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Transition-Age Youth

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CASE HISTORY

Ebony was 17 years old when she moved from a state psychiatric facility to a community residence for young adults. She had been in psychiatric treatment since age 7 years, when she was first hospitalized for aggressive behavior. Since then, she has had multiple hospitalizations and medication trials for bipolar disorder. Ebony had been removed from her mother in infancy due to neglect, and she had not met her father, who had been in prison most of her life. She was physically abused in one foster home and has been in group homes and residential treatment since age 12 years. She denies most of the classic symptoms of post-traumatic stress disorder (PTSD), but trauma has affected her ability to form trusting relationships.

When she first arrived at the residence, Ebony presented as disorganized and impulsive—she slept at odd hours, missing meal and medication times, her room was a mess, and she spent her personal needs allowance on tattoos and electronics. She had frequent loud arguments with peers and staff, sometimes banging on walls and doors and making threats. Staff worried about her—like many of her peers transitioning from state facilities, this was her first time living independently.

In keeping with residence procedures, Ebony began her tenure there by developing a service plan with a case manager, discussing her personal goals, her barriers to goal achievement, and her strengths. Ebony wanted to complete school, get a job, and become part of a permanent family, including exploring the possibility of being adopted as an adult. An ultimate goal would be to transition out of the residence to a more independent setting. The residential staff took time getting to know Ebony and reinforcing that she was welcome. They patiently and consistently engaged and redirected her to focus on what she needed to do in order to achieve the goals she set for herself.

Clinical Pearl

The term *transition-age youth* (TAY) typically describes people aged 17–25 years who are transitioning from child social services, including foster care, to the adult system. Many have severe behavioral health issues, 75% will drop out of

school, and 73% will be arrested 3–5 years after leaving school (Levitan, 2005). Many of these youth become homeless. They are making the difficult transition to adulthood with additional burdens of trauma and mental illness and without the family and community supports that peers outside the social service system have.

Many TAY exhibit behaviors consistent with complex trauma and loss, with poor distress tolerance, problem-solving, and impulse control. They often have attachment and trust issues, needing support to develop healthy boundaries and relationships.

At the same time, TAY are an underserved population. Approximately half as many 18- and 19-year-olds are in treatment as 16- and 17-year-olds (Pottick, Bilder, Vander Stoep, Warner, & Alvarez, 2007). This is partly because they seek independence from authority figures at this developmental stage of identity versus role diffusion (Erikson, 1963). More concerning is the fact that our fragmented health care system, with artificial divides between child and adult health care and few cross-links between child and adult diagnostic categories, prevents TAY from accessing treatment.

Breaking through those barriers and engaging TAY in services requires taking time to establish trust, focusing on their personal goals, and providing "scaffolding" as they take risks and learn the natural consequences of their choices.

Ebony tried numerous medications from age 7 to 17 years before finding relief with clozapine. Clozapine helped her manage irritability and aggressive outbursts, and it stabilized her mood, which typically varied from hypomanic to depressed. Challenges to maintaining this treatment included difficulty adhering to blood work and clinic appointments and the medication itself, as well as a period of mild neutropenia that led her psychiatrist to decline to prescribe clozapine for her.

When she arrived at the residence, Ebony voiced her preference for clozapine. Staff advocated unsuccessfully with her psychiatrist, and they finally consulted the agency medical director, who reviewed the record, discussed the situation with the treating psychiatrist, and recommended a retrial of clozapine. This ultimately required a transfer of care to a new clinic.

Ebony connected well with her new psychiatrist and therapist and was enthusiastic about treatment. However, she often forgot appointments or slept in, and she struggled with getting blood work done before an appointment for clozapine renewal. A system had to be developed to help her remember her appointments, including a wall calendar, smartphone notifications, staff reminders, and communication between the clinic and residence when appointments were missed. Continued challenges led the team to suggest she transfer to another clinic nearer the residence or one with more flexible scheduling, but Ebony wanted to stay with her current providers. The treatment team supported this decision but was consistent in helping Ebony understand that she needed to manage her appointments in order to make this successful. It was a great relief, and a marker of her perseverance, when Ebony was able to move from weekly to biweekly and then to monthly blood work requirements for clozapine.

Clinical Pearl

Ebony's motivation to participate in treatment may be exceptional, but the amount of support needed from the team to maintain her connection to treatment is typical for TAY. TAY need providers who will align treatment with their personal goals, be flexible with scheduling and missed appointments, and nurture a capacity for attachment that may have been damaged by past trauma. Some calculated risk-taking in the interest of person-centered care may also be needed, as was exemplified by the choice to retry clozapine despite previous neutropenia. A great deal of inter-provider communication is needed to create an adequate, if not seamless, support system for each young person.

