for this program were discretionary, and not dictated from Congress, making it vulnerable to changes in priorities and other factors. Many programs were being cut, making it a difficult time to advocate for continuation or new programs. While many target groups (such as children or particular minority groups) have specific advocacy groups, the transition age youth population does not have such a group to lobby for continuation of this program, or at least the level of advocacy needed to make it succeed.

WHAT CAN WE LEARN FROM THESE EFFORTS?

While each story of pioneering program establishment was unique, there were some strong common threads. These are described briefly below.

1. The problem becomes apparent to individuals or groups who mobilized necessary supports and resources.

In several instances, individuals in programs or provider agencies became aware of a need to serve the transition age population in a different manner from their own clients. Others experienced the loss of their own program (Community Connections, JOBS, PACT-Adolescent), and sought alternative program funding. In three instances, individuals from public MH agencies had come to recognize the need and sought a means to establish a special program in response (SEP,TCTT, PYT). In other instances, the issue was raised in another forum, but the need was recognized locally and action was taken (CORE, WYF, MD-TYI).

2. Leadership played a key role.

In most instances, one or two (in JOBS case, three) individuals took it upon themselves to seek a solution (Community Connections, JOBS, PACT-Adolescent, SEP, TCTT, WYF, PYT). Many efforts lead by individuals were greatly facilitated by strong pre-existing relationships with funders (JOBS, PACT-Adolescent), or with the added support of interagency or advocacy groups (Community Connections, TCTT, WYF). In a few cases, the individuals who took the lead were also in a position to capitalize on funding opportunities presented within their MH agency (SEP, TCTT, PYT).

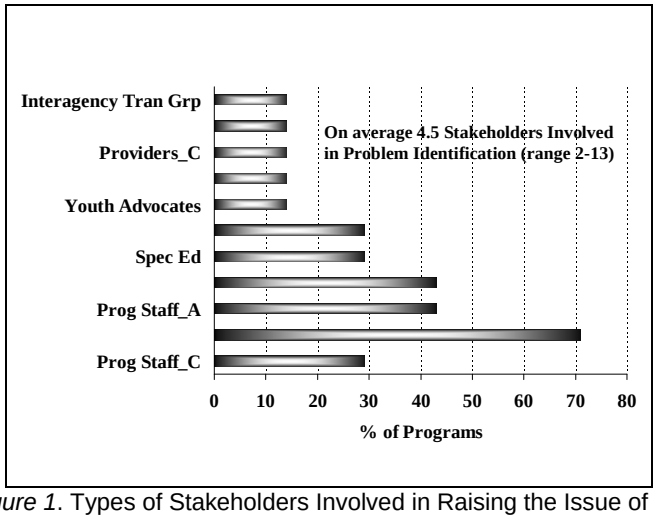

Figure 1. Types of Stakeholders Involved in Raising the Issue of Needing a Pioneering Program. *"C" refers to Child system; "A" refers to Adult system*

3. The problem was recognized in conjunction with other stakeholders.

Community Connections, CORE, JOBS, PACT-Adolescent, TCTT, MD-TYI, and PYT programs all benefited from multiple stakeholders recognizing the problem, which facilitated the

efforts of the leading individuals to garner support for a solution. Figure 1 shows the different types of stakeholders that were involved. It is clear from this figure that child MH administrators were almost always involved.

4. The design of the program was often achieved by a small group of stakeholders building on existing expertise in related populations.

The specific design of the pioneering program typically arose out of pre-existing experience, and through trial and error, rather than from external expertise or evidence-based practices. For Community Connections, JOBS, and PACT-Adolescent, the program was largely conceived of by individuals who ran programs related to the population and then contributed their expertise to design the new program. Community Connections benefited from program developers that had offered a successful program for transition age youth. JOBS and PACT-Adolescent took their existing expertise with populations close to the transition age group and tried to extend it logically for their specific needs. WYF was designed over time by the youth participants themselves. For SEP and TCTT, the RFP set out guidelines, and knowledgeable providers, again building on existing expertise in populations close to this age group, submitted compelling and successful proposals.

