Beyond Fort Bragg:

Ensuring a Brighter Future for Youth and Young Adults in the United States

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What is Fort Bragg?

The Fort Bragg Evaluation Project (FBEP) showed that children in a well implemented and expensive continuum of care had no better clinical outcomes than those experiencing more traditional and fragmented services.

In an article published in this journal that was critical of the evaluation, Mordock argued that the FBEP results be viewed with skepticism because of what he perceived to be methodological, design, measurement, and analytic failures of this study. The writer’s respond to Mordock's critique since it contributes to the great reluctance to seriously consider the study's findings and their implications.

Rejoinder to Mordock's Critique of the Fort Bragg Evaluation Project: The Sample Is Generalizable and the Outcomes Are Clear. Bickman L.; Salzer M.S.2; Lambert E.W.2; Saunders R.2; Summerfelt W.T.2; Heflinger C.A.2; Hamner K.2 Child Psychiatry and Human Development, 1998, vol. 29, no. 1, pp. 77-91(15)

Fort Bragg Findings Consistent with National Systems Level Research on Adults

Amount of Services is Unrelated to Mental Health Outcomes

- Ohio DMH Longitudinal Consumer Outcomes Study
- Robert Wood Johnson Nine Cities Demonstration Program on Chronic Mental Illness
- McKinney Research Demonstration Program for Homeless Adults
- Access (Access to Community Care and Affective Service and Supports) Demonstration Program
- Fort Bragg Children's Mental Health Managed Care Demonstration Program

Service Amount is Unrelated to Consumers' Perceptions of Needs.

- Ohio DMH Longitudinal Consumer Outcomes Study

What Determines Good Outcomes for Adults with Mental Illness?

Consumers' perceptions that their needs are being met are the best predictors of positive mental health outcomes.

Consumers' perceptions of their level of service empowerment (e.g., their involvement in treatment planning and decisions about services) was the variable most highly correlated with the degree to which they felt their needs were being met.

Ohio DMH Longitudinal Consumer Outcomes Study

WHO ARE TRANSITIONAL YOUTH ?

Adolescence: from the onset of puberty to full adulthood

The exact period varies from person to person and falls approximately between the ages 12 and 20. The physical changes are puberty.

Important psychological changes also occur.

- **Questioning of identity and achievement of an appropriate sex role**
- **Movement toward personal independence**
- **Social changes in which, for a time, the most important factor is peer group relations**

Adolescence in Western societies tends to be a period of rebellion against adult authority figures, often parents or school officials, in the search for personal identity.

Many psychologists regard adolescence as a byproduct of social pressures specific to given societies, not as a unique period of biological turmoil.

In fact, the classification of a period of life as "adolescence" is a relatively recent development in many Western societies, one that is not recognized as a distinct phase of life in many other cultures.

Ref: T. Hine, The Rise and Fall of the American Teenager (1999).
http://www.answers.com/topic/adolescence

AGE CRITERIA DISTINGUISHING YOUTH FROM CHILDREN AND/OR ADULTS

The term 'child' means an unmarried person under twenty-one years of age. . .
Definition of Child in the US Immigration and Naturalization Act

"A "qualifying child" . . . must be under the age of 19 at the end of the tax year or under the age of 24 if. . .
Uniform Definition IRS, U.S. Department of Treasury

A "child 6 to 21 years old" and an "adult over 18 years old"
US Department of Health and Human Services, Progress Review, Disability and Secondary Conditions, Healthy People 2010 January 15, 2003

10-14 years old
Sacramento County, California Alcohol and Drug Services Division, Transitional Aged Youth Project

14-25 years old/SAMHSA Partnerships for Youth Transition
A 4-year program, funded CMHS in partnership with the U.S. Department of Education, offering long-term support to young people with serious emotional disorders and emerging serious mental illnesses during the crucial developmental window between the ages of 14 and 25.

Global Variations Distinguishing Children and Youth from Adults

The age at which a person is considered a "youth," and thus eligible for special treatment under the law varies around the world by location, race, religion, and other cultural norms.

In Canada after age 24, youth are no longer eligible for adolescent social services.

Under Muslim Law, a child becomes an adult upon attaining puberty, which varies with gender. An average female child ceases to be a child upon attaining puberty at the age of 12 years and an average male child upon reaching 15-16 years.

In Europe, the laws regarding child pornography vary from country to country, but generally the definition of "child" for defining child pornography is linked to the age of consent for sexual activity.

In Scandinavia, the age of consent is 13 years and in the Netherlands it is 16. Photographs of a nude 13-year-old taken in Scandinavia would not necessarily be illegal.

Why Do Transitional Aged Youth Need Special Attention?

