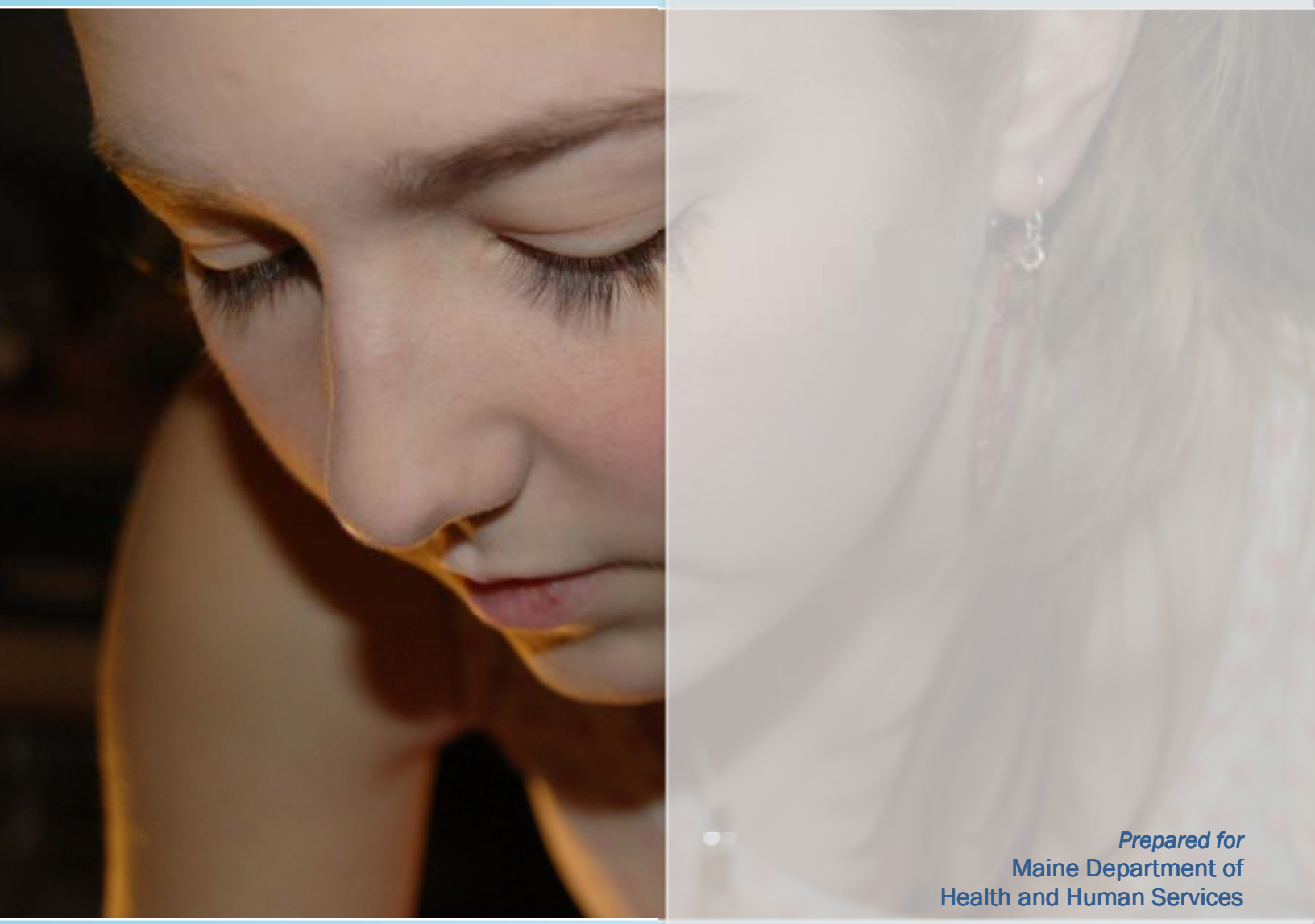
MOVING FORWARD

Final Evaluation Report



Prepared for
Maine Department of
Health and Human Services

by
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Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives
Paul R. LePage, Governor Mary C. Mayhew, Commissioner

December 2015

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Contents

Chapter 1. Overview of *Moving Forward*

National Perspective

From the adolescent years to the late 20s youth typically remain dependent upon their families of origin for numerous purposes even as they are transitioning to adulthood (Settersten and Ray, 2010). There is a general consensus that the time frame to transition has become elongated over the past 20 years. Research shows that today it takes longer than it did in the past to complete tasks that are integral to reaching full adulthood, including educational completion, financial independence, the establishment of stable housing, and gaining independence from parents (Arnett, 2007).

Youth and young adults who have spent years in the mental health, juvenile justice, or foster care systems face even greater challenges. Often homeless, disconnected from their families of origin, and perhaps having experienced significant trauma, they lack adequate and appropriate supports to help them navigate a safe and healthy path to adulthood. With little family support available during this critical period of development, vulnerable youth are often left to themselves to learn the custodial and non-custodial systems upon which they must rely for support and safety (Osgood, Foster, & Courtney, 2010).

Further, youth require significant and continual support during the transition years to learn adult roles and responsibilities. Many families of these individuals are unable to provide the level of support necessary, often due to their own emotional or mental disturbances, poverty, and lack of resources (Gruttadaro, 2006). For youth and young adults without stable familial relationships such as those emerging from foster care, there is often little available support (Casey Family Programs, 2006). Many systems could be involved depending on the challenges for each individual including:

- Secondary educational institutions
- Mental health service agencies
- Pediatricians
- Children's case management agencies
- Juvenile justice systems
- MaineCare for children
- Substance abuse treatment providers
- Primary care physicians and other health providers including dental health
- Vocational educational programs
- Colleges or universities
- Parenting programs
- Department of Labor
- Temporary Assistance for Needy Families
- Housing authorities
- Social Security for dependents
- Social Security for disabled adults
- Criminal Justice System
- Community services for both children and adults

Each of these systems has different requirements and processes. Moreover, most encompass different age spans. Negotiating the systems for needed services is daunting as well as, sometimes, contradictory. Getting them all to develop a single system of responding to transition aged youth is unlikely.

State Perspective

In 2009, Maine's Office of Child and Family Services (OCFS), within the Department of Health and Human Services (Department), embarked on an initiative to improve successful transitions to adulthood for youth and young adults with mental health disorders who are homeless or at risk of homelessness. Supported by SAMHSA, the Healthy Transitions Initiative (HTI) occurred at two levels: first, at the state level to affect policy changes to decrease systemic barriers to successful transition; and second, at a local level to implement an evidence-supported model of case management specifically designed for this population in Androscoggin County, as well as to engage youth from a minority sub-population, Somali youth.

The federal grant required states to work towards policy changes that would create a seamless system of care for youth and young adults with mental health challenges and assure successful transition to adulthood. Of specific concern was the challenge presented when these young people age out of the children's mental health systems yet continue to need services from the adult mental health systems.

Meaningful policy change required *Moving Forward* to collaborate with a number of partners from other state agencies as well as community partners sharing similar goals. The program created an Advisory Committee which met monthly or semi-monthly to discuss issues related to youth transition. These stakeholders included representatives from state agencies, local case management agencies, and from complementary initiatives such as Keeping Maine's Children Connected, Maine Shared Youth Vision, Youth Move Maine, and the THRIVE Initiative. Individual youth and family representatives were also present for these discussions.

Local Perspective

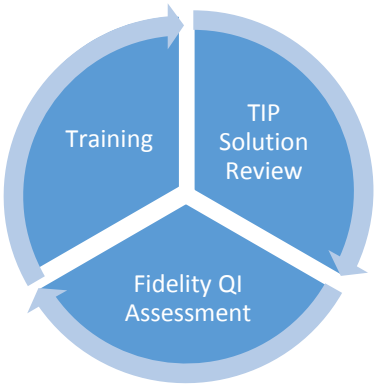
Moving Forward selected the Transition to Independence (TIP) model of case management to use with the young people transitioning to adulthood, and supplemented it with two enhancements: flexible funding and youth peer support. The initiative trained case managers from agencies in Androscoggin County willing to participate, originally, numbering three: Common Ties, New Beginnings, and Tri-County Mental Health Services. Later, Learning Works, and Health Affiliates of Maine also joined. Each participating agency maintained at least two TIP trained case managers and signed a Memorandum of Understanding (MOU) agreeing to maintain their capacity to serve youth with the model. In subsequent years, the initiative also trained agencies in other counties that were not involved with the project, but wanted to learn about the model and become "TIP-informed."

Moving Forward established a Local Workgroup to plan the local efforts, monitor implementation of the program, and to troubleshoot any areas of concern. The Local Workgroup reviewed program data regularly and made recommendations to the local management team to address areas of concern that they identified. They were especially adept in identifying resources in the community that were particularly useful to this transition age population. The Local Workgroup provided input and assistance throughout the project and in the final year took on the task of assuring no services or areas of

assistance were lost as the program shifted from the local to the statewide *Moving Forward* project.

Transition to Independence Process (TIP) Case Management

Moving Forward adopted the evidence-supported Transition to Independence Process (TIP) case management model to assist youth and young adults with mental health diagnoses to successfully transition to adulthood. Implementing the TIP model requires three on-going efforts:



- training case managers to understand the principles of the model and to learn how to implement it;
- on-going TIP Solution Review to reinforce the skills learned during the training through facilitated case review and group problem solving; and
- fidelity reviews of each agency to measure the level of support provided and identify areas that could be improved.

The TIP model provides a number of tools for case managers to work with these young people to facilitate their transition to adulthood and achieve their dreams. The model rests on a set of guiding principles that requires that the services be youth-driven, culturally competent, non-judgmental, trauma-informed, and interesting to the youth and young adults. Case managers are trained using a standardized manual; the training incorporates a significant amount of time for active learning in the use of the model tools. Regular case reviews allow the case managers to analyze real cases, how the tools were used to achieve what outcomes, and to speculate how a different tool might have worked better or how to implement in a different way to get better outcomes.

Local Program Enhancements

Moving Forward added two components to support young people receiving the TIP model of case management services in Maine in hopes of enhancing the effectiveness of the model:

- *Flexible funding* which could be used to purchase goods or services needed to fulfill the case plan once other community resources had been exhausted; and
- *Youth peer mentoring*, to provide support to the youth and young adults in the program from young people who have lived through similar experiences. Grounded in the principles of Certified Intentional Peer Support,[1] the Peer Mentor program got under way in October of 2013. All Peer Mentors participated in the state's Certified Intentional Peer Support Specialist Training.

[1] More information can be found at the following link (accessed October 1, 2015): http://www.maine.gov/dhhs/samhs/mentalhealth/wellness/intentional_peer.shtml

Purpose of This Report

The Department of Health and Human Services contracted with Hornby Zeller Associates, Inc. (HZA) to evaluate the implementation and efficacy of strategies utilized by the initiative to deliver and improve services for transition-aged youth. This final report represents the findings for the full six years of the initiative which operated from October 1, 2009 to September 30, 2015.

The report evaluates progress in meeting the initiative's objectives and the processes used to reach them. The report first presents the major evaluation questions and describes the methods by which information is collected and analyzed. The next section examines the local level service provision and infrastructure development, and also discusses state-level efforts to implement a policy to enhance transition-focused infrastructure and service delivery. The report then shifts focus to local implementation, first describing program participation, goal achievement and the characteristics of the youth and young adults served. The next section presents the outcomes of TIP involvement, looking at the gains observed among youth who received TIP services. It concludes by summarizing all these findings, sharing the lessons learned and discussing the implications for *Moving Forward* as it transitions into the next phase of its implementation.