Resources that currently exist to help guide transition programs did not exist when the oldest programs were established. The first book on how to provide services to this population was published in 2000 (Clark, H., & Davis, M. (Editors.). *Transition to Adulthood: A Resource for Assisting Young People with Emotional or Behavioral Difficulties.* Baltimore: Paul H. Brookes, Co.). There is also a detailed web site that offers guidance and links to other relevant web sites (http://tip.fmhi.usf.edu/). These types of resources were not mentioned by most of the newer programs.

TABLE 2 - Problem Identification Phase Characteristics

Source of Evidence of Need		
	Direct Work With This Age Group	57%
	Exposure to Good Model	29%
	Data	14%
Leaders in Raising Issue and Seeking Solution		
	Program/Agency	57%
	Mental Health Administrators	29%
	Work Group	14%
Child/Adult Primary Leadership		
	Child and Adult System	42%
	Adult System	29%
	Child System	29%

As can be seen from Table 2, it was direct work with this age group that lead individuals to seek a solution most of the time (57%). Most typically, it was individuals from agencies or programs that sought a way to fund a pioneering program, and the leadership in seeking the solution most commonly came from individuals representing both child and adult services.

5. Funding was often achieved through trusting relationships.

For JOBS, and PACT-Adolescent, the providers obtained initial funding from organizations with which they had an existing and trusting relationship. For CORE, SEP, and TCTT, the funding was released through the RFA process, however, the agencies who received the funding had long-term and solid relationships with the funding sources. SEP was able to extend the age group served, and maintain that age group after it could have been restricted, in part because the relationship with the funder was strong. WYF initially "funded" the program themselves, through in-kind support, and a small carve-out from existing funding.

6. Most programs expanded through incremental increases in funding.

Most programs started with a relatively small amount of funding, demonstrated their worth, and subsequently obtained more funding. Community Connections started with a small grant and then additional funding allowed them to find ways to build the work into existing billing opportunities. CORE began with state funding and then had to obtain local funding to make it sustainable. JOBS began with VR funding that allowed them time to demonstrate program success and garner support from child MH. SEP was able to extend the age group served by leveraging small contracts with vocational rehabilitation into more capacity for MH clients. WYF ran on a tight budget and then was able to use the program's success to access additional MH funding.

7. For several programs, funding was provided because it was viewed as a small amount.

JOBS, PACT-Adolescent, SEP, and WYF all critically accessed small amounts of funding that helped make the program viable, and the small size of the request seemed to facilitate the funding process.

8. Funding decisions were typically made locally.

CORE, PACT-Adolescent, SEP, TCTT, and WYF were all funded through mechanisms that provided a fair amount of local autonomy in decision making. While CORE was funded through state dollars, the decision about who the provider was and what the program looked like was largely the result of the local interagency transition group. Moreover, with the exception of Community Connections and JOBS, funding of these programs in general, came through local funding, or locally dictated funding.

Statewide funding initiatives that allow for the extension of programs across the transition age appear to be uncommon. In searching for pioneering programs, only two other statewide initiatives were encountered—one in PA that funded CORE, and one in NY. The NY program was part of a statewide initiative to enhance the state's Individualized Placement and Support program capacity. There were no age limits on the funding, and supporting the successful transition into adulthood was part of the target population described. However, the proposals did not span the child/adult age group and eventually, the funding was assigned to child MH for the programs that served adolescents, and to adult MH for programs serving adults. Thus, TYI in Maryland is a remarkable example of a longstanding state-level effort to enhance programs that can serve youth across the transition age.