Supporting TAY requires a delicate balance between keeping natural consequences at bay (e.g., issuing a prescription despite a missed appointment to prevent recurrent mood symptoms) and allowing learning from natural consequences (e.g., setting limits regarding how many appointments can be missed before treatment may be put on hold). Achieving this balance may require case conferences between providers who may hold different viewpoints.

When Ebony first came to the residence, she had no consistent relationships in her life, let alone trusting ones. Her ability to establish strong relationships with staff members was a testament to her resilience, given her history of trauma and loss. However, she had difficulty avoiding conflict with peers, even when consistently taking clozapine. She isolated herself to "stay out of trouble." A few romantic relationships only made her feel "used" or maligned in the end, reinforcing her mistrust of peers. The staff's consistent supportive stance, even when she was angry or frustrated, helped her learn to regulate her moods. In particular, the presence of a peer specialist at the residence provided a positive experience with someone closer to her age. Gradually, emotional outbursts and conflict decreased, communication and coping skills increased, and Ebony was able to make strides toward her goals.

Clinical Pearl

Ebony's experiences highlight the importance of the presence and support of reliable adults in TAY progress and success. A helpful therapeutic stance includes the following:

1. Consistency and repetition—and repetition! TAY need multiple opportunities to learn and practice skills that will help them succeed in the larger community.
2. "Outside the box" thinking: Traditional approaches are not always appropriate for this age group. TAY need providers to support them in finding multiple solutions to a problem.
3. Developing natural supports and full community integration: TAY must develop a network of natural supports that includes reliable adults, supportive peers, mentors, providers, employers, and family. These connections must link TAY firmly to the larger community—a community that is not defined only by their mental health needs.

Vocational/educational and peer specialists at the residence encouraged Ebony to explore different avenues for education and employment. She had left school in

grade 10 and had no work experience. Ebony tried completing high school, a GED program, considered college, participated in an internship program, and applied for and worked at several jobs, including a peer position. Many of these explorations lasted only a week or two, but staff supported her in regrouping and choosing a new path each time.

When Ebony first arrived, healthy eating and physical activity had not been a priority for her—her focus had been on staying out of the hospital. However, although clozapine increased her stability, it also increased her weight. Her treatment team began providing wellness education, using motivational enhancement techniques to encourage her to try new health behaviors. For example, her psychiatrist printed out recipes for baked foods that she might like, and she reported on the recipes after she tried them with the help of residential staff. Her focus had moved from day-to-day survival to achieving the best for her future, and her whole health became very relevant to this aim.

Now at age 21 years, Ebony has moved into a supported apartment and is learning to manage roommate issues. She is trying anew to obtain her GED. She is still taking clozapine, having become excessively irritable the two times she tried to taper it off. However, the dose has been minimized, and she has her blood work done on time without staff prompting approximately 50% of the time. She has become more savvy with dating, which also reflects a more secure sense of self. She maintains contact with a few of the staff from the residence, who remain among her champions as she pursues her goals.

DISCUSSION

Background

For TAY, moving out of the youth services system poses unique challenges, beyond those experienced by peers who can rely on parental support. The change is often abrupt, with a dearth of support from the health and social services systems, making it difficult for TAY to obtain housing and income, let alone to pursue education and build healthy relationships (Manno, Jacobs, Alson, & Skemer, 2014; Osgood, Foster, & Courtney, 2010). Negative outcomes are more common among TAY, including legal issues, incarceration, homelessness, and experiencing violence in a relationship (Courtney, Piliavin, Grogan-Kaylor, & Nesmith, 2001; Reilly 2003).

The majority of TAY have experienced abuse and neglect that eventually led to their placement in the youth services system, and trauma is also common during their time in foster care (McDaniel, Courtney, Pergamit, & Lowenstein, 2015). Youth in the foster care system often have attachment problems and emotional dysregulation due to family instability and maltreatment (Harden, 2004). Their adult appearances may be misleading if their childhood developmental needs were not met (Aledort et al., 2011). On the other hand, resilience among TAY has been shown to be predicted by female gender, exiting care at an older age, lower perceived life stress, and higher levels of support from family and friends (Daining & DePanfilis, 2007). Participation in services, skills training, and employment leads to better outcomes and greater satisfaction for TAY (Reilly, 2003).

Proposed Approaches

INDEPENDENT LIVING PROGRAMS

The Foster Care Independence Act of 1999 doubled federal funding available for states to provide independent living services for youth transitioning out of foster care, and the 2008 Fostering Connections to Success and Increasing Adoptions Act also increased funding to allow states to provide foster care for youths through age 21 years. Some of this funding was channeled to the creation of independent living programs (ILPs), which include housing, vocational and educational services, mentoring, behavioral health services, permanency enhancement, pregnancy prevention, parenting support, financial literacy, and asset-building support (McDaniel et al., 2015). Trauma-focused cognitive–behavioral therapy, an evidence-based psychotherapy model that addresses PTSD symptoms, is used in various ILPs; its focus on trauma narratives can help TAY to develop a sense of mastery over their traumatic memories (Ford, Kerig, & Olafson, 2004).