Chapter 2. Methodology

This evaluation employs multiple research methods designed to capture both process-level information as well as client-level information. The specific questions for the process and outcomes evaluations are presented below, followed by a detailed description of each source of information collected.

Evaluation Questions

Process Evaluation

The process evaluation determines the extent to which the originally identified local service and implementation goals are met. Process evaluation relies on examination of multiple administrative documents as well as conducting of interviews. The process evaluation addresses the following questions.

- What are the characteristics of the population being served?
- Is *Moving Forward* reaching its intended population?
- What is rate of retention of youth in the program? Does retention affect outcome?
- What problems were encountered? How were they addressed?
- What components enhance goal achievement for youth/young adults? Flex funds? Peer Mentors?
- Were policies or procedures changed at the state level to support smooth transitions?
- What were enhancers and barriers to producing system change?

Outcome Evaluation

The second component to the evaluation is an outcome evaluation to measure progress towards goal achievement and client outcomes. HZA monitored client situations through baseline and follow-up interviews and tracked goal achievement through case plans. The outcomes evaluation addresses the following questions.

- Did youth/young adults achieve the stated outcomes?
- What were the immediate effects of TIP on participants, that is, did they achieve housing, employment or other goals?
- What were the longer-term effects related to job retention, housing stability, ability to seek needed services, social connectedness?
- Were any individual factors or characteristics associated with these outcomes?
- What is relationship between service duration and service intensity to client outcomes?
- Were any programmatic or contextual factors associated with the outcomes?

Data Sources and Processes

Document Review

The evaluation team reviewed meeting minutes, agenda, and other documents used by *Moving Forward*, to support meetings such as the Local Planning and Implementation Committee and TIP Solutions Review. The evaluators looked for activity and involvement through things like attendance, representation of community and youth, and State involvement. The agendas and topics that were discussed helped identify themes and shed light on accomplishments, progress and barriers encountered.

Administrative Record Review

The evaluators created an electronic data system to capture process data regarding referrals, demographics, lengths of stay in program, providers, case plan participation, and reasons for service termination. The system also maintains data on flex fund expenditures, Peer Mentor involvement, training of case managers, and meetings.

Staff Interviews

Evaluation staff interviewed case managers and their supervisors and *Moving Forward* administrative staff in the last year of the grant to elicit their thoughts about the TIP model and the administration of the program. Of specific interest was what worked well, what could be improved and ideas for making the program work better. Responses are incorporated throughout the report and help to inform the lessons learned and recommendations.

Fidelity Reviews

Moving Forward program staff conducted five fidelity reviews of three of the participating case management agencies. Of the two remaining case management agencies in *Moving Forward*, one had never received a referral for TIP model case management and the other agency significantly reduced its participation in the latter years of the grant. The results of these reviews are included in this report. The review consisted of three components which could be implemented at different times, given an area of particular concern or to consider logistics:

- *Practice implementation* gathers data from interviews with the case managers to determine how well the case managers know the youth and young adults, how well they use the TIP tools, their rationale for using those tools in particular cases, and how well they document the use of the tools and the rationale.
- *Youth/young adult focus groups* gather information directly from youth and young adults who have received TIP services about their knowledge of their own goals, use of TIP tools, to what extent goals are youth driven, whether they have found the model useful and any challenges they have identified.
- *Organizational support* compares the perspectives of case managers, supervisors, and assessors regarding the extent to which the TIP model has been implemented and sustained within the organization as well as accessibility and continuity of services.

Service Plan Analysis

Individual Service Plans (ISPs) track the case management process and can be used to evaluate progress towards goals set by the client with the assistance of his or her case manager. Often referred to as a case plan, the ISP documents the individual participant's goals and objectives. Updates of ISPs are generally required every 90 days, although some may take longer to complete.

The case plans consist entirely of narrative text. The evaluators created a system of domains and subdomains that relate to the ISP information to translate the narrative case plans into quantifiable data. The case plans were reviewed and recoded into the following TIP domain topics:

- Education
- Justice system involvement
- Employment and career
- Housing
- Physical health and wellbeing
- Mental health and wellbeing
- Parenting
- Communication
- Daily living needs and skills, and
- Community inclusion and participation.

To classify the degree of progress toward goals, evaluators reviewed case plans and coded progress using the following scale:

- Unmet: indicates a goal that has either not yet been worked on, or remains wholly unmet , and is expected to change with progress
- Problem: indicates identifiable personal, programmatic, or policy level obstacles or barriers that are a constraint to the realization of the goal
- Satisfactory: indicates the participant is making positive progress toward the objective of the goal, even when in small increments
- Complete : Indicates that this goal is reached or finalized, and
- Abandoned: indicates a personal decision to discontinue the pursuit of the goal by the participant, or a failure to reach after attempts are made.

This component of the evaluation explored the patterns of goals identified by *Moving Forward* participants, the number of goals satisfactorily pursued, the rates of completion and time to completion, and whether these indicators differed across the identified domains.

Client Interviews

Moving Forward invited each youth/young adult enrolled in the program to participate in evaluation interviews, a baseline interview within 30 days of enrolling in the program and then again every 6 months during program involvement, and lastly at program exit when feasible. The interview protocol collected program performance measures required by the Federal Transformation Accountability (TRAC) System for Children's Mental Health Services

(CMHS), supplemented with metrics that reflect the core components of the TIP model. The protocol included questions in the following areas:

- Functioning and well-being,
- Emotional and mental health,
- Substance use and abuse,
- Daily functioning,
- Living situation,
- Education and job training,
- Employment, career, and finances
- Law enforcement and criminal justice,
- Parenting,
- Social connectedness,
- Trauma history, and
- Military service.

In addition to the federally required measures, the evaluation protocol asked participants about their trauma history and trauma-related symptoms using the Lifetime Incidence of Traumatic Events (LITE) and the Trauma Symptom Checklist (TSC). Lite is a 16-item checklist reflecting a broad range of potential trauma and loss events that determine an estimate of emotional impact at both the time of occurrence and in the present. The Trauma Symptom Checklist (TSC-40) is a 40-item self-report instrument consisting of a total score within six subscales: anxiety, depression, dissociation, sexual Abuse Trauma Index, sexual problems, and sleep disturbance.

The follow-up and exit interviews contained the same information for the period preceding their interviews, allowing the evaluators to capture change in the perception of wellbeing and other dynamic results. Evaluators compared the indicators for each TIP domain and the trauma-related symptoms at intake and at six months to determine whether participants exhibit changes in outcomes and symptoms after TIP enrollment.

Chapter 3. Implementing *Moving Forward*

Moving Forward operated from 2009 to 2015. This section describes the implementation of the various components of the program during the full duration of the grant, starting with the state policy development and then moving into the local infrastructure which includes TIP training and developing youth peer supports. It concludes with a description of the community engagement efforts.

State Policy Development

The federal Healthy Transitions Initiative (HTI) Grant required states to implement policy change to address the needs of transition-aged youth. Meaningful policy change would require *Moving Forward* to collaborate with a number of partners both within government administration and with separate initiatives with common and similar goals; policies in need of change were to be identified, and actions taken to change them. *Moving Forward* addressed this requirement by creating a State Policy Advisory Committee comprised of key stakeholders, which met bi-monthly to discuss issues related to youth transition. Members included State-level (decision-making) staff, youth and young adults, consumers of mental health services, case management-providing agencies, and *Moving Forward* staff.

Initially, the Advisory Committee agreed to focus on incorporating provisions for youth transition services into the state's new managed care system. However, in 2011 the Commissioner and Governor decided to discontinue the managed care plan and pursue a different direction for funding Medicaid services. After this decision, the Advisory Committee began in-depth review of existing policies affecting transition aged youth and young adults across all relevant state agencies. The initiative hired a part-time staff person to conduct this policy review, determine which policies needed to be addressed to improve transition for youth and young adults, and lead the effort for affecting policy change in these areas.

The State Policy Advisory Committee drafted a comprehensive policy statement directing all state offices to implement an effective transition planning process with youth and young adults, ages 14 to 26 who are entering, exiting, or navigating state service systems (see Appendix A for the draft). After being reviewed and endorsed by executive management from the Office of Child and Family Services (OCFS), the policy review and draft statement were forwarded to the DHHS Commissioner in early 2013. Subsequently, the Department converted the policy statement to a Memorandum of Understanding, with the intent of gaining signatures from the Commissioners of all the state agencies providing services to transition age youth.

By the conclusion of the final year, the MOU remains unsigned by the DHHS Commissioner's office. Two factors complicated the initiative's efforts in pushing the policy work ahead. First, in the summer preceding the fourth year, the Office of Child and Family Services underwent a major reorganization which integrated Children's Behavioral Health Services (the area overseeing the initiative at the state level) into a newly formed Division of Community Partnerships. The state did not decide where the initiative fit into this new structure until January 2013. Simultaneously, the statewide director of the initiative resigned and the state

designated existing staff to fill that role, leaving the policy submitted but lacking someone designated to follow up and promote it.

Local Level Implementation

TIP Case Management

During the early years of the grant, *Moving Forward*'s Operations Coordinator became Maine's first certified trainer in the TIP case management model and, to this date, remains the only trainer in Maine. By having a certified trainer, *Moving Forward* was able to continuously train case managers and other staff in the model, which helped the initiative to overcome staff turnover within the collaborating agencies. Throughout the grant period the Operations Coordinator trained 62 case managers from the agencies participating in *Moving Forward*. Twenty others (including supervisors, administrative staff and case managers from other agencies) participated in the TIP training either to appropriately supervise or otherwise support case managers or to learn more about the model. On average, *Moving Forward* exceeded its annual goal of training ten case managers each year.

The original training was designed to take five days to complete. This allowed time for case managers to try out the new tools they were learning. The training was shortened to accommodate busy schedules resulting in the elimination of some of the practice time, which is critical to learning a new skill. Case managers appreciated learning the tools of the TIP model and liked having the techniques named. Role-playing provided good learning opportunities, but all those interviewed recognized they could not become proficient in the use of the model in one single three to five day training. Once case managers were actually on the job they could see situations as they played out and could better see how the tools could be used effectively.

To reinforce the skills learned during the initial training, *Moving Forward* facilitated monthly case reviews, called TIP Solution Reviews, which were open to all case managers in the program, and their supervisors. At each meeting one or two case managers presented a case, describing the young person's situation and how the case manager used the TIP tools to help the young person achieve his or her goals. Often, the case manager selected a challenging case to solicit advice on how to proceed or identify resources that could be helpful. During the grant period *Moving Forward* conducted forty-four (44) TIP Solution Review meetings with an average attendance of over six (6.3) case managers at each, and 13 attending at least one review per quarter, thus exceeding the goal of averaging ten case managers attending per quarter.

Although most case managers found the TIP Solution Reviews valuable, they said that the review of only one or two cases per month was insufficient to broaden their knowledge and understanding of how best to use the TIP tools. They did profit from gaining a broader understanding of resources available in the community to address specific types of issues and developmental goals. Thus, the reviews helped participants learn about local resources, but more emphasis on the tools might have improved their skill development.