9. Program development is more rapid with state or federal sponsorship.

Maryland's grant program and the Federal Partnerships for Youth Transition grant program demonstrate that decisions to fund pioneering programs at higher levels of government lead to more rapid development of such programs. Similarly, the statewide initiative that funded the CORE program also funded several other pioneering type programs at the same time. One of the issues that may remain for state or federally-initiated funding is sustainability, if the initial funding is time-limited.

10. It was unusual for mental health funding to come from both child and adult sources.

Many of the programs had mixed sources of funding including billable Medicaid hours, state or local MH funds, private foundation grants, funds from other systems, and the like. Funding from public MH agencies is dichotomized in most of these settings. JOBS, SEP, and WYF received only child MH funding, and TCTT and PACT-A received only adult MH funding (although TCTT could tap into the child flex fund into which all child agencies contributed). The CORE program was primarily self-funded through billable Medicaid funding handled through the local mental health authority (both child and adult funds). The Community Connections program received initial funding that came from the state's MH block grant funds and the program was later transferred to the state's child division. Similarly, Maryland's TYI program was also initially funded through the state's mental health block grant. The Federal PYT program also utilized "child" funding as the basis for the grant (from their Child, Youth, and Family Division funds).

TABLE 3 – Funding

Duration From Identifying Need to Funding		
	1-2 Years	57%
	Less Than 1 Year	29%
	3-5 Years	14%
Long-Term and/or Trusting Relationship with Funder		
	Yes	86%
	No	14%
Level of Funding Decisions		
	Local	57%
	Other	14%
	State	29%
Initial Primary Funding From Non-Mental Health Agency		
	Yes	43%
	No	57%

As can be seen in Table 3, establishing funding that would allow a program to open its doors typically took 1-2 years. Further, initial primary funding often did not come from MH. The WYF program obtained initial funding from its mother agency, the JOBS program from the state's VR program, and the CORE program from private foundation and state health grant funds.

DISCUSSION AND CONCLUSIONS

It is clear from these local, state, and federal programs that establishing programs that can serve youth continuously across the transition stage is possible. It is also clear that it takes special efforts to establish these types of programs. One central question that this project attempted to address was whether the approaches to their establishment were any different from the establishment of innovative programs for other groups of individuals.

What appears to be unique in the efforts of the pioneering programs studied was the need to address the absence of an established category of services that could be used to fund these transition ages. For example, if a state MH authority issues a RFP for psychosocial rehabilitation programs, it is typically issued out of the adult system and while the general type of service would be appropriate for transition age youth, funding is typically limited to those who fall into the adult age categories and eligibility criteria. In this circumstance, it would be difficult to use those funds to provide psychosocial rehabilitation to 16 or 17 year olds. Or, as the PACT-adolescent program found, they could make an argument to serve those under age 18, but those under 18 had to meet the more strict disability eligibility criteria for adult services.

A similar funding challenge raised by the programs was relying on Medicaid reimbursement for their services. The issue was that eligibility criteria for Medicaid are stricter for adults than children, resulting in the loss of eligibility for some when they reach age 18 (or in some states, age 21). Continuing to provide the services to those who lose eligibility while in the program requires creativity. For example, the Community Connections program used Medicaid reimbursement for many of its services. They had to obtain a contract from the local mental health board to serve low income, non-Medicaid-eligible clients. They reported that they end up subsidizing a lot of costs. This requires significant support from the mother agency.

These types of funding challenges meant that all of these programs had to be creative in funding their pioneering program. The demand for this kind of creativity reduces the number of providers who are willing or have the capacity to make the efforts that these programs have made for this purpose, and likely contributes to the small numbers of such programs. Further, if programs need to ask for special funding, there is evidence from these programs' experiences to suggest that special funding will be quite limited, and that the amount of special funding is small, perhaps to avoid having to make policy change, or perhaps because of budgetary limitations. These forces may also contribute to the small number of pioneering programs that were identified.