One ILP model, the Youth Villages Transitional Living Program, features intensive case management with small caseloads and a treatment manual guiding care. This model has been implemented in six states, and it was evaluated in Tennessee, with 1,322 youth randomized to the program condition or a control group that received only a list of community resources. At 1 year, program TAY had better outcomes in terms of earnings, housing stability, economic well-being, and health and safety, although there were no significant differences in education, social support, and criminal involvement (Valentine, Skemer, & Courtney, 2015).

YOUTH-DRIVEN APPROACHES

Using a person-centered or "youth-driven" approach values TAY's coming of age as adults: The service provider's role is to assist them to set their own goals and make their own informed decisions, providing guidance to develop skills and establish supports for long-term outcomes (Manno et al., 2014). Conventionally, "cultural competence" means understanding the norms of an ethnic group; "cultural humility" involves an open, learning stance in working with people of another ethnicity. Working with TAY may require the same kind of understanding and openness to behaviors, language, customs, beliefs, and perspectives specific to youth culture (Daining & DePanfilis, 2007). Communicating with young adults in a nonjudgmental way that is coherent to youth culture, including making use of the Internet, texting, and social media, can help the clinician engage fully with TAY clients (Aledort et al., 2011).

Involvement with youth services can be associated with stigmatizing labels that may affect sense of self. Paradoxically, youth with mental health problems may also be held to higher standards: Behaviors such as transient truancy or experimentation with substances that might be attributed to a developmental stage for other youths may be regarded as high-risk for TAY (Youth Power, 2015). Involving TAY in treatment planning and allowing them to have space to explore their own individual strengths, abilities, interests, and identity are key in supporting the development of independence (Berzin, Singer, & Hokanson, 2014).

HOUSING, EDUCATION, AND EMPLOYMENT SUPPORT

Housing, education, and employment outcomes are interlinked: A high school diploma, job skills training, and employment all tie in to influence whether a

young adult can maintain satisfactory housing (Choca, Minoff, Angene, & Byrnes, 2004). Housing services include the provision of subsidized housing and supportive programs that assist young adults in obtaining and maintaining housing in the community (McDaniel et al., 2015). Additional support to learn housekeeping, culinary, and financial management skills is usually necessary to help TAY develop and maintain independent living.

High school completion or equivalency programs, college access, and college success programs are among educational services that TAY need. Social support, school stability, and communication with teachers and school administrators are key to academic success. Innovative education strategies—including competency-based learning, focused on mastering particular subject areas instead of completing a classroom time requirement, and blended and extended learning, using technology to permit youth to learn outside of the traditional classroom and class time—may help TAY to overcome traditional barriers to learning (Rath, Rock, & Laferriere, 2012).

A comprehensive approach to supported employment utilizes ongoing assessment of skills and support needs by a multidisciplinary team, including trainers and co-workers, and on-the-job observations and interest inventories (Carter & Lunsford, 2005). Starting to seek employment at a younger age and high future work expectation portend better outcomes (Burke-Miller, Razzano, Grey, Blyler, & Cook, 2012). Conventional employment programs in the behavioral health domain often promote more technical vocations; helping TAY explore and develop longer term career pathways and professional interests may increase their employment potential in the long term (Berzin et al., 2014).

MENTORSHIP

Many TAY were pushed to become self-reliant in the context of insufficient social support, and they missed the opportunity to explore their identities, roles, and beliefs that is part of the usual transition to adulthood (Arnett, 2004; Greeson, Garcia, Kim, Thompson, & Courtney, 2015). Social support can be provided in various forms, including instrumental, emotional, informational, and affirmational support—all of which are useful for TAY at different moments in their development. Although research on the effectiveness of formal mentorship programs has been inconclusive, reliable adults are crucial to a TAY's success (Collins, Spencer, & Ward, 2010). Mentorship may help youth become more articulate and open with their emotions; establishing mentorship well in advance of the transition age at 18 years supports development of a long-term relationship (Osterling & Hines, 2006). Assisting youth to develop natural social supports with adults and peers eventually helps them to integrate with their communities (Aledort et al., 2011; Collins et al., 2010).

TAY have only recently been recognized as a particularly vulnerable population, underserved by both the youth and adult health and social systems. Public psychiatrists have an opportunity to use an understanding of systems to work toward policies that help TAY to meet basic needs and move toward independence. Skill in using trauma-informed, recovery-oriented, integrated, person-centered, and flexible care helps these young people to transcend the challenges of their past and achieve their goals.

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