Fidelity Reviews

In addition to training the TIP Solution Reviews, Fidelity Quality Improvement Assessment comprises the third component of the TIP model of case management. All of the agency reviews found the case managers knew the young people well and understood their strengths, goals, challenges and risk behaviors. They also had substantial knowledge of community resources and frequently helped young people connect with those resources. Case managers also used problem solving and preparation planning to help youth work towards their goals, and supported youth decisions even when they (the case manager) did not agree.

The challenges centered on the use and documentation of the TIP tools themselves, and agency-level commitment to the model through supervision and review opportunities. Although the agencies generally supported the idea of case managers using the TIP model to work with youth and young adults, they did not seem to be actively engaged in helping staff to make the best use of the model. Record reviews found that the TIP language was rarely included in the charts, and when found, was vague and not easily located within the charts. Case managers reported little assistance in documenting the use of TIP tools in client records and could list only one tool that they used, adding that they "use it without writing it down." The tools were infrequently followed up in subsequent meetings to determine the outcome or how well it worked.

Similarly, monthly clinical supervision received by case managers at their agencies was often general, not based on the TIP model although TIP trained supervisors consulted with non-trained supervisors to assist with incorporation of the TIP model. One agency did provide TIP specific supervision for almost three years (that is, separate for general supervision) but that stopped when a particular supervisor left the agency. Thus, the only consistent TIP-specific supervision available to case managers was the monthly TIP Solution Review meetings; however, not all TIP case managers could attend every meeting.

The practices described above undermined the point of using TIP tools to help youth/young adults express their own goals and use the tools independently. Indeed, the youth and young adults who participated in the fidelity review process expressed concerns about case managers who seemed to have their own agenda rather than being driven by the youth. They spoke about how case managers needed to better listen to the youth/young adults, and that youth voice was missing. Youth/young adults expressed many concerns about case managers' lack of time to spend with them, being rushed, having a heavy caseload, needing to be more resourceful and having high staff turnover. This is not to say the young people did not share positive experiences; indeed, they often said case managers were helpful, knew about community resources, made them feel safe and supported their goals.

While feedback was provided to each agency, the time remaining on the grant and the limited leverage associated with an MOU provided little opportunity to implement and monitor any improvement plans.

Peer Mentoring Support

Non-professional support has been shown in other communities to be valuable when delivered by individuals with like experience (Mead & McNeil, 2005). *Moving Forward* expected to enhance TIP delivery by engaging young adults in multiple aspects of the initiative. Early in the life of the grant, the initiative attempted to hire Peer Mentors, although finding people who met the stringent qualifications of the role proved challenging. Moreover, partner agencies pushed back on the idea of having Peer Mentors physically stationed on their premises or participating on a youth/young adult's treatment team. *Moving Forward* next reached out to Youth M.O.V.E. Maine (YMM), the state level chapter of the Youth M.O.V.E National organization to provide the Peer Mentoring service. Ultimately, however, this collaboration proved unsuccessful and the initiative decided directly to hire two Peer Mentors as staff.

The Peer Mentors began serving youth in October of 2013. Training of the Peer Mentors emphasized the importance of the young person's choice in the creation and maintenance of the relationship and was informed by a successful adult consumer model currently in use in Maine. Meetings could comprise a short telephone call to follow up with a particular issue or three hours with a young person at court or the doctor's office.

Throughout the life of the project, a total of 53 young people participated in 948 meetings with a Peer Mentor for a total of 842 hours, an average of 18 meetings per young person with an average of 0.9 hours per meeting. Some of the youth and young adults found the ongoing meetings, support, and assistance in working through issues very helpful in reaching their own goals, while others believed that the Peer Mentors became just another person to coordinate into their everyday lives.

The Peer Mentors also coordinated 35 different workshops while they were with *Moving Forward*. Although seven workshops were cancelled because of a lack of attendance, most were rescheduled at a later date. Attendance at workshops ranged from a low of one to a high of 23, although the average was about four young people. Topics ranged from cooking with ramen noodles, art projects, knowing your rights, accessing housing, healthy relationships, and drop-ins at the park for ice cream and conversation.

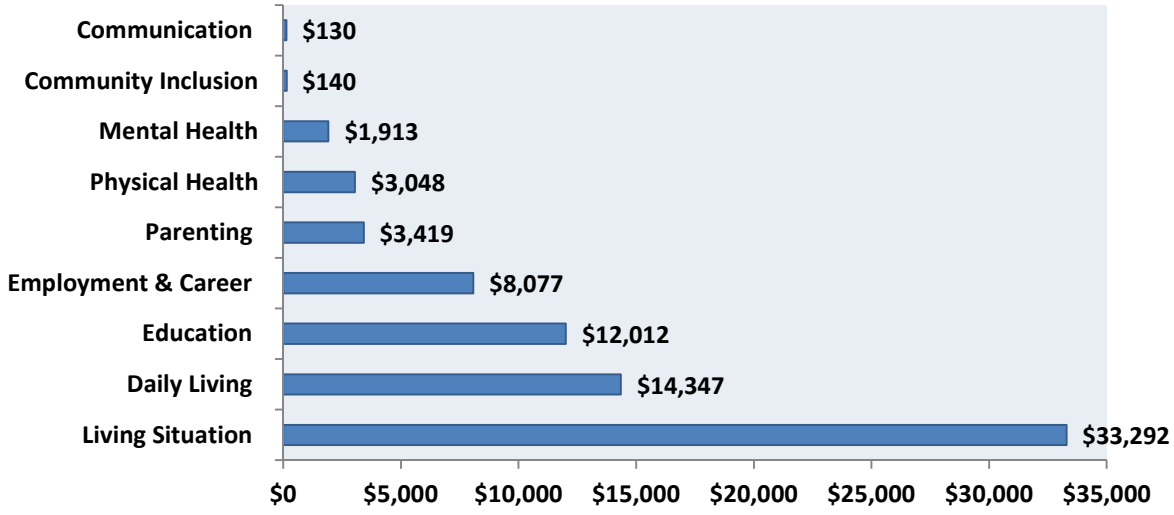
Several conditions were needed for workshops to be successful. For young people to acquire useful living skills, the youth community resource coordinator needed time to become acquainted with young people and community to learn what people want, best ways to deliver, and availability of community resources. Young people embarking on adulthood do not have natural places to gather. Children gather at school, and, once in the employment market adults have their places of work. Peer Mentors struggled to find appropriate places to hold workshops that were within easy traveling distance and where the young adults felt comfortable. These factors affected attendance rates at the workgroups.

Flexible Funds

Since its inception, *Moving Forward* fulfilled 363 separate flexible spending requests for 95 youth to help them to achieve their treatment goals, for a total of $76,379. Youth requested

flex funds for a variety of items and services, when other resources were not available and the identified need was directly related to a youth's treatment goals. The TIP model of case management categorizes each young person's goals into life areas called domains. Case plans developed with the young people focus on the young person's goals in these areas. Figure 1 shows the flexible funding expenditures, by TIP domain.

Figure 1. Flexible funding expenditures, by TIP domain



The most predominant use of the flex funds, more than double the amount of any other category, was to help young people to support their living situation goals ($33,292), that is, to move into their own apartments or maintain them. Security deposits and or first month rent enabled the young people to move into an apartment (funds were not approved if the young person was not able to show how next month's rent was going to be paid). Other living situation expenses included unpaid utility bills, heating fuel, cleaning supplies, trash removal, storage, and furniture. The second most frequently supported domain was daily living goals ($14,347) which sustained items such as seasonal clothing, hygiene and personal care and transportation. This was followed by education goals ($12,012) and employment goals ($8,077). Those categories included transportation to and from a job or class, appropriate clothing (e.g., uniforms), fees, books and supplies, as well as identification which is often required to register for classes or apply for work. Note that the types of expenditures are associated with more than one type of goal category, depending on what each individual youth needs to reach his or her goals.

Case managers observed that flex funds frequently enabled young people to acquire goods and services often not funded by the usual community resources, such as food banks, clothes closets, General Assistance, or local community projects. For many accessing flex funds assured attainment of their treatment goals. However, the case managers also observed that they could be an "easy" way to acquire necessary items for the young people rather than scour the community looking for them. In some cases young people looked to the flex funds as an additional component to the program with an expectation that they would get a certain amount of funds every year.

Engaging Somali Youth

Moving Forward operated in Androscoggin County, which has one of the largest refugee communities in Maine with over 1,000 Somalian refugees, many of whom have experienced war-related trauma prior to arriving in Maine. The initiative planned to engage youth members of the local Somali community in its training and outreach efforts. The staff explored ways to engage the Somali Refugee community in Lewiston by reaching out to one of the new partnering agencies who served Somali youth to learn more about their needs and their culture. One of these efforts included inviting the case management agency to review the TIP model and the evaluation interviews for cultural competency.

After this review, the case managers believed the TIP model of case management should be offered to those Somali youth with interest in participating, and two case managers involved in the focus group were trained in the TIP model. Moreover, they did not believe the interview questions should be altered in any way.

Ultimately, four young women between the ages of 16 and 20 received TIP case management services under *Moving Forward*. They were all at risk of homelessness or were homeless and struggled to manage their mental health challenges. Education was an important goal for each of these young women and three of the four had already received their high school diplomas at the end of the program; the fourth was continuing her high school education.

In addition, the Peer Mentors at *Moving Forward* collaborated with local community organizations to develop workgroups of interest to the youth and young adults while learning important life skills. Many of these local organizations work closely with the Somali community in Lewiston including Youth Move Maine, Tree Street Youth, and Maine Immigrant and Refugee Services (MIRS) at the B-Street Clinic. The increased collaboration between these organizations fostered a better understanding of the Somali community as well as aided in creating trusting relationships with the youth.

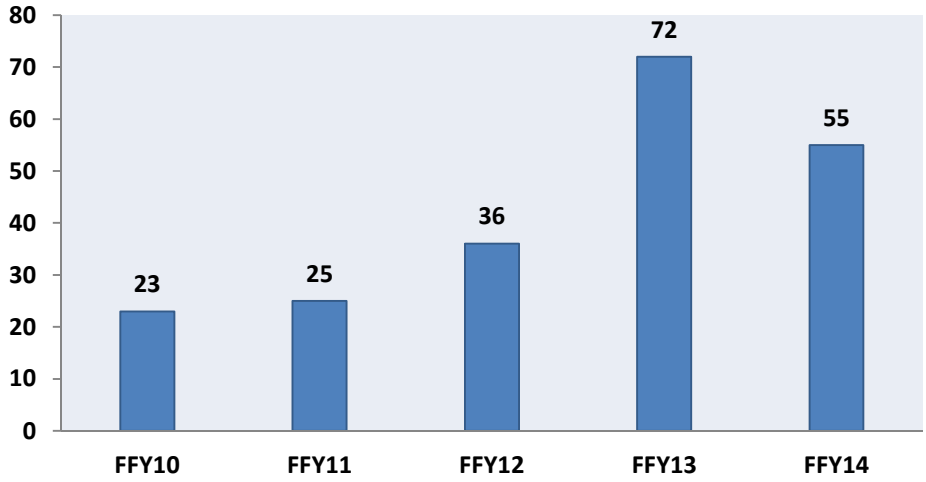
Chapter 4. Youth and Young Adults Served

Youth between the ages of 16 and 25 were eligible to receive services from *Moving Forward* if they lived in Androscoggin County, were homeless or at risk of homelessness, experienced mental health challenges, and were eligible for MaineCare (Maine's Medicaid program). This section presents a summary of the program referrals and participation. It also compares those referrals who did not engage with services to those who did, to better understand trends in program participation and inform future efforts.