It may also be that local autonomy in funding decisions facilitates the development of innovative programs, one at a time. Most of these local programs obtained their original funding through convincing someone at the local level, who had sufficient autonomy to make this decision, to provide funding for their program. While this situation allows local programs and MH authorities to work out individual program funding and support, it is not a mechanism for statewide change. In states where public mental health programming is largely dictated at the state level, convincing state-level administrators that these types of programs are needed and finding the

funding for them is a much larger task. Maryland's program is one such example, resulting in pioneering programs in approximately one-third of the state. Another state that has recently taken this step is Massachusetts, resulting in a program change to include pioneering programs across the state. However, it appears that such state-level change is extremely rare. Similarly, federal programs can support system change in numerous sites simultaneously, as is evidenced from the Partnerships for Youth Transition (PYT) program, and from other federal efforts in other areas. However, the PYT program is the only one at the federal level targeted at this population, and it has ended. (For a full description of federal programs serving transition age youth, see the David L. Bazelon Center for Mental Health Law's report; http://www.bazelon.org/publications/movingon/index.htm and the national expert panel's recommendation for federal action to improve transition support services for this population; http://www.umassmed.edu/uploadedfiles/YouthTPM.pdf.)

It also appears that many of the mechanisms that commonly support any innovative programming are also at work in the establishment of pioneering transition programs such as leadership, multiple stakeholder buy-in, and good relationships. These mechanisms were at work in all of these programs, including the state and federal initiatives.

References

Davis, M., & Koroloff, N. (2006). The great divide: How public mental health policy fails young adults. In *Community Based Mental Health Services for Children and Adolescents,* Vol. 14.W.H. Fisher (Ed.). Oxford, UK, Elsevier Sciences. pp.53-74.

Davis, M. (2001). *Transition Supports To Help Adolescents in Mental Health Services*. Alexandria, VA: National Association of State Mental Health Program Directors.

Davis, M., & Hunt, B. (2005). *State Adult Mental Health Systems' Efforts to Address the Needs of Young Adults in Transition to Adulthood.* Rockville, MD: U.S. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

Clark, H., & Davis, M. (Eds.).(2000). *Transition to Adulthood: A Resource for Assisting Young People with Emotional or Behavioral Difficulties.* Baltimore: Paul H. Brookes, Co.

Appendix A
Programs and Interviewed Individuals

Program Name	Interviewee Name	Relationship to Program	Phone Number
COMMUNITY CONNECTIONS, of Community Services of Stark County, Canton, OH	Patrice Fetzer	Program Coordinator	330- 455-0374
	Daniel J. Fuline	CEO/Executive Director	330-455-0374
CORE, of Family Services of Western Pennsylvania, Pittsburgh, PA	Shannon M. Fagan	Westmoreland County CASSP Coordinator	724- 830-3617
JOBS, Washington County Mental Health Services, Barre, VT	Phil Wells	Director of Individualized Services, WCMHS	802-476-1480
	Michael Curtis	Director of Children Youth and Family Services, WCMHS	802-476-1480
	Paul Miller	JOBS Coordinator	802-223-6355
	Charles Biss	Director of State Child Mental Health, VT Division of Mental Health	802-652-2009
PACT-Adolescent Program of Mendota Mental Health Institute, Madison, WI	Suzanne Senn-Burke	PACT Community Treatment Specialist	sennbsc@dhfs.state.wi.us
	Shelley Chevalier	Community Services Manager of Dane County Adult Mental Health	608-242-6468
	MaryKay Wills	Manager of Dane County Child Mental Health	608-242-6404
SUCCESSFUL EMPLOYMENT PROGRAM, of South Shore Mental Health, Quincy, MA	Deborah Jean Parsons	Original Program Director	617-983-5852
	Rebecca Walters	Current Program Coordinator	
	Linda Stanton	Child Services Coordinator, DMH Metro Suburban Area	617-626-9035
TRANSITION COMMUNITY TREATMENT TEAM, of North Central Mental Health Services, Columbus, Ohio	Dan Bridgeo, PhD	Original Program Director	614-299-6600 x3022
	Beth Ullery Maxwell	Former Director, Children's services, Alcohol, Drug and Mental Health Board of Franklin County	614-885-5496
WESTCHESTER YOUTH FORUM, Family Service of Westchester, White Plains, NY	Myra Alfreds	Director Children's Mental Health Services	914-995-5250
	Carol Hardesty	Executive Director, Family Ties of Westchester, Inc.	914-995-5219
	Michael Friedman	Former Regional Director Children's Services, Office of Mental Health	212-614-5753