The plain fact is that when a teenager grows out of youth oriented services there is NO rational process for being received in a program designed for adults. **Youth over 18, or 21 up to 25 or 30 just don't fit**. They have all the aspirations of young adults, are resistant to being regimented, controlled and living under rules.

Most adult programs are oriented to persistently mentally ill individuals who need some shelter if they are to proceed in a recovery process. The two don't mix. In residential services for adults, youth who want to drink, carouse, and express their distress with their illness in behavioral ways, are simply not welcome, and the youth don't want that type of housing.

In our system, as we were exploring gaps in services, NO youth between 18 and 21 lived in the shelter residences for adults. Yet they were no longer welcome in youth residential programs, foster homes, or even juvenile justice residential programs.

Charley Huffine, M.D., Medical Director, Child and Adolescent Program , King County Department of Community and Human Services, Mental Health, Chemical Dependence and Dependency Services Division

What are the Seminal Transitions for Youth and Young Adults ?

Legally, the same or a different minimum age may be applicable to various rights and obligations.

Various Rights as an Adult

Age 14 – right to become an emancipated minor

Age 14 – right of consent for mental health services

Age 16 – right to drive

Age 18 – right to vote; additional legal rights

Age 21 – right to consume alcohol; additional legal rights

Other Rights and Obligations of Adults

Engaging in a contract

As a parent, losing parental rights and duties

As a parent, losing financial responsibility

Getting married

Having a job

Being a soldier

Buying or possessing firearms

Driving

Traveling abroad

Smoking

Having Sex

Being a client of a prostitute/sex worker, being a model or actor in pornography, etc.

Being a prostitute/sex worker

Children Have Basic Rights and Protections

Children are generally afforded the basic rights embodied by the Constitution.

The equal protection clause of the 14th Amendment is said to apply to children, born within a marriage or not, but excludes children not yet born.

State and federal child-rights laws require governments to:

Provide special protections for children who are not receiving adequate, appropriate, and/or safe care and supervision, and

Provide health and human services for children and families with problems that interfere with the well-being and successful development of youth into adults and to reduce the risk for bad outcomes for both these children and their families.

Other Key Transitional Points

Educational

Age 17 – able to drop out of school without parental consent

Middle school to senior high school

Grade to next grade

Public school to approved private school

Drop out to GED

Drop out back into school

High school to postsecondary education

High school to vocational school

High school to employment

Living Situation

Foster care to independent living

Residential treatment to independent living

Group home to independent living

Parents' home to independent living

Foster care to homelessness

Residential treatment to homelessness

Group home to homelessness

Parents' home to homelessness

Return to parents' home from any other living situation

Roommates

Marriage

Juvenile Justice/Criminal Justice

From the Juvenile system to the Adult System

Into or out of the Juvenile Justice System

Into or out of the Criminal Justice System

Employment

Ages 14, 15, and 16 – Right to work

Finding a job

Starting a job

Sustaining a job

Changing jobs

Losing a job

Behavioral Health

First major symptoms of serious mental illness

Admission to or discharge from:

- a psychiatric hospital
- a residential treatment facility
- a drug/alcohol rehabilitation facility
- any drug/alcohol program

Change in one's key behavioral health staff

Community and Social Relationships

Involvement with Child, Youth, and Families (CYF)

Enlistment or discharge from the military

Becoming a parent

Significant change in relationship with one's family

Death of a loved one

Significant change in peer or social relationships

What Do We Know About the Causes of Mental Illness?

Most mental illnesses are heritable

Mental Illnesses are caused by environmental factors

Psychiatric Genetics: A Current Perspective, Kenneth S. Kendler, Virginia Institute of Psychiatric and Behavioral Genetics, Departments of Psychiatry and Human Genetics, Virginia Commonwealth University. Stromgrem Award presentation provided to presenter.

Heritability of Mental Illness

Heritability	Psychiatric Disorders	Other important familial traits
zero		Language, Religion
20-40%	Anxiety Disorders, Depression, Bulimia	MI, blood pressure, personality
40-60%	Alcohol and Drug Dependence	IQ, plasma cholesterol, adult-onset diabetes
60-80%	Schizophrenia, Bipolar Illness	Weight
80-100%		Height

Psychiatric Genetics: A Current Perspective, Kenneth S. Kendler, Virginia Institute of Psychiatric and Behavioral Genetics, Departments of Psychiatry and Human Genetics, Virginia Commonwealth University. Stromgrem Award presentation provided to author.

What do we know about the Interaction and Relative Contribution of Genetics and Environment to Risk and Prevalence of Mental Illness?

The inter-relationship of genetic and environment risk factors is likely to be subtle.