Program Referrals

Between April 1, 2010 and September 30, 2014 *Moving Forward* received 211 referrals involving 195 different youth and young adults (some were referred more than once). Figure 2 shows the referrals by each year of operation, with the greatest number received in the fourth year.

Figure 2. Number of referrals to Moving Forward, by grant year (N = 211)



Oftentimes referrals came from the agencies providing case management using the TIP model, although referrals could be submitted by anyone including the young person him or herself. Most referrals came from the participating partner agencies and could represent existing clients who were starting TIP, or new clients who were just beginning to receive services. Common Ties and Health Affiliates referred 28 percent and 27 percent of all youth and young adults, respectively, while 15 percent came from New Beginnings and another 14 percent from Tri-County Mental Health Services. Eight percent of referrals were self-referrals and the remainder came from other community sources.

Program Participation

Not all referrals to the program participated in TIP case management services through *Moving Forward*, however. Of the 211 referrals, 17 were found to be ineligible (e.g., moved

from area, incarcerated) and are not included in any further discussions (Table 1). Some youth were referred and/or opened multiple times; when their records were unduplicated, 19 referral records were removed.[2] In total, 175 youth and young adults were opened to receive TIP case management services from the *Moving Forward* program and agreed to share information. At the end of the grant, 27 youth and young adults remained active clients continuing to receive case management services through *Moving Forward*, while 111 had been discharged after receiving services for more than 90 days. Thirty-seven youth and young adults are listed as "did not engage" which means they participated in the program for less than 90 days and were therefore not considered to have received TIP services.

Table 1. Youth Referred, Opened and Served

	Number
Referrals	**211**
Duplicate referrals	19
Inappropriate referrals	17
Did not consent	3
Youth Opened to TIP	**175**
Did not engage (<90 days)	37
Total Served (> 90 days)	**138**
Discharged	111
Active at Closing	27

The agencies overall served 79 percent of the youth who opened to TIP case management (that is, the youth were open to services for more than 90 days). The grant began with three case management agencies providing service to transition-aged youth using the TIP model. Two additional agencies joined later, although one opened only one client who was not served. As shown below, Common Ties and Health Affiliates Maine opened and served the most youth (note, the rates of youth *served* by each agency differ somewhat from the rates of youth *referred* by each agency that were cited previously).

Table 2. Youth Opened and Served, by Agency

Agency	Number Opened	Number Served	Percent of Total
Common Ties	57	47	34%
Health Affiliates Maine*	52	45	33%
Learning Works*	1	0	0%
New Beginnings	33	21	15%
Tri-County Mental Health Services	32	25	18%

**Joined after Year 3.*

[2] For these referrals, the episode of service with either a longer length of stay or the one with more comprehensive data was selected to be included and the duplicates deleted. In two instances, the duplicate records were combined into a single episode of service due to the short timeframe between discharge and re-referral.

When youth who did not engage with the program were compared to those who did, some interesting patterns emerge, as can be seen on Table 3. Notably, youth who did not engage were more likely to be male (41% to 28%), and to be served by New Beginnings (32% compared to 15%). They were also slightly more likely to have primary diagnosis of anxiety or panic disorder (16% compared to 9%) but less likely to have Post-Traumatic Stress Disorder (14% compared to 22%).

Table 3. Comparison of Youth Served and Youth Who Did Not Engage, By Selected Characteristics

Characteristic	Served (N = 138)	Did Not Engage (N = 37)
Age		
Average	18.9	18.8
Median		
Gender		
Male	28%	41%
Female	72%	59%
Agency		
Common Ties	34%	27%
Health Affiliates Maine*	33%	19%
Learning Works*	0%	3%
New Beginnings	15%	32%
Tri-County Mental Health Services	18%	19%
Primary Mental Health Diagnosis		
Depression/Depressive Disorder	32%	27%
Post-Traumatic Stress Disorder	22%	14%
Mood Disorder	12%	8%
Bipolar Disorder	8%	11%
Anxiety/Panic Disorder	9%	16%
ADHD/ADD	7%	11%
Adjustment Disorder	4%	3%
Disruptive Behavior Disorder	1%	0%
Developmental Disorder	1%	3%
Obsessive Compulsive Disorder	1%	0%
Psychotic Disorder	1%	0%
Factitious Disorder	1%	0%

**Joined after Year 3.*

Goal Attainment at Discharge

Case managers using the TIP model work with the youth and young adults to identify their dreams and set goals to achieve them. The case managers classify the goals within the transition life domains developed within the TIP model. Every three months, case managers reviewed the goals with the young people and together determined the status of reaching each goal. In some cases, they decided that a goal should be abandoned; that is, the youth lost interest in a particular goal, resources were not available, or the goal was not appropriate at that time.

Case managers ideally discharged youth and young adults from the program when they mutually agreed that the goals they had set were either abandoned or completed, and there was no further need for support. However, in some instances, case managers lost contact with a youth and they were discharged from the program without reaching their case plan goals. Looking at the youth who were discharged from the program, 109 had complete case plan records. The case plans show that youth enrolled in the program worked on a total of 904 goals for an average of just over eight goals each. Table 4 shows the number of goals youth selected to focus on while in the program for each domain area, as well as the proportion of youth working on any goals in that area. The goal attainment rate was calculated by dividing the number of goals completed by the number set.

Table 4. Number of Goals Identified and Completed by TIP Domain

TIP Domain	Number of Goals (N = 904)	Number of Youth (N = 109)	% of Youth	Completion Rate
Daily Living	243	91	83%	29%
Mental Health and Wellbeing / Emotions and Behaviors	164	90	83%	7%
Education	109	85	78%	19%
Living Situation	94	75	69%	41%
Employment and Career	97	72	66%	22%
Physical Health and Wellbeing	124	67	61%	23%
Parenting	36	26	24%	19%
Justice System Involvement	18	13	12%	28%
Community Inclusion/Participation	10	8	7%	20%
Communication	9	8	7%	22%

Most youth (83%) selected goals related to the area of daily living which included things like getting identification documents, learning to drive, developing budgeting skills, and otherwise working on skills that affect their daily lives. Twenty-nine percent of the goals in this domain were completed at the time of discharge. The second most common area that youth wanted to focus on was goals related to their mental health and well-being (83%) with a total of 164 goals. However, this domain had the lowest completion rate at seven percent. The third most frequently selected area of focus was education (78%) with a completion rate of 19 percent, followed by goals related to living situation at 69 percent. This area showed the greatest success rate with 41 percent of goals being attained by discharge.

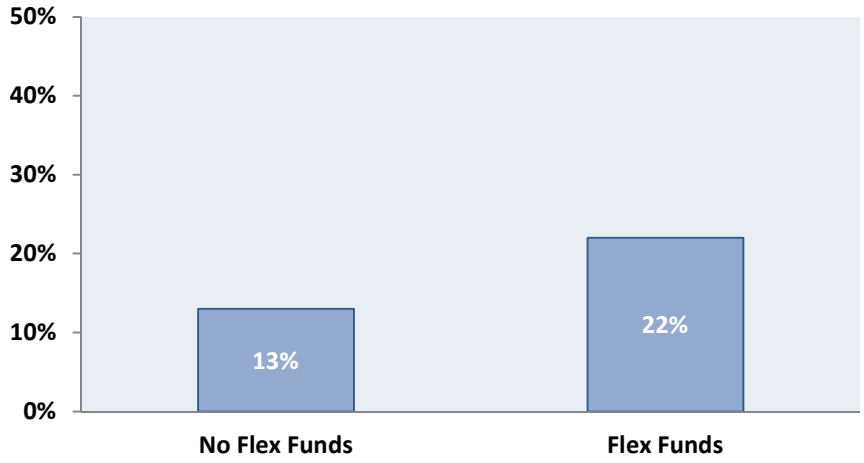
Programmatic Factors and Goal Attainment

As previously described, Moving Forward added two enhancements to its program thought to improve goal attainment: flexible funding and peer support. The next few sections examine goal attainment in relation to those program components to see if there were detectible impacts. The evaluation team also explored length of stay in relation to goal attainment to see whether the length of time a youth was involved with the program played a role in goal attainment.

Flexible Funding

The concept of flexible funding (flex funds) was built into the program under the theory that access to funding would increase the probability that youth could reach their goals when a lack of resources was a primary barrier. Just over half of the young people served by the program (61 youth) requested and received flex funds in support of their case plans at an average amount of $487.47 per youth. As shown in Figure 3, the goal attainment rate for youth and young adults who received flex funds was higher (22%) than for those young people who received no flex funds (13%).

Figure 3. Comparison of goal attainment rates by flexible fund support

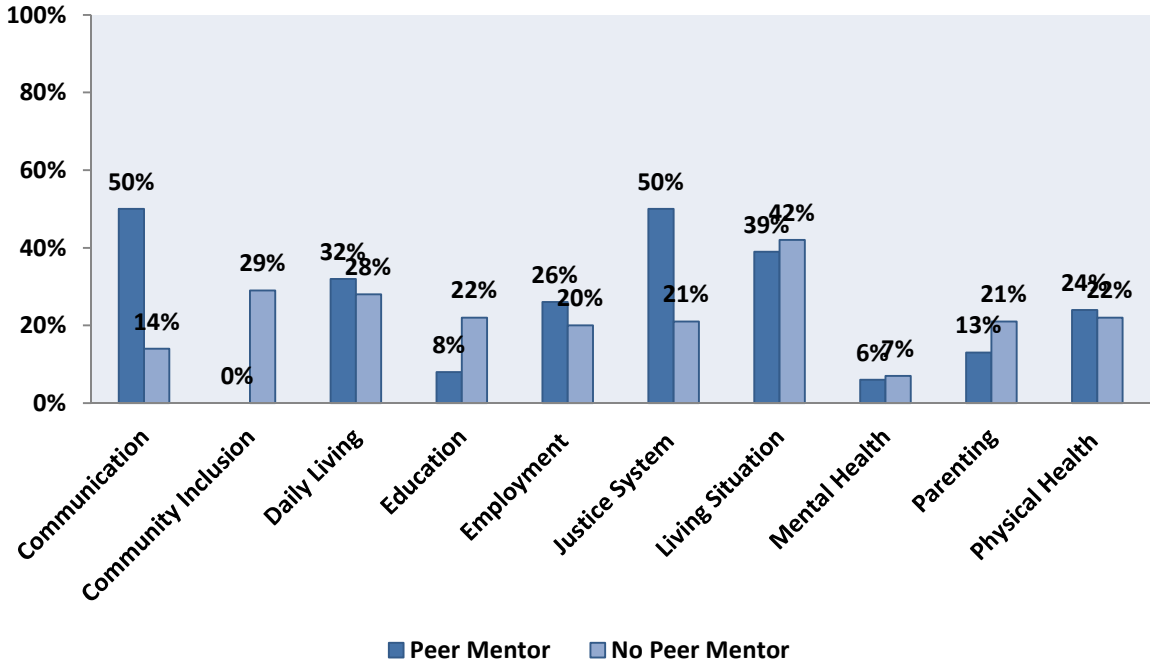


When tested for statistical significance, accessing flex funds was weakly associated with whether or not a young person was more likely to attain his or her goals. Many other factors played a role in goal attainment, such as fidelity to the treatment model, the young person's family or living situation and level of functioning, and the unique challenges facing each individual. Conversely, accessing the flex funds often relied on the case manager's willingness to ask for funds, the young person's natural resourcefulness, and whether other community services were available.