Continued on next page

Program Name	Interviewee Name	Relationship to Program	Phone Number
TRANSITION AGE YOUTH INITIATIVE, Mental Hygiene Administration, MD	Steven Reeder	Program Administrator for Vocational Services, Adult Service Unit, Maryland Mental Hygiene Administration	410-402-8484
PARTNERSHIPS FOR YOUTH TRANSITION, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration	Diane Sondheimer,	Deputy Chief, Child Adolescent and Family Branch, Center for Mental Health Services	301-443-1333

Appendix B
Interview Instrument

PIONEERING PROGRAMS QUESTIONNAIRE
STAFF

The following questions will be addressed during the interview regarding the [NAME OF PROGRAM]. Please answer to the best of your knowledge. The purpose of the interview is to obtain the perspectives of various stakeholders involved with this program, thus we are asking for your best representation of relevant events and issues as well as your opinion. Please fill out the final section (Section II) on your own time and e-mail or fax it directly to: Maryann Davis, (508) 856-8700, e-mail maryann.davis@umassmed.edu.

SECTION I

1. The following are some basic characteristics about [NAME OF PROGRAM];

Does this description sound right to you? __Y __N

2. Is there anything you would like to add or change about way in which I have described this program?
3. When did the program first open its doors?_____

I would like to find out, from your perspective, how this program came into existence.

4. In rough chronological order, what efforts lead to its establishment? (note approximate date of start of efforts, and involvement of other key stakeholders and their contact information)
5. Did any policies, administrative rules, or contract language need to be changed in order to establish this program?
6. How was funding established, and what were those sources of funding?
7. How was an appropriate provider identified?
8. How did the program's staff learn how to work with this specific population?
9. What role did family or consumer advocacy groups or individuals play in the establishment of this program?
10. What role did leadership play in establishing this program?
11. What kinds of barriers within MA's child mental health agency were encountered to the establishment of this program?
12. How were those barriers addressed?
13. What kinds of barriers within MA's adult mental health agency did you encounter in establishing this program
14. How were those barriers addressed?
15. What kinds of barriers within other state/local agencies were encountered to the establishment of this program?
16. How were those barriers addressed?
17. Were there other barriers to establishing this program that we have not yet

discussed?

18. How were those barriers addressed?
19. Within the *child* mental health agency, what factors facilitated the establishment of this program?
20. Within the *adult* mental health agency, what factors facilitated the establishment of this program?
21. Within other state/local agencies, what facilitated the establishment of this program?
22. What other factors facilitated the establishment of this program?
23. Once the program was established, what efforts have been necessary to keep the program running in the same capacity?
24. What barriers to the program's maintenance (within Mental Health, other agencies, local agencies, other factors) have there been?
25. How have these barriers been addressed?
26. Is there anything else that is important to understanding the *establishment* of this program?
27. Is there anything else that is important to understanding the *maintenance* of this program?
28. What does the program do to address the concerns of key stakeholders?
29. What do you see as the strengths of the program?
30. What do you see as its greatest challenges?

FOR PROGRAM STAFF FROM CLOSED PROGRAMS

31. Is there anything else that is important to understand about the *closing* of this program?

SECTION II

Please tell me about your agency and program.
Is your program administratively housed within a larger agency? __ Yes ___ No
If **No**, please skip to #36
If **Yes**, please complete all of the following questions

AGENCY QUESTIONS

32) About how many people are employed by your agency? _____

33) What types of services does your agency offer (please circle all that apply)?