Likely importance of genotype-environment correlation (genetic control of exposure to the environment)

Probable importance of genotype-environment interaction or "genetic control of sensitivity to the environment"

We know little about the "Development of Risk -- the dance through time of genetic and environmental risk factors."

We know little about the possible impact of historical and population differences on our estimates of the importance of genetic and environmental risk factors.

Relationship Between Genetic Architecture and Our Nosologic Systems is Likely to be Complex.

Two examples

1. **7 Common Psychiatric and Drug Abuse Disorders**
2. **Abuse/Dependence of 6 Different Substance Classes**

Psychiatric Genetics: A Current Perspective, Kenneth S. Kendler, Virginia Institute of Psychiatric and Behavioral Genetics, Departments of Psychiatry and Human Genetics, Virginia Commonwealth University. Stromgrem Award presentation provided to presenter.

MENTAL ILLNESS & SUBSTANCE ABUSE

Different, competing views, definitions, and data

- Etiology and definition of mental illness
- Incidence/prevalence of mental illness
- Validity and Utility of Psychiatric Diagnoses
- Importance of Diagnosis in assessment and treatment
- Appropriateness and effectiveness of medical and biological models in the assessment and treatment of emotional and mental disorders in adults and children
- What interventions demonstrate the best long-term quality of life outcomes

YOUTH PREVALENCE OF MENTAL ILLNESS

Percentage of Youth Aged 9-17 years with Emotional Disturbances by level of severity (presumed lifetime prevalence, but not specified)

20% have any diagnosable mental disorder with at least mild function impairment

9-13% have a serious emotional disturbance (SED), with substantial functional impairment

5-9% have a serious emotional disturbance (SED), with extreme functional impairment

Emotional and behavioral problems and associated impairments in Children Aged 1-19 years

17.6 to 22 %

16 %

Friedman et al., (1996b). Prevalence of serious emotional disturbance in children and adolescents. In R.W. Manderscheid & M.A. Sonnenschein (EDS.), Mental Health, United States, 1996. President's New Freedom Commission Report on Mental Health http://www.dmh.co.la.ca.us/stp/documents/SEDSMIDefinitions.pdf

Friedman, R.M.; Katz-Leavy, J.W.; Manderscheid, R.W.; et al. Prevalence of serious emotional disturbance: An update. Mental Health, United States, 1996 DHHS Publication Number (SMA) 96-3098. Rockville, MD: HHS, PHS, SAMHSA, CMHS, 1996.

Costello, E.J.; Angold, A.; Burns, B.J.; Erkanli, A.; Stangl, D.K; and Tweed, D.L. . (1996). The Great Smokey Mountains Study of youth: Functional impairment and serious emotional disturbance. Archives of General Psychiatry, (12):1137-1143. 53.

Roberts, R.E.; Attkisson, C.C.; and Rosenblatt, A. . (1998). Prevalence of psychopathology among children and adolescents. American Journal of Psychiatry, (6):715-25. 155

Prevalence of Mental Illness and Substance Use Disorders in Adults

9% of all U.S. adults have any mental disorder and experience some significant functional impairment

[Best estimate 12-month prevalence rates based on Epidemiologic Catchment Area Study (ECA) and National Comorbidity Survey (NCS)]
President's New Freedom Commission Report on Mental Health/ http://www.dmh.co.la.ca.us/stp/documents/SEDSMIDefinitions.pdf

7% of adults have mental disorders that persist for at least a year

Regier, et al., The epidemiology of mental disorders treatment needs: Community estimates of "medical necessity". In G. Andrews & S. Henderson (Eds.), Unmet needs in mental health service delivery.

Proportion of Adults Aged 18-54 Years with Mental Illness by level of severity

23.9% have any diagnosable mental disorder

5.4% have Serious Mental Illness that interfere with some area of social functioning

2.6 % have Severe and Persistent Mental Illness

Kessler, R.C.; Berglund, P.A.; Zbao, S.; et al. The 12-month prevalence and correlates of serious mental illness. Mental Health, United States, 1998, DHHS Publication Number (SMA) 99-8235. Rockville, MD: HHS, PHS, SAMHSA, CMHS, 1999.

74% of 21 year olds with mental disorders had prior problems

Roberts, R.E.; Attkisson, C.C.; and Rosenblatt, A. . (1998). Prevalence of psychopathology among children and adolescents. American Journal of Psychiatry, (6):715-25. 155

Prevalence data do not correspond with changes in psychiatric classifications of mental disorders.

For the major epidemiological studies by Kessler and Regier, mental disorder, serious mental illness and serious and persistent mental illness definitions reference the *Diagnostic and Statistical Manual of Mental Disorders, III, Revised*, American Psychiatric Association, 1987.

Since then, the DSM has been revised twice and is soon to undergo another revision in creation of the DSM-V.