Peer Mentoring

Peer Mentors supported youth and young adults as they worked towards the goals of their case plans with their case managers. Peer Mentors met the youth and young adults at their convenience and focused on topics of their interest, strategically sharing information from their own lives whenever they felt it would be helpful. However, the rate of goal attainment for youth and young adults discharged from the program who had the support of a Peer Mentor compared to those without that support did not show any significant differences as shown in Figure 4. The two areas where the greatest differences are observed (communication and justice system involvement) relate to only a handful of youth and therefore cannot be considered representative or statistically significant.

Figure 4. Goal attainment, by peer mentor support

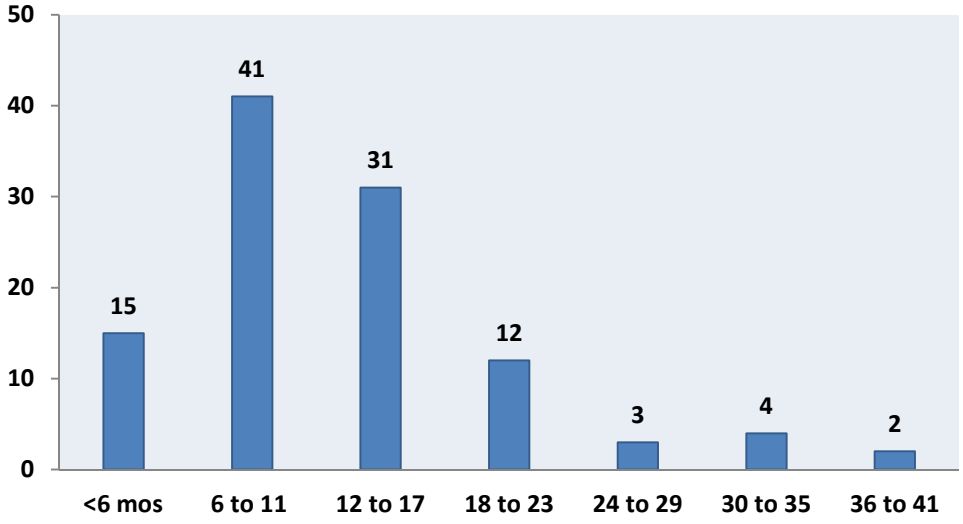


Length of Stay

All young people must deal with a multiplicity of issues in the transition to adulthood: finishing their education, seeking and pursuing careers, leaving their family homes, developing relationships with their peers, establishing their own living arrangements, coping with romantic relationships, and often beginning families of their own. Youth and young adults with mental health challenges must add the chore of managing their illnesses to this long list.

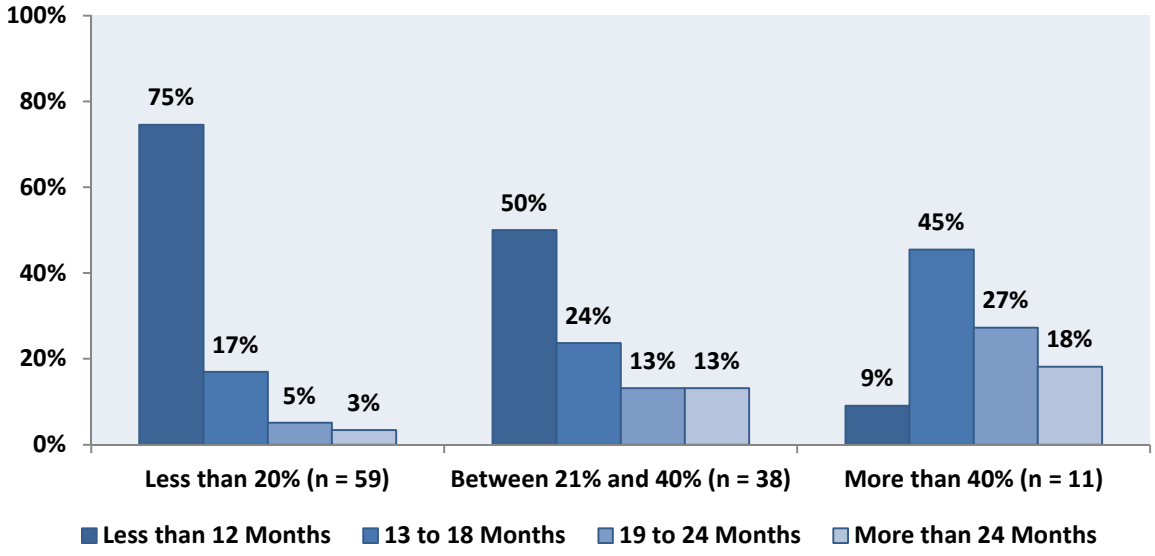
A major challenge when serving this age group is to provide the right amount of assistance for the amount of time needed to achieve a solid path to a successful adulthood. Figure 5 shows the number of youth discharged from the program by length of stay. Two-thirds of the youth stayed in the program between six and 18 months.

Figure 5. Number of youth, by length of stay in months



Overall youth involved in the program for shorter lengths of time did not achieve as many of their goals as those who participated for longer. An analysis of the correlation between the length of time and the rate of goal attainment finds a weak relationship between the two. Figure 6 below shows that youth who attained less than 20 percent of their goals were more likely to have been involved with the program for a shorter period of time (75%), compared with those who attained a greater proportion of their goals (50% and 9%, respectively). Moreover, youth engaged between one and two years yielded the greatest rates of attainment.

Figure 6. Rate of goal attainment, by length of program invovlement



Chapter 5. Observed Gains After Program Involvement

This section draws from the client level interviews which were conducted in-person at baseline and every six months for the duration of their participation in the program. The study group is comprised of youth and young adults who were eligible for the program, participated in the program for more than 90 days, and completed a baseline and at least one follow-up interview. However, as previously shown, the length of participation in the program's services varied across individuals and evaluation participation was not always consistent. Therefore, this analysis examines outcomes at three points: at baseline (n = 72), six months (n = 72) and 12 months or more, which represents information from the most recent interview conducted prior to discharge (n = 35).

Characteristics of the Outcomes Study Population

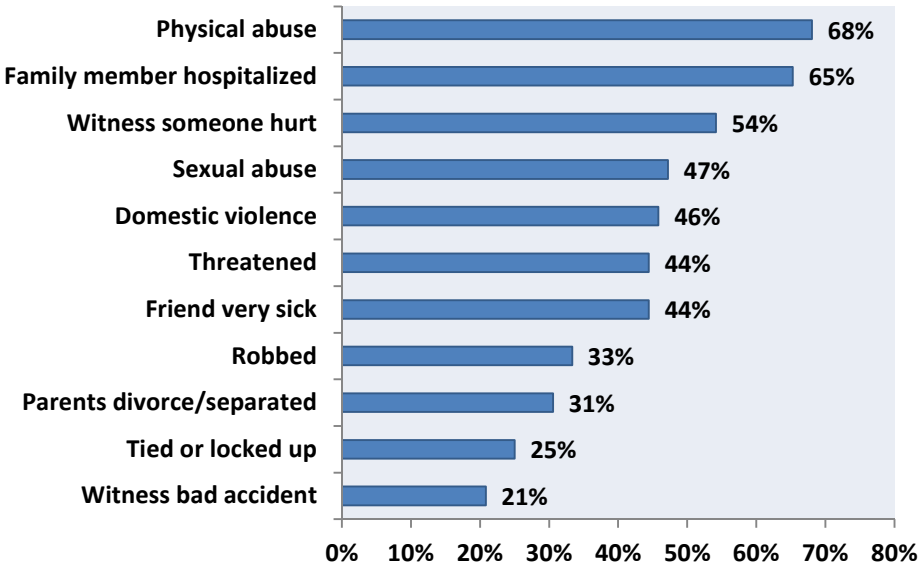
The outcomes study population represents 52 percent of all youth served. When compared to all youth served, the outcomes study sample differed little in terms of age or mental health diagnosis. They were slightly more likely to be female (76% compared to 72%), and to be served by Health Affiliates of Maine (40% compared to 33%).

Most were White, non-Hispanic (72%), eight percent were Black, non-Hispanic and 16 percent were Hispanic. Most were single (68%), 25 percent were partnering and the rest were married. Similarly, 71 percent were independent adults, followed by 19 percent who were still in custody of their parents, and seven percent who were emancipated under the age of 18. Slightly less than half (44%) reported they had at least one child when they started the program, or were expecting their first child. One-quarter had been in foster care at some point in their lives.

The most common primary mental health diagnosis was depression at 31 percent, followed by Post Traumatic Stress Disorder (PTSD) at 21 percent and mood disorders at 14 percent. Ten percent reportedly had bipolar disorder or and anxiety. Over half of the youth participating in the outcomes evaluation (56%) had more than one diagnosis.

Regardless of diagnosis, however, many of the youth included in the outcomes study had experienced a wide array of traumatic events in their lifetimes. The average number of events experienced was 5.3 (ranging from zero to 11); 82 percent had ever experienced three or more different kinds of trauma before the age of 18. Figure 7 shows the ten most frequently experienced traumatic events reported, with the most common being physical abuse (68%), closely followed by having a family member hospitalized (65%) or witnessing someone get badly hurt (54%). Forty-seven percent reported having been sexually abused before the age of 18 and 46 percent lived in a domestic violence environment.

Figure 7. Lifetime experience of traumatic events



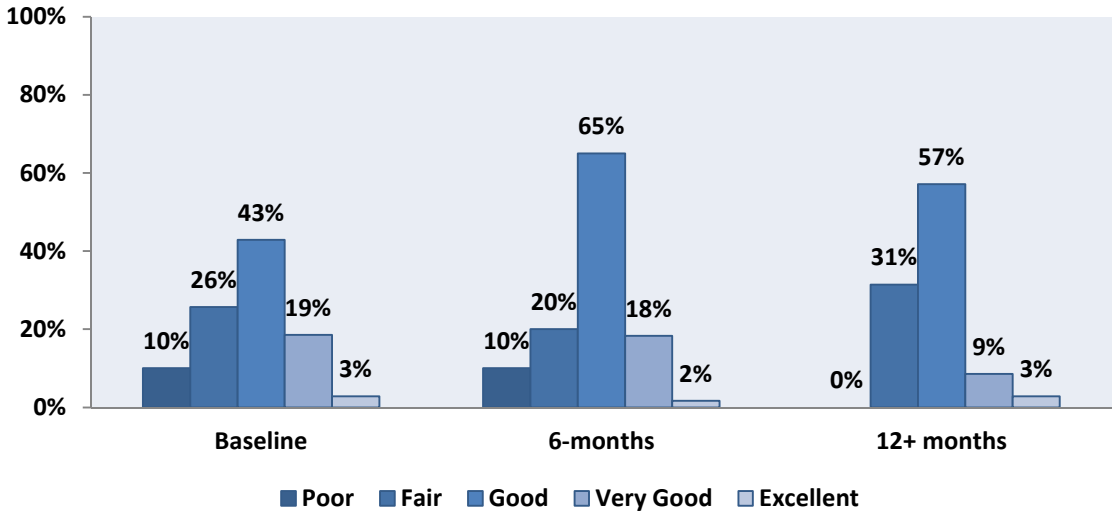
Physical Health

As young people go through their teenage years, they become responsible for seeking their own medical care. While young people of this age group do not usually need a lot of health care, those struggling with mental health may need greater amounts of health care to deal with medication issues and or somatic complaints generated by their mental health disorders.