1……Mental Health Service
2……Vocational Rehabilitation Service
3……Education or Special Education Service
4……Substance Abuse Service
5……Developmental Disability Service
6……Housing Service
7……Independent Living Service
8……Delinquency Rehabilitation Service
9… Child Welfare Services
10….Child Protection Service
11….Public Safety Service
12….Medical Health Service
13….Recreation Service
14….Advocacy/support Services
15….Other (*please describe*)
_____

34) How long has your agency been providing services? _____ years

35) How many clients received services in your agency in FY 2004?_____

[Please note, this should be an **unduplicated count**- number of distinct individuals]

36) Does your agency primarily serve (*check one*)

__ Youth (up to age 18 or 21) __ Adults (age 18 or 21 and older) __ Both youth and adults

PROGRAM QUESTIONS
These questions refer to _____ (name of program).

37) About how many people are employed in your program? _____

38) How many clients received services in your program in FY 2004?_____

[Please note, this should be an **unduplicated count**- number of distinct individuals]

39) Within your program, approximately what proportion of those served have serious emotional disturbance or serious mental illness? _____%

40) Within your agency, approximately what proportion of those served have serious emotional disturbance or serious mental illness? _____%

41) Within your program, what are the different funding sources for your services and the approximate percentage of support they provide?(e.g. special education, 75%, child mental health 20%, Medicaid 5%)

42) Within your agency, what are the different funding sources for the services, and the approximate percentage of support they provide?(e.g. special education, 75%, child mental health 20%, Medicaid 5%)

SECTION III

Information about the Informant

Name:_____

Position:_____

Relationship to Program:_____

_____

Date of Interview:_____

Permission to publish contact information: ___ granted ___ denied

PIONEERING PROGRAMS
NON-STAFF

Guidelines for Interviews with Professional Stakeholders (Not Program Staff)
The following questions will be addressed during the interview regarding the [NAME OF PROGRAM]. Please answer to the best of your knowledge. The purpose of the interview is to obtain the perspectives of various stakeholders involved with this program. Thus we are asking for your best representation of relevant events and issues as well as your opinion.

The following are some basic characteristics about the [NAME OF PROGRAM];

Does this description sound right to you? __Y __N

31. Is there anything you would like to add or change about way in which I have described this program?
32. When did the program first open its doors?_____

I would like to find out, from your perspective, how this program came into existence.

33. In rough chronological order, what efforts lead to its establishment? (note approximate date of start of efforts, and involvement of other key stakeholders and their contact information).
34. Did any policies, administrative rules, or contract language need to be changed in order to establish this program?
35. How was funding established, and what were those sources of funding?
36. How was an appropriate provider identified?
37. How did the program's staff learn how to work with this specific population?
38. What role did family or consumer advocacy groups or individuals play in the establishment of this program?
39. What role did leadership play in establishing this program?
40. What kinds of barriers to the establishment of the program were encountered within the child mental health agency?
41. How were those barriers addressed?
42. What kinds of barriers did you encounter within the adult mental health agency in establishing this program?
43. How were those barriers addressed?
44. What kinds of barriers within other state/local agencies to the establishment of this program were encountered?
45. How were those barriers addressed?
46. Were there other barriers to establishing this program that we have not yet discussed?
47. How were those barriers addressed?

48. Within the *child* mental health agency, what factors facilitated the establishment of this program?
49. Within the *adult* mental health agency, what factors facilitated the establishment of this program?
50. Within other state/local agencies, what facilitated the establishment of this program?
51. What other factors facilitated the establishment of this program?
52. Once the program was established, what efforts have been necessary to keep the program running in the same capacity?
53. What barriers to the program's maintenance (within MH, other agencies, local agencies, other factors) have there been?
54. How have these barriers been addressed?
55. Is there anything else that is important to understanding the *establishment* of this program?
56. Is there anything else that is important to understanding the *maintenance* of this program?
57. What does the program do to address the concerns of key stakeholders?
58. What do you see as the strengths of the program?
59. What do you see as its greatest challenges?