The version currently in use is the DSM-IV-TR.

Prevalence studies have different severity classifications.

Serious mental illness (**SMI)** is defined as having at some time during the past 12 months a diagnosable mental, behavioral, or emotional disorder that met the criteria for a DSM-IV disorder and that resulted in functional impairment that substantially interfered with or limited one or more major life activities.

American Psychiatric Association, 1994.

Serious emotional disturbance (SED): A diagnosable mental disorder found in persons from birth to age 18 years that is so severe and long lasting that it seriously interferes with functioning in family, school, community, or other major life activities.

Serious mental illness (SMI): A diagnosable mental disorder found in persons aged 18 years and older that is so long lasting and severe that it seriously interferes with a person's ability to take part in major life activities.

SAMHSA/Healthy People 2010 Progress Review/Focus Area 18: Mental Health & Mental Disorders

Severe and Persistent Mental Illness (SPMI): persons diagnosed with severe and persistent mental illness are persons aged 18 and older who have a current DSM-IV designated mental illness diagnosis and experience substantial impairments in functioning due to the severity of their clinical condition. These adults currently experience substantial dysfunction in a number of areas of role performance or are dependent on substantial treatment, rehabilitation, and support services in order to control or maintain functional capacity. Furthermore, they have experienced substantial impairments in functioning due to mental illness for an extended duration on either a continuous or episodic basis.

NYS Office of Mental Health, Mental Health Statistics Unit 2000 New York State Chartbook of Mental Health Information

Results from a Study Integrating Data from State Mental Health, Substance Abuse, and Medicaid Agencies

The following table compares

primary mental health diagnoses across youth served by any type of state organization and

Primary mental health diagnoses across adults served by mental health agencies and/or Medicaid only providers

in Delaware, Oklahoma, and Washington states.

For these analyses, seven diagnostic groups were collapsed to three

Serious mental disorders

Childhood disorders

Other mental disorders included stress/adjustment, mood/anxiety,

Do Youth and Adults Have Different Mental Illnesses?

Type of Mental Disorder	Youth	Adult
Serious mental disorders as defined by schizophrenia, major depression, and psychoses	5-13 %	25-78%
Childhood disorders, such as attention deficit/hyperactivity disorder	38-77%	1-15%
Mood/anxiety disorders and stress/adjustment disorders, personality, and sexual disorders, as well as physiologic malfunctioning related to mental factors and organic brain damage.	17-55%	22-61%

Mental Health and Substance Abuse Treatment: Results from a Study Integrating Data from State Mental Health, Substance Abuse, and Medicaid Agencies / http://csat.samhsa.gov/idbse/idbrptch3.asp

A prospective longitudinal study in England followed up a representative birth cohort (N = 1037) to see if adults with mental disorders had a juvenile psychiatric history

They wanted to see if adults with mental disorders had a juvenile psychiatric history, reasoning that is so this should shift etiologic research and prevention policy to focus more on childhood mental disorders.

Findings:

Adult disorders were generally preceded by their juvenile counterparts (e.g., adult anxiety was preceded by juvenile anxiety), but also by different disorders.

25% to 60% of cases of adults with mental disorders had a history of conduct and/or oppositional defiant disorder. Specifically, adult anxiety and schizophreniform disorders were preceded by a broad array of juvenile disorders.

The findings supported the conclusion that most adult disorders should be reframed as extensions of juvenile disorders. In particular, juvenile conduct disorder is a priority prevention target for reducing psychiatric disorder in the adult population.

Prior juvenile diagnoses in adults with mental disorder: developmental follow-back of a prospective-longitudinal cohort. Kim-Cohen J, Caspi A, Moffitt TE, Harrington H, Milne BJ, Poulton R. Arch Gen Psychiatry. 2003 Jul;60(7):709-17. Institute of Psychiatry, King's College, London, England. t.moffitt@iop.kcl.ac.uk

Serious Potential Consequences of First Episode or Emerging Mental Health Problems for Youth 16-24

Homelessness/Runaway

- Resulting life as a street youth if not supported by family of origin
- May be the result of youth leaving because of in-home or foster care abuse

Retraumatization

- Unsafe or dangerous environment
- Police intervention
- Separation from self-identified family or community
- Involuntary hospitalization in an adult inpatient unit or setting
- Incarceration
- Violence - may become victimized living on the street, but can also be subject to school yard bullying due to stigma of mental Illness

Other Potential Negative Outcomes

- Death/Suicide/Homicide
- Unwanted pregnancy
- Prostitution
- Life-threatening medical illness
- Educational Delays/Failures
- Trauma to family or dependents

Presentation and Consequences of Mental Illness for Youth and Young Adults

More than 3 million transition age youth
have been diagnosed with a Serious Mental Illness.