Perception of Overall Health

At each interview, youth were asked to rate their overall health, from "poor" to "excellent." Figure 8 shows that almost two-thirds of youth (64%) believed their own health was good to excellent at baseline. This increased to 85 percent at six months, but declined after that to 69 percent. Although the numbers are small, the findings suggest that 25 percent of the youth in the program perceived an improvement in their health within six months of starting TIP case management services but that the advantage may fade sometime after the one year interval.

Figure 8. Perceived status of overall health

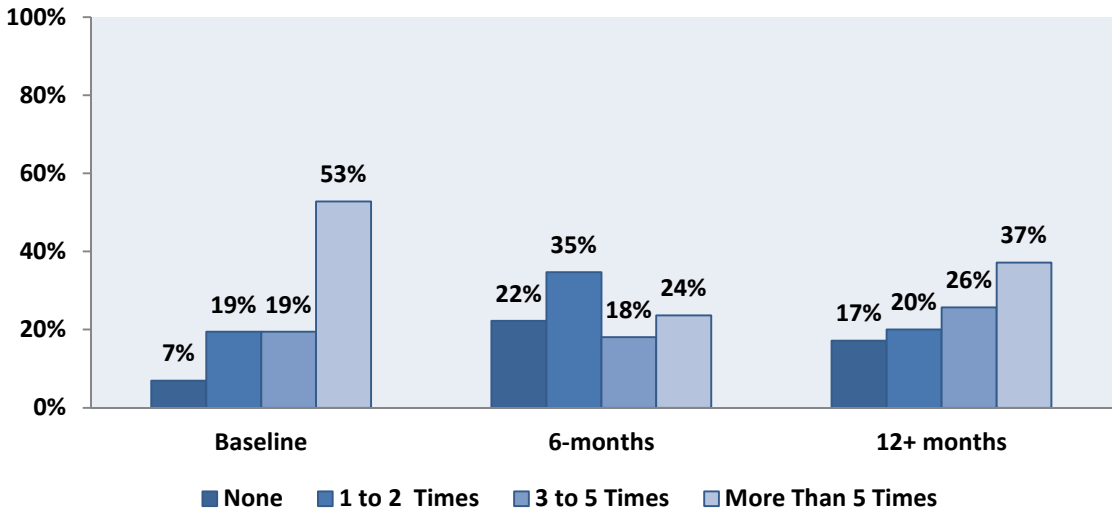


Access to Care

Most youth and young adults in the program received MaineCare benefits which covers their case management services as well as physician and dental services. This coverage assures the young people can access care whenever it is needed.

At program initiation, only seven percent of the youth had not seen a doctor in the past year, and 53 percent had seen a doctor more than five times (Figure 9) which may reflect expectant parents accessing prenatal care. At the six-month point, 22 percent of the youth had not seen a doctor during the follow-up period. After the twelve-month point, the percentage of youth not having seen a doctor in the prior six months dropped to 17 percent.

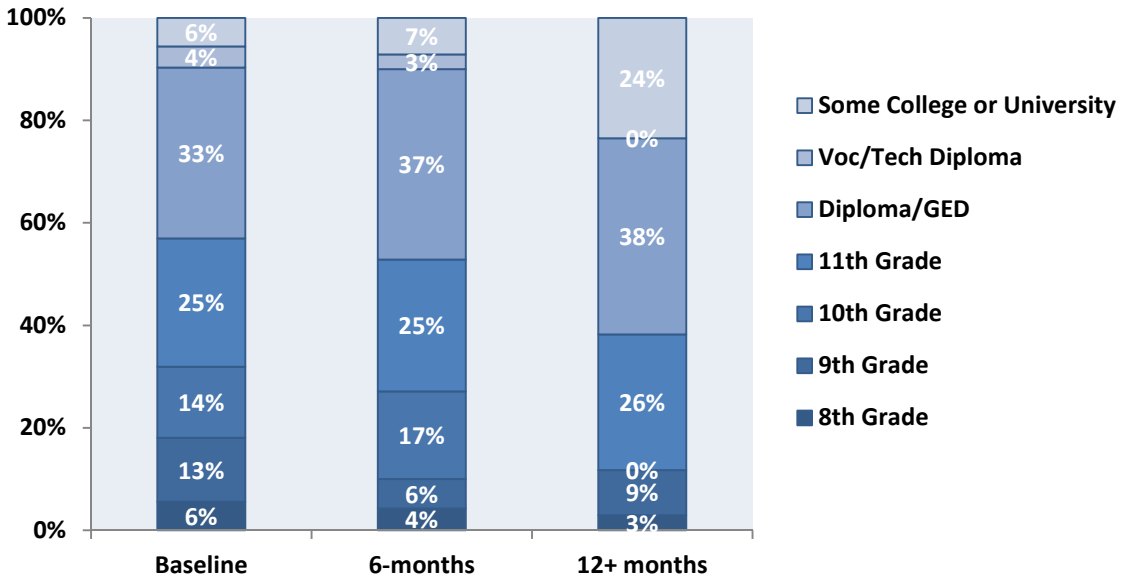
Figure 9. Number of doctor visits



Education and Employment

The youth and young adults in the program span the age range of completing school and entering the labor market. Often youth in this age group will begin with some type of part time employment while attending school. At the start of the program, 33 percent reported that their highest level of education was a high school diploma or GED. As shown in Figure 10, program participants showed a modest progression through high school, and high school completion; among the group whose final discharge occurred after one year or more, there was a clear continuation to postsecondary education. Similarly, the case plan analysis revealed that while education was a goal for 78 percent of youth, only 19 percent successfully attained those goals before discharge, which makes it difficult to discern the extent to which the program versus natural progression accounts for these improvements.

Figure 10. Highest education level



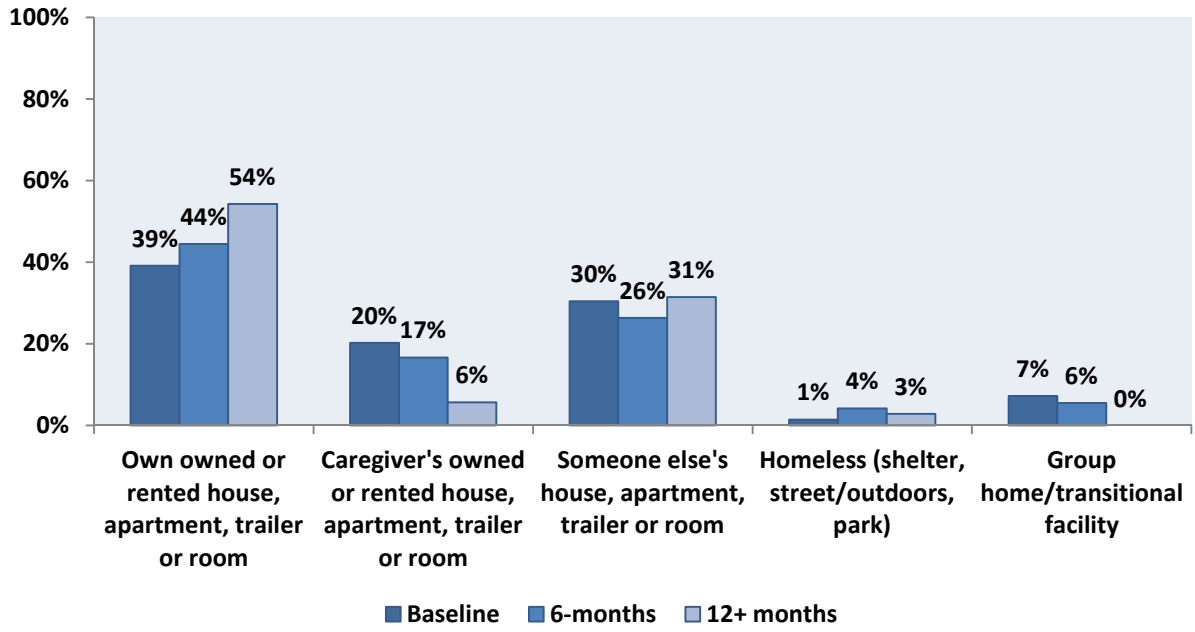
Unlike education, employment rates were flat over a 12-month period, with 21 percent of youth being employed (full or part time) at intake, 22 percent at six months, and 21 percent employed after one year or longer. That is not to say that youth did not gain and lose employment in between these six month intervals; however, it does suggest that employment gains were not as easily observable as education-related outcomes.

Living Situation

Between the ages of 18 and 26, youth/young adults move away from their parental homes and toward independent living, either living alone or with their own families. As show in Figure 11, 39 percent of the youth and young adults were living in their own homes at baseline; that is, they were no longer living with parents or other caregivers. Twenty percent were living with their caregiver, and 30 percent were living with someone else. Just over one percent of participating youth/young adults were homeless. After six months, 44 percent

appear to have moved into their own living space, which increased to 54 percent after 12 months. Recall as well that 69 percent of young people had goals about improving their living situations, and 41 percent attained those goals; moreover, the greatest portion of flex funds were spent to help young people secure improved living situations. These points combined suggest that *Moving Forward* was successful in helping young people acquire a stable and independent living situation.

Figure 11. Current living situation

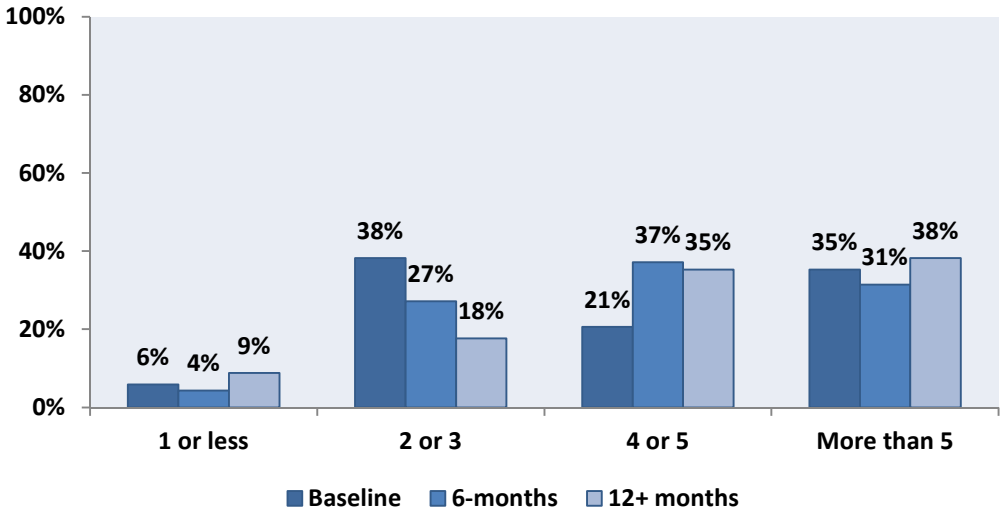


Social Connections and Support

People of any age rely on their friends and family to deal with life's challenges, both big and small. At the baseline interview the youth and young adults are asked how many positive, supportive people they have in their lives. Every six months thereafter they are asked the same question, to see if the number has grown.

Figure 12 shows that many of the youth and young adults were able to identify numerous positive, supportive people in their lives. After being involved in the program, it appears that many young people reported having more positive, supportive people in their lives. In particular, the proportion of young people who had two or three supportive people declined (from 38% at baseline to 27% after six months) while those reporting having four or five increased (from 21% to 37% after six months). Those trends continued at 12 or more months. This suggests that the program helped young people to identify and engage their natural supports.