FOR NON- STAFF REGARDING CLOSED PROGRAMS

60. Is there anything else that is important to understand about the *closing* of this program?

SECTION II

Information About the Informant

Name:_____

Position:_____

Relationship to Program:_____

Date of Interview:_____

Permission to publish contact information: ___ granted ___ denied

PIONEERING PROGRAMS QUESTIONNAIRE *STAFF*
State and Federal Grant Programs

The following questions will be addressed during the interview regarding the NAME OF GRANT program. Please answer to the best of your knowledge. The purpose of the interview is to obtain the perspectives of various stakeholders involved with this grant program, thus we are asking for your best representation of relevant events and issues as well as your opinion. Please fill out the final section (Section III) on your own time and email or fax to us directly: FAX to Maryann Davis, 508 856-8700, email maryann.davis@umassmed.edu.

Date of Interview: _____

Permission to publish contact information: _____ granted ____ denied

Start time: _____ End time: _____

SECTION I

1) Please describe the grant program as it relates to services for youth with serious mental health conditions of transition age (i.e. ages 15-25):

2. When was the grant program initiated?_____
3. For how many years has it been in existence? _____

I would like to find out, from your perspective, some of the details about the grant program:

4. What is the basic purpose of this grant program?
5. What was/were the source/s of the funds for the grant program?
6. Were these funds limited to any particular age group? If yes, please describe.
7. Were these funds limited to any particular disability group (e.g. those with serious emotional disturbance, special education students, etc.)? If yes, please describe.
8. Were the services funded by this grant program limited to a population by any other criteria? If yes, please describe.
9. How much was the total grant program budget for the first year?
10. How many programs/services were those funds distributed across?
11. Was it intended as ongoing funding, seed funding, or something else?

I would like to find out, from your perspective, how this grant program came into existence.

12. In rough chronological order, what efforts lead to its development and issuance? (note approximate date of start of efforts, and involvement of other key stakeholders and their contact information).
13. Did any policies, administrative rules, or contract language need to be changed in order to develop this grant program?
14. How was funding established?

15. How did the services identified in the grant program become a focus for this funding stream?
16. What role did family or consumer advocacy groups or individuals play in the establishment of this grant program?
17. What role did leadership play in developing this grant program?
18. Were there any barriers within child or adult mental health that made the grant program a challenge to develop? *If so, what were they?*
19. How were those barriers addressed?
20. Were there factors within child or adult mental health that facilitated the development of this grant program? *If yes, please describe*.
21. Were there barriers within other state/local agencies that were encountered to the development of this grant program? *If yes, please describe.*
22. How were those barriers addressed?
23. Were there factors within other state/local agencies that facilitated the development of this grant program? *If yes, please describe*.
24. Were there other barriers to developing this grant program that we have not yet discussed? *If yes, please describe.*
25. How were those barriers addressed?
26. Were there other factors facilitated the establishment of this grant program? *If yes, please describe.*
27. Once the grant program was issued and funded, what efforts have been necessary to maintain its funding and scope of services?
28. Have there been barriers to the grant program's maintenance (within MH, other agencies, local agencies, other factors)? *If yes, please describe.*
29. How have these barriers been addressed?
30. Is there anything else that is important to understanding the *establishment* of this grant program?
31. Is there anything else that is important to understanding the *maintenance* of this grant program?

SECTION II

Please tell me about your agency and grant program.

What is the name of the agency that issued the grant program?_____

Is your grant program administratively housed within a larger agency? __ Yes ___ No

If **Yes**, what is the name of that agency?_____