Vander Stoep A., Beresford S., Weiss N., McKnight B., Cauce M., and Cohen P., (2000). Community-based Study of the Transition to Adulthood for Adolescents with Psychiatric Disorders. American Journal of Epidemiology, 152, no4, 352-362.

Common Presenting Problems

Suicide
Anxiety/depression
Alcohol and drug abuse
Disordered eating
History of physical and sexual abuse
Psychosis
Conduct and antisocial disorders

Significant lack of studies and available data on co-occurring mental and substance abuse disorders among youth populations
Significant lack of studies and available data on prevalence of different types of substance abuse disorders among different youth populations

RISK FACTORS

Transitional age youth with a Serious Mental Illness have higher rates of **substance abuse** than any other age group with mental illness.

U.S. Department of Health and Human Services. Mental Health: A Report of the Surgeon General-- Children and Mental Health. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

Adolescents transitioning to adulthood with a Serious Mental Illness are three times more likely to be involved in **criminal activity** than adolescents without one.

Vander Stoep, A., Beresford S., Weiss N., McKnight B., Cauce M., and Cohen P., (2000). Community-based Study of the Transition to Adulthood for Adolescents with Psychiatric Disorders. American Journal of Epidemiology, 152, no4, 352-362.

Suicide

An estimated 20 percent of youth receiving treatment for emotional or behavioral problems have either contemplated suicide or attempted suicide.

Less than 40 percent of youth at risk of suicide receive treatment.

Suicide is the third leading cause of death among young adults age 15 to 24.

U.S. Department of Health and Human Services (2002). Results from the 2002 National Survey on Drug Use and Health. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.
U.S. Department of Health and Human Services (2002). The National Household Survey on Drug Abuse Report. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.
Miniño AM, Arias E, Kochanek KD, Murphy SL, Smith BL. Deaths: final data for 2000. National Vital Statistics Reports, 50(15). Hyattsville, MD: National Center for Health Statistics, 2002.

Diagnoses of Youth Referred by Child Welfare

ADHD – 33% - Symptoms must be present before age 7

Oppositional Defiant Disorder – 27%

excludes Conduct Disorder if under 18 years and Antisocial Disorder if over 18 years

Mood Disorder – 33%

Adjustment Disorder – 15%

Conduct Disorder –15%

Serious violations of rules before age 13

PTSD – 14%

Substance Use – 6% Likely underdiagnosed

Psychosis – 3%

Learning Disabilities – 4%

Mental retardation – 6%

2 or more Diagnoses – 19% Likely underdiagnosed

(ORC Macro, 2004) http://www.macroint.com

MOST COMMON DIAGNOSES OF JUVENILE OFFENDERS

Conduct Disorder (CD)

Oppositional Defiant Disorder (ODD)

Alcohol Dependence

Major Depression; Dysthymia

Attention Deficit Hyperactivity Disorder (ADHD)

Bipolar Disorder (Manic Depression)

Generalized Anxiety Disorder

Post-Traumatic Stress Disorder

Lexcen, F. & Redding, R. E. (2000). Mental Health Needs of Juvenile Offenders. Juvenile Justice Fact Sheet. Charlottesville, VA: Institute of Law, Psychiatry, & Public Policy, University of Virginia. http://www.ilppp.virginia.edu/Publications_and_Reports/MHNeedsJuvOff.html

Diagnoses of Incarcerated Youth

Incarcerated youth age 18-22 are more likely to have a mental illness than younger adolescents in the juvenile justice system.

While estimates of the percentage of juvenile offenders who have mental health problems vary widely depending upon what is included and defined as a mental illness, most prevalence estimates are significantly higher for juvenile offenders than those in the non-delinquent adolescent population.

Multiple diagnoses of mental illnesses ("comorbidity") are common among juvenile offenders, as are co-occurring mental and substance use disorders.

The most common diagnosis for boys is Oppositional Defiant Disorder or Conduct Disorder, often with additional diagnosis of ADHD and/or Alcohol dependence.

The most common diagnosis for girls is Depression, often with additional diagnosis of Oppositional Defiant Disorder and/or Alcohol Dependence.

Teplin L., (1994). Psychiatric and Substance Abuse Disorders among male urban jail detainees. American Journal of Public Health, 84, 290-293.