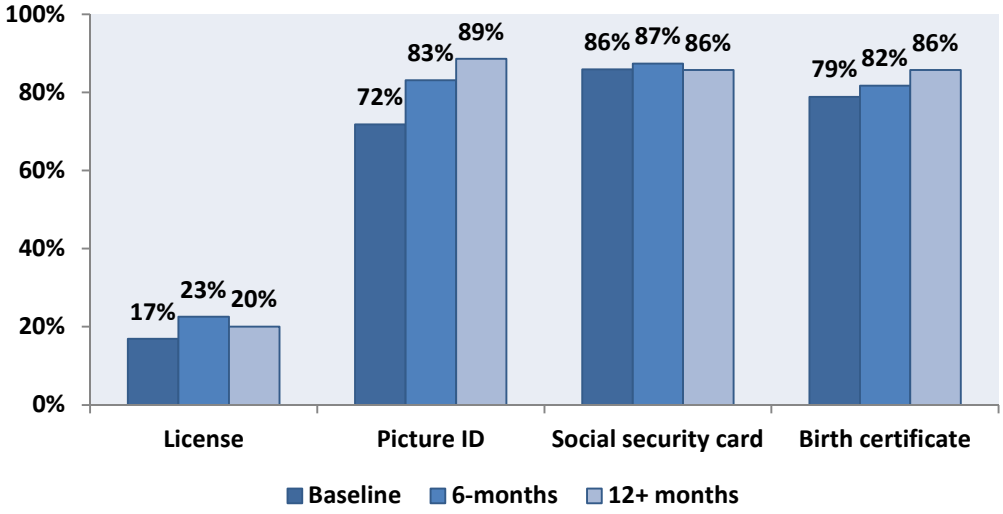
Figure 12. Number of positive, supportive people



Social Preparation

Independence can also be measured through achievements such as attainment of drivers' licenses, birth certificates, government issued photo IDs and social security cards. Progress and achievement in these goals is often a stepping stone towards achieving other long-term goals. Figure 13 illustrates an overall increase in completion of social participation requirements for youth and young adults engaged with the program. For example, 72 percent of youth at baseline had picture identification, which increased to 83 percent within the first six months.

Figure 13. Social participation and prepartion



Arrests

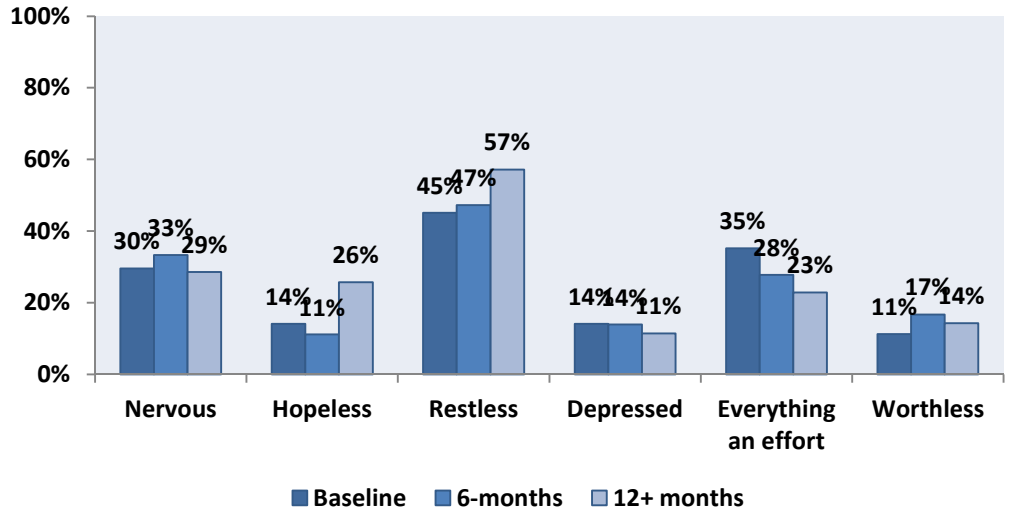
Of the program participants, 42 percent reported at the start of program participation that they had been arrested at least once in their lifetimes. At the first follow-up, 13 percent reported being arrested in the prior six months. Of those enrolled for 12 months or longer, nine percent reported being arrested in the past six months prior to discharge. Since the first figure represents lifetime arrests it is difficult to interpret whether the changes were significant. However, only a handful of youth identified goals related to justice system involvement in their case plans (12%) with limited success, so it is unlikely that the program impacted these outcomes.

Mental Health and Well-being

Emotional Well-being

At each interview point, youth are asked how often in the past month they have felt nervous, hopeless, restless or fidgety, depressed, that everything was an effort or worthless. Figure 14 shows the proportion who responded all or more of the time at each interview point. The most notable change can be observed in the perception that everything was an effort, which decreased from 35 percent at baseline to 28 percent after six months. The other areas changed little, or even increased for those who remained with the program for 12 months or longer. Goals related to mental health and well-being/emotions and behaviors were the second most common goals identified by youth enrolled in the program (83%), and the least likely to be considered "complete" at the time of discharge (7%). To some degree, these mixed results are to be expected since maintaining mental and emotional health poses lifelong challenges compared to other outcome areas that are more concrete, such as educational attainment or housing. It is also worth noting that over this time period, a handful of young people turned 21 and lost access to MaineCare; although two agencies continued to provide TIP case management services free of charge, this lack of insurance impacted their ability to access other formal treatment services.

Figure 14. Emotional well-being (all or most of the time)

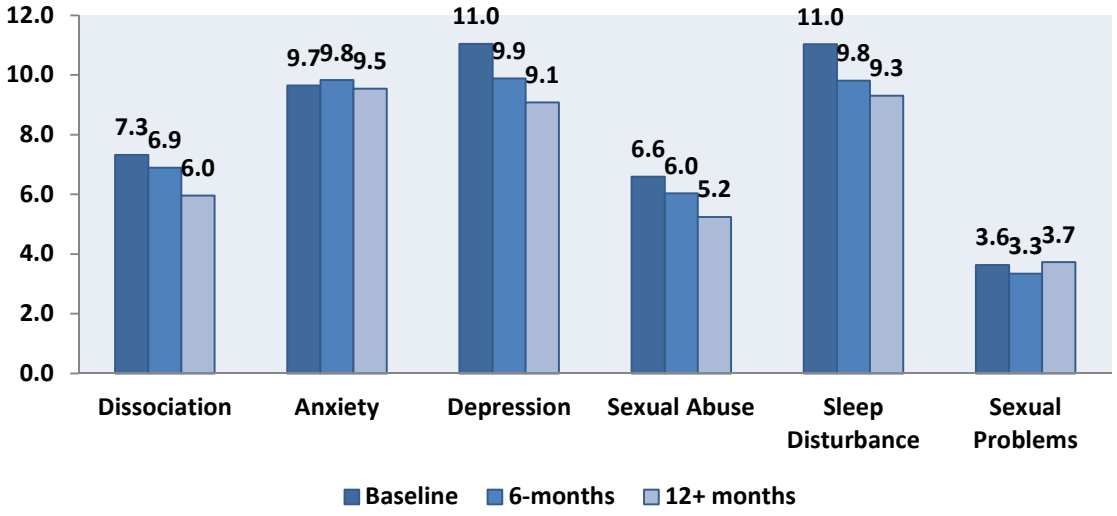


Trauma Symptoms

Every young adult who is interviewed is asked a series of questions that gauge trauma-related symptoms including dissociation, anxiety, depression, sexual abuse trauma, sleep disturbance and sexual problems. For each category, the responses on particular items are averaged and higher scores indicate a greater extent of reported symptoms in that area; the scores in each should not be compared to one another. Figure 15 shows the average scores over time for each group of trauma-related symptoms.

Generally, program participants showed the greatest degree of symptoms related to sleep disturbance, depression and anxiety. After program involvement, many youth reported that their symptoms decreased with the exception of anxiety and sexual problems (which was low to begin with). This suggests that the supports provided by the program helped to ameliorate symptoms related to trauma for many of the young people served.

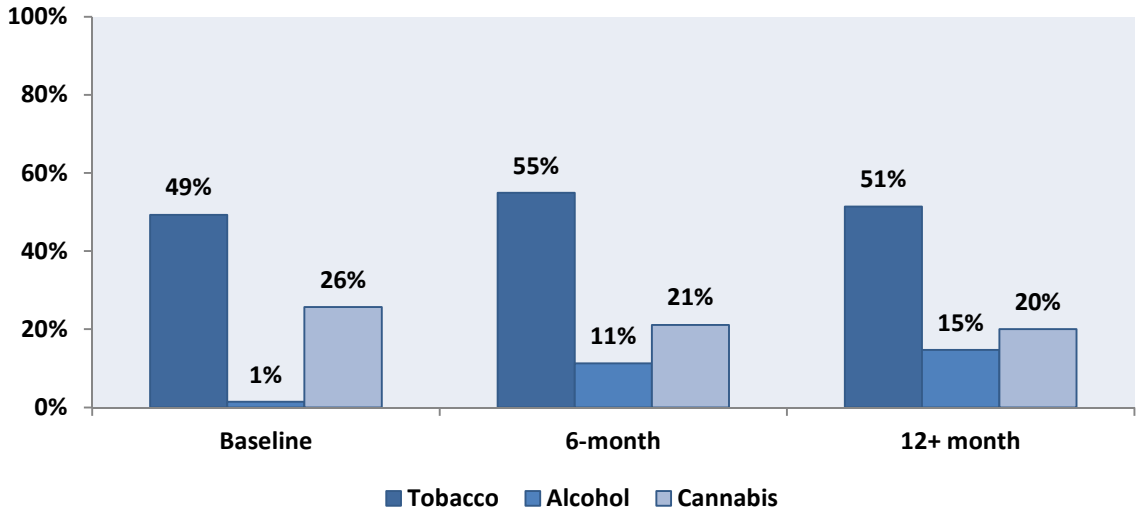
Figure 15. Trauma-related symptoms



Substance Use

Substance use and abuse is another area of interest for transition-aged youth. Figure 16 depicts self-reported "regular" substance use, defined as daily and weekly "regular" use. While few reported using alcohol at the start of program participation, 26 percent reported regular use of marijuana and almost half (49%) reported using tobacco. Alcohol use increased over 12 months (which makes sense as young people may reach the legal age) while marijuana use appeared to decrease. Tobacco use, however, remained fairly stable.

Figure 16. Self-reported substance use



Summary of Outcomes

The outcomes analysis shows that youth who received TIP case management services and other supports as part of Moving Forward experienced mixed results. Perhaps the greatest success of the program was helping young people to improve their living situation and expanding their network of natural supports. The program also showed modest success in helping youth to reach their educational goals and access to important personal documents. However, the outcomes analysis shows little impact in the areas of improved general health, employment and mental and emotional health, although self-reported trauma symptoms did improve after program involvement.

Chapter 6. Conclusions and Implications for Future Efforts

This chapter begins with a summary of responses to the process and outcome questions and concludes with recommendations for future efforts to improve the services and supports available to transition-aged youth in the state of Maine.

Process Findings

At the state level, *Moving Forward* successfully brought together a group of state-level stakeholders to draft a high-level policy statement geared towards transition-aged youth; however, it remains unsigned. This was largely due to changes in leadership at both the lead state agency as well as within the project itself that limited the initiative's capacity to drive policy changes at the state level.

