Theory and Research Underpinnings Supporting the *Transition to Independence Process (TIP) Model™*

The goal of a service delivery system for transition-age youth and young adults (14-29 years old) with emotional behavioral difficulties (EBD)* is to assist them in making a successful transition into adulthood. Successful transition into adulthood for youth include achievement of their potential and progressing on their personal goals in the transition domains of employment/career, education, living situation, personal effectiveness/wellbeing, and community-life functioning. To accomplish this service system goal, personnel at all levels of the transition system must: a) engage young people; b) ensure the delivery of coordinated, non-stigmatizing, trauma-informed, developmentally-appropriate, appealing supports and services to these young people; c) involve and support their families and other informal key players (e.g., friend, foster parent, aunt, girlfriend) as relevant; and d) build a "community of practice" across relevant agencies and resources throughout the community or region (Clark & Hart, 2009).

Background on Transition Challenges

Emerging adults experience dramatic changes across all areas of development during their transition to adulthood (Arnett, 2004). Young people's decisions, choices, and associated experiences set a foundation for their transition to future adult roles in the domains of employment, education, living situation, and community-life functioning. This period of transition is especially challenging for the more than 2.4 - 5 million youth and young adults with *emotional and/or behavioral difficulties (EBD)* (Davis, Sabella, Smith, & Costa, 2011). This population of young people have higher secondary school dropout rates, higher rates of arrest, incarceration, and unemployment, and lower rates of independent living compared to their peers without disabilities (Clark & Unruh, 2009a; Wagner, Kutash, Duchnowski, Epstein, & Sumi, 2005; Wagner, Newman, Cameto, & Levine, 2005; Vander Stoep, Beresford, Weiss, McKnight, Cauce, & Cohen, 2000; Vander Stoep, Weiss, Kuo, Cheney, & Cohen, 2003). According to the U.S. Department of Education (2011), nearly 45% of students with EBD drop out of high school annually which is related to lower wages (Rouse, 2007), lower employment rates (U.S. Department of Labor, Bureau of Labor Statistics, 2010), and poorer health (Pleis, Ward, & Lucas, 2010). Additionally, there are increased costs to society due to dropouts including an average of $240,000 over one's lifetime related to lost tax contributions, reliance on Medicaid and Medicare, criminality, and welfare (Levin & Belfield, 2007).

Difficulties in accessing appropriate supports and services continue to plague young people and their parents and providers. Fragmented services, varying eligibility criteria, different funding mechanisms, and different philosophies across the child and adult mental health systems offer challenges to obtaining appropriate services for young people with EBD (Davis, Green, & Hoffman, 2009; Pottick, Bilder, Vander Stoep, Warner, Alvarez, 2008). The fragmentation and silo nature of services systems complicate access to other needed services related to employment, career training, housing, and postsecondary education (Clark & Unruh, 2009b; Davis & Koroloff, 2006).

Transition to Independence Process (TIP) Model

The *Transition to Independence Process (TIP) model* was developed to engage youth and young adults in their own futures planning process, provide them with developmentally-appropriate and appealing supports and services, and involve young people and, as relevant, their families and other informal key players in a process that prepares and facilitates their movement toward greater self-sufficiency and successful achievement of their goals related to each of the transition domains (Clark & Hart, 2009). The TIP system is driven by seven guidelines or principles that provide the basis for: a) engaging youth and young adults; b) advancing their goal setting and achievement; and c) providing a framework for the program and community system to support and sustain these activities. To learn more about the TIP Model™, please see an overview of the model on the TIP website (www.TIPstars.org).

Outcome Research Findings

The complex challenges of the transition period for emerging adults with EBD and their unique needs pose major hurdles to parents, practitioners, educators, administrators, policy makers, and researchers alike. This situation presents a compelling argument for designing transition systems around a solid framework of empirically-supported strategies. Many of the TIP Model™ principles and practices have been incorporated into a number of other promising transition program approaches (Bullis & Fredericks, 2002; Bullis, Morgan, Benz, Todis, & Johnson, 2002); wraparound process for teenagers (Walker & Child, 2008; Walker, Pullmann