Mental Illness and Foster Youth

More than 500,000 American children live in foster care, with estimates up to over 700,000

30-70% of children and youth in foster care have a serious emotional disturbance

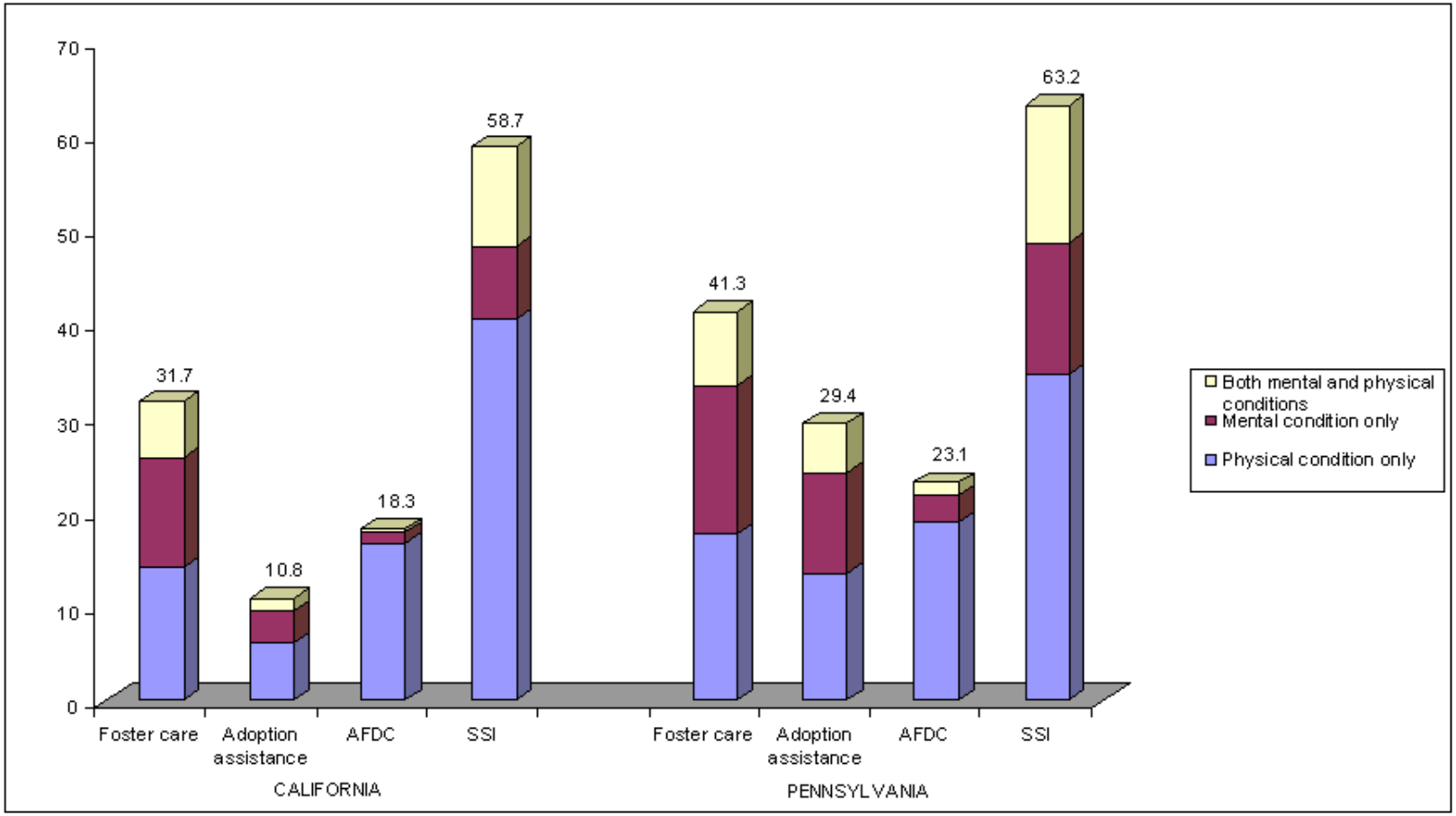
Child Welfare League of America, Standards for Health Care Services

Rates of Serious Mental Illness are highest among young adults age 18, and rates decrease for each year thereafter.

U.S. Department of Health and Human Services. (2001). Results from the 2001 National Survey on Drug Use and Health: Prevalence and Treatment of Mental Health Problems. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration

FIGURE 2

FREQUENCY OF CHRONIC ILLNESS AND DISABILITY, BY CATEGORY OF MEDICAID ELIGIBILITY, 1994



SOURCE: HCFA State Medicaid Research Files.

Children in foster care are more likely than other groups of Medicaid children to have a mental health or substance abuse condition — either alone or in combination with a physical condition. They had a higher likelihood of comorbidities than AFDC and adoption assistance children, but were less likely than SSI children to have multiple diagnoses.