In terms of service delivery, the project trained 62 case managers from five provider agencies in the Transition to Independence (TIP) model of case management over its six-year timeframe. In turn, those agencies provided TIP services to 138 transition-aged youth. The program reached its intended population, serving youth over the age of 18 who were most likely diagnosed with depression, post-traumatic stress disorder or a mood disorder and most had experienced trauma within their lifetimes. Of interest was that females were more likely than males to engage with the program, although the reasons for this pattern are unknown.

In addition to TIP case management, the initiative also supplied flexible funding to support the treatment goals of youth receiving services, and, in the final two years of the grant, offered one-on-one peer mentoring as well as group-based informational sessions and recreational opportunities. These innovations were weakly associated with whether a youth achieved his or her treatment goals. The amount of time a youth was involved in the program was also correlated with goal attainment, with youth engaged between one and two years showing the greatest rates of success.

In the latter years of the project, fidelity reviews showed that case managers understood and applied the core concepts of the TIP model, and had a deep understanding of local community resources to which they could link participants. However, the reviews also revealed that using and documenting the TIP tools was lacking, and that evidence of the agency-level commitment to the model varied. While this feedback was provided to agencies, the MOUs provided little leverage by which to hold the agencies accountable to the model.

Outcome Findings

Most youth who engaged with TIP case management services had goals related to daily living, mental health and well-being, education, living situation and employment. Youth were most likely to complete goals related to living situation by the time they discharged from the program and the outcomes evaluation showed that more youth had secured independent living arrangements after program involvement. This area is clearly the initiative's greatest impact in terms of youth outcomes. *Moving Forward* also demonstrated modest successes

in helping youth to expand their network of natural supports and in reaching their educational goals.

The outcomes analysis shows that *Moving Forward* had less impact on the areas of general health, arrests, employment and mental and emotional health. Very few of the youth served had goals related to law enforcement, and while close to half had come into contact with the law at some point in their lifetimes, very few had contact while they were engaged in services. Thus, it is difficult to determine the extent to which the program affected arrests. While many youth identified employment goals, few achieved them and the employment rates stayed relatively flat, although it is likely that these youth were adversely affected by the economic recession. Although mental health-related goals were second only to living situation in terms of frequency, they were the least likely to have been "attained" by youth at program exit. The results from a range of self-reported mental well-being indicators were mixed, although self-reported trauma symptoms did improve after program involvement.

Recommendations

The findings from the six-year *Moving Forward Initiative* have implications for future efforts regarding transition-aged youth in Maine. Recommendations for the state of Maine to consider in its future efforts are as follows:

Identify policy change(s) early, as well as roles and responsibilities for completing the work. Policy work at a very high level proved difficult to implement. The initiative struggled initially to figure out how policy change should be accomplished, and who was responsible for seeing the proposed changes come to fruition; this was further exacerbated by leadership changes at the state and within the project itself. Future efforts should consider whether the proposed policy changes are feasible to implement in the time given and with the existing resources. One avenue to explore would be narrowing the focus to policy changes that address the specific challenges experienced by the provider agencies implementing transition services, or the needs expressed by clients enrolled in those services.

Increase the opportunities for on-going support and communication for service delivery. TIP Solutions Reviews did not provide enough support for case managers to implement the model with full fidelity; the use of tools and TIP-specific documentation were the greatest challenges. Future efforts should provide additional support for case managers, through boosters and on-going Learning Collaborative activities. Moreover, frequent communication among provider agencies and all other partners (state, peer support and evaluation) was critical to success, but often difficult to achieve. The Learning Collaborative model could be an effective platform for communicating across all these stakeholders.

Provide youth peer support separately from provider agencies. Peer support was linked to promising outcomes but took time and effort to develop and oversee; embedding peer support within an agency was unsuccessful. Future efforts spanning multiple agencies should ensure youth peer support is delivered by one organization with capacity to provide consistent training, support and oversight to all the youth peer mentors.

Use contracts rather than MOUs to secure provider agency participation. Agency commitment and accountability to the project varied and was sometimes a barrier to successful implementation. Contracts and funding for direct services ensure a greater level of commitment and accountability from partner agencies.

Use Fidelity Reviews more effectively. When fidelity reviews demonstrate that the case managers are not using the TIP tools there should be more follow up to correct the problem. If contracts rather than MOUs are employed, as recommended above, then negative reviews should lead to an analysis of the reasons the model is not being followed, plans to address the reasons, and follow-up reviews. Ultimately the contracts should not be continued if the protocols are not being followed.

Establish clear procedures for requesting and approving flexible funding. Flex funds may help with an immediate problem, but there was little correlation between the use of flex funds and the achievement of long-term goals. The disbursement of flex funds needs to follow clear procedures for requesting funds and approving requests. The procedures should consider the balance between independence (e.g., acquiring goods and services from other sources) and treatment need(s).

Incorporate gender responsivity and trauma-informed practices into TIP services. Youth entered the services with a high degree of trauma experiences; they also were often parenting and unemployed. Young men were more likely to drop out than young women. Direct service providers need to take into account these needs, as well as parenting and healthy relationships; linkages to resources that address these areas need to be nurtured.

Encourage more scrutiny of substance abuse screening and disclosure. The rate of co-occurrence of substance abuse and mental health is known to be much greater in the adult population than found in *Moving Forward*'s population. Although low self-reporting may be at play, dependency and use should not be overlooked as normal "youthful" behavior.

Appendix A: State of Maine's Draft Policy on Transition

I. Subject

Development of comprehensive state policy for youth and young adults age 14 up to age 26 to enable a seamless transition from child serving systems to adulthood.

II. Policy Statement

The Departments of Corrections, Education, Health and Human Services and Labor shall support effective transition planning for youth and young adults age 14 up to age 26 transitioning to adulthood. Effective transitions to a healthy adulthood will improve the quality of life for these individuals; increase access to educational and employment opportunities thereby diminishing the risk of chronic homelessness, incarcerations and/or hospitalizations throughout adulthood, and will be cost effective by lessening the need for intensive level of services from the state adult services Departments.

III. Guiding Principles:

Guiding Principles:

This Transition Planning Policy directs the co-signatories of this document to ensure that:

practice guidelines be developed in their respective offices so that meaningful transition planning occur for all youth and young adults served beginning at age 14 up to age 26;

the respective offices affected by this policy work together toward streamlining a meaningful transition planning process creating any written binding agreements that may be necessary to achieve the policy's intended purpose;

a uniform transition planning document be created and utilized by all relevant offices affected by this policy;

the transition planning process and document(s) will be consistent with the tenets listed below:

1. Any youth and young adult age 14 up to age 26 and receiving services from the Departments of Corrections, Education, Health and Human Services or Labor will participate in meaningful transition planning reflecting the young person's interests, wishes and goals for future.

2. Transition planning will be based on a strengths-focused approach identifying the individual's interests, capabilities and supports needed for successful transition to adulthood.

3. Youth and young adults must be central to their own transition planning and will direct the process throughout from initiation to completion.

4. Transition planning must be comprehensive and holistic reflecting the young person's wishes and goals in all of the major life domains.

5. All transition planning will emphasize the development and/or participation of important connections to include family, friends, co-workers, etc. as identified by the young person.

6. Transition planning will be culturally competent, linguistically appropriate, trauma informed and compliant with all regulations pertaining to accessibility.

7. Transition planning will be integrated throughout other relevant state and contracted provider agencies to support strong and effective transitions to healthy adulthood for Maine's youth.

8. The transition planning process will be transparent and the various relevant state offices will develop and disseminate informational products describing the transition policy.

IV. Practice Guidelines

This state policy provides the framework for the development of practice guidelines for transition-aged individuals presently served by the various state Departments listed above, or those individuals newly seeking services as an adult, or exiting state services. The practice guidelines developed by each individual agency will adhere to and support this comprehensive transition policy.

1. All youth and young adults age 14 up to age 26 receiving state services will have a written individualized transition planning document.

2. All transition planning meetings and activities will be documented on the Maine State Uniform Transition Planning form#_____.

3. All youth and young adults receiving direct or contracted state services will have, at a minimum, an annual meeting involving the youth or young adult, family and/or friends and natural supports, any relevant professionals or others of the young person's choice, to update, revise or finalize the transition planning process as needed.

4. All transition planning will be strengths-focused and will be directed by the young person's personal interests, wishes, talents, abilities and goals.

5. The transition planning process will be accessible, culturally competent and trauma-informed throughout its duration, and various means of support (technological, peer, communication, venue) will be provided the young person if requested.

6. All state offices and contracted agencies will incorporate language in contracts and job descriptions requiring case managers to routinely seek opportunities for informal

conversations to explore wishes and goals for the future in the various life domains to encourage and support youth and young adults in life planning.

7. All young persons receiving services directly from a state office, or through an agency contracted with a state Department, will routinely be invited to engage in ongoing informal discussions with their case managers about their dreams, wishes and goals for the future in each of the life domains.

8. All state contracted provider agencies serving youth and young adults, and all state Departments, will gather outcome data on the above expectations.

9. _____will track _____of each individual's transition planning process and adherence to the practice guidelines of the responsible office.

10. Specific data collected will include the youth or young adult, transition planning history, and outcomes relevant to the documented goals in the various life domains and be given to the ____Office of Quality Management for individual and aggregate tracking and analysis.

11. The Department of Health & Human Services, the Department of Corrections, the Department of Education, and the Department of Labor will collaborate in the development and provision of statewide trainings for state staff, contracted provider agencies and youth, young adults and families on the comprehensive state policy on transition policy.

V. Policy Development

This policy was developed by a Healthy Transitions Initiative/Moving Forward policy group which includes DHHS offices of Child & Family Services, Adult Mental Health Services, Maine Care Services, Substance Abuse Services, Family Independence Services; the Department of Correction, the Department of Education; and the Department of Labor, Office of Vocational Rehabilitation, in collaboration with youth and adult consumers advocates of mental health services, and 3 agencies serving youth, Tri-County Mental Health Services, Common Ties, and New Beginnings, and the administrative agency, Hornby Zeller Associates, Inc.

VI. Background

This policy was developed as part of a federal Substance Abuse Mental Health Services Administration (SAMHSA) Healthy Transitions grant awarded to DHHS in 2009. The grant directed the state to seek to create policy at the state level which has direct impact on the practice level and to have the practice level advise the state level on the policy development.

VII. Policy Definitions

Individuals of Transition Age: youth and young adults age 14 up until 26 presently served by the various state Departments listed above, or those individuals newly seeking, or exiting, state services from these Departments.

Cultural Competence: the transition planning process must demonstrate understanding, respect and capability of working effectively with persons/groups from various cultural identities and backgrounds including age, gender, nationality, ethnicity, etc.

Transparent/transparency: transition policies and practices which are easily found, understandable, and consistent.

Accessible/accessibility: Transition planning practices are available to meet the diverse and unique needs of youth and young adults across the state Departments and their contracted agencies.

Strengths-focused: Youth and young adults experience transition planning where they identify, build upon, and utilize their unique strengths.

Integrated: Youth and young adults experience care that has smooth transitions in and out of services, and which addresses the culture, strengths and needs of the participants.

Life Domains: all important areas of life identified by individual youth and young adults (education, jobs, health, family, etc.)

Transition Planning: the process of planning with a youth or young adult ages 14 up to age 26 in preparation for adult life. The plan will be directed by the young person and will include his or her strengths, wishes and goals in self-identified important life domains.