Outcomes for Youth Aged Out of Foster Care

Substance use – 50%

Involvement with criminal system – 32%

Emotional problems – 38%

Incomplete high school education - 61%

Limited to no job experience – 61%

Homeless for at least one night – 25%

(Cook, A National Evaluation of IVE Foster Care …1990, 1992)

Economic Disparities

The percent of children living in "high-risk" families is based on a family risk index, which reflects four separate measures of vulnerability:

Child lives in a family with income below the poverty line

Child lives in a single-parent family

Child lives in a family where no parent has full-time, year-round employment

Child lives with a household head who is a high school dropout

Children at Risk/State Trends 1990-2000 KIDS COUNT, a project of the Annie E. Casey Foundation, is a national and state-by-state effort to track the status of children in the U.S.

Impact of Economic Disparities and Ethnicity

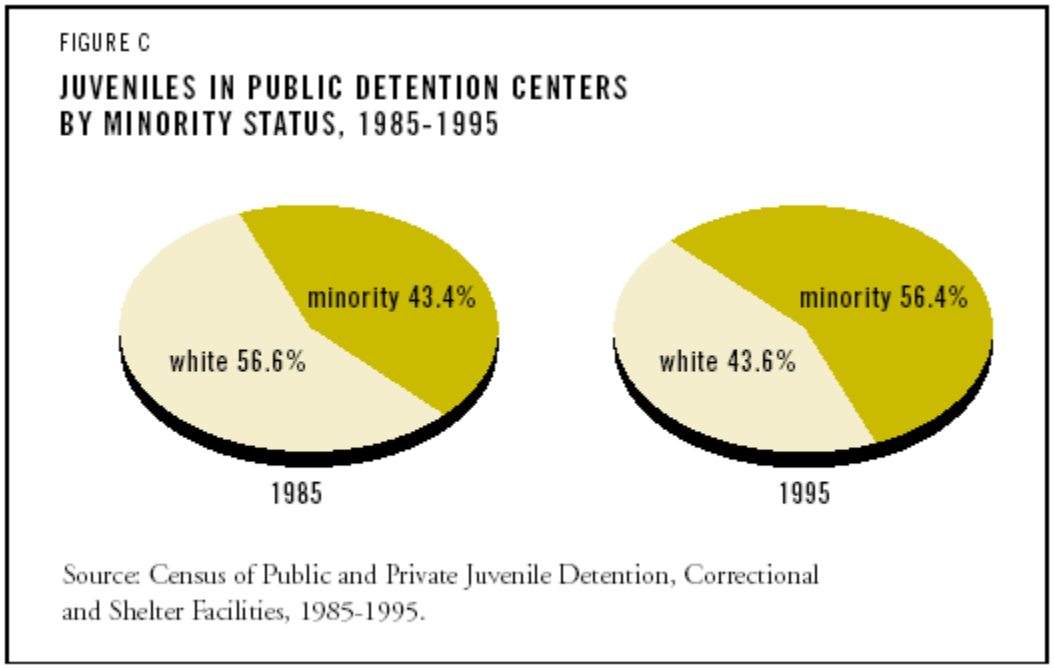
Ethnic differences in psychiatric morbidity are analyzed using data from the National Comorbidity Survey (NCS). The three largest ethnic groups in the United States--Hispanics, Non-Hispanic Blacks and Non-Hispanic Whites were compared with respect to lifetime risk and persistence of three categories of psychiatric disorder: mood disorder, anxiety disorder, and substance use disorder

Where differences were found in persistence of disorders, disadvantaged groups had higher risk. Hispanics with mood disorders were more likely to be persistently ill as were Non-Hispanic Blacks with respect to both mood disorders and anxiety disorders. Closer examination found these differences to be generally consistent across population subgroups.

Future research should focus on explanations for these findings, including the possibility that these comparisons are biased, and on potential means of reducing the disparity in persistence of disorders across ethnic groups.

Lifetime risk and persistence of psychiatric disorders across ethnic groups in the United States.
Breslau J, Kendler KS, Su M, Gaxiola-Aguilar S, Kessler RC. Psychol Med. 2005 Mar;35(3):317-27.

RACIAL DISPARITIES IN JUVENILE JUSTICE



Pathways To Juvenile Detention Reform, Reducing Racial Disparities in Juvenile Justice. A PROJECT OF THE ANNIE E. CASEY FOUNDATION by Eleanor Hinton Hoytt, Vincent Schiraldi, Brenda V. Smith, and Jason Ziedenberg

Other High Risk Groups

The vast majority of youth who do not make a successful transition fall within one or more of the following four groups of 14-17 year olds

1) those who do not complete high school,

2) youth deeply involved in the juvenile justice systems,

3) young, unmarried mothers, and

4) adolescents who experience foster placement.

Connected by 25: Improving the Life Chances of the Country's Most Vulnerable 14-24 Year Olds, Michael Wald and Tia Martinez, Stanford University, William and Flora Hewlett Foundation Working Paper, November, 2000

Crossing the Great Divide
Gaps Across Child and Adult systems

There are many smart and systemically sophisticated folks who know better then set up a fragmented mental health center, so why does it happen? Look to how money flows. Programs from the feds, the state and the related subsystems are all different from small children, school kids and adolescents, adults and older adults. Programs targeting special populations with dollars and lots of good ideas and some clear success has the paradoxical effect of leaving out other compelling individuals who don't fit and who have no special program. A program protecting a slimmed down budget assigned to care for small kids can't afford to devote time and resources to treating moms and dads as individual patients. If moms and dads are in treatment in the adult systems, their therapists/case managers are too overwhelmed to meaningfully collaborate with the overwhelmed caregivers of their children. Doing the job right (which happens sometimes) happens when staff take initiative that has them working after hours, and outside of policy and supervisory approval.

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Important Domains & Principles of Care

Housing

Education

Employment

Social Skills and Life Management

Physical and Mental Health Care

Law Enforcement – Lack of contact

Cultural and Personal Identify Formation

Community Connections and Supportive Relationships

Transition to Adulthood: California Mental Health Directors Association. Services for Youth Ages 14-24. A Resource Manual
It's My Life: A Framework for Youth Transitioning from Foster Care to Successful Adulthood. Casey Family Programs. 2001
http://www.casey.org/Resources/Publications/ItsMyLife.htm

The Transition to Independence Process (TIP) system prepares and supports young people with emotional and behavioral difficulties (EBD) in their transition into the domains of employment, educational opportunities, independent living, and community life through a comprehensive, individualized process.

The Four Transition Domains of TIP

Three setting domains

- **Employment**
- **Education**
- **Living Situation**

One community life functioning domain

- **Community Life Functioning**

TIP Community Life Functioning:

Personal-Effectiveness and
Community-Living Skills and Resources

Daily Living
Leisure Activities
Community Participation
Health
Self-Determination
Communication
Interpersonal Relationships

Transition to Independence Process (TIP) System Guidelines

1. Engage young people through relationship development, person-centered planning, and a focus on their futures.

2. Tailor services and supports to be accessible, coordinated, developmentally appropriate, and build on strengths to enable the young people to pursue their goals across all transition domains.

TIP Guidelines adapted from Clark (1993), Clark (1995), Clark & Foster-Johnson (1996), Clark, Unger, & Stewart (1993), and Clark et al. (2000).

Transition to Independence Process (TIP) System Guidelines

3. Acknowledge and develop personal choice and social responsibility with young people.

4. Ensure a safety-net of support by involving a young person's parents, family members, and other informal and formal key players.

TIP Guidelines adapted from Clark (1993), Clark (1995), Clark & Foster-Johnson (1996), Clark, Unger, & Stewart (1993), and Clark et al. (2000).

Transition to Independence Process (TIP) System Guidelines

5. Enhance young persons' competencies to assist them in achieving greater self sufficiency and confidence.

6. Maintain an outcome focus in the TIP system at the young person, program, and community levels.

7. Involve young people, parents, and other community partners in the TIP system at the practice, program, and community levels.

TIP Guidelines adapted from Clark (1993), Clark (1995), Clark & Foster-Johnson (1996), Clark, Unger, & Stewart (1993), and Clark et al. (2000).

The community-based interventions with an evidence base share the following six characteristics:

1) They function as service components in a system of care and adhere to system of care values (e.g., individualized, family-centered, strengths-based [not pathology-oriented] and culturally competent);

2) They are provided in the community, homes, schools, and neighborhoods, not in an office;

3) With the exception of multisystemic therapy and sometimes case management, the direct care providers are not formally clinically trained. They are parents, volunteers, and counselors, although training and supervision are provided by traditionally trained mental health professionals;

Barbara J. Burns, Ph.D., Duke University Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda Washington, DC: Department of Health and Human Services, 2000.

The community-based interventions with an evidence base share the following six characteristics:

4) These interventions may operate under the auspices of any of the human service sectors (i.e., education, mental health, child welfare, or juvenile justice), not just mental health;

5) Their external validity is greatly enhanced because they were developed and studied in the field with real-world child and family clients, in contrast to volunteers in university studies; and

6) They are much less expensive to provide than institutional care when the full continuum of care in the community is in place.

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DISCUSSION

Engagement and Hope First

Utility of Diagnosis

Behavioral/Environmental versus Emotional/Biological

Broadened View of Evidence Based Interventions

Interpretation of Shift in Evidence as Child > Adult

Role of Incarceration and Foster care in Increasing Risk

Early Intervention versus Crisis Intervention

Treatment and Support of Whole Family versus Individual Youth

Wellness/Recovery Approach Driving All Processes and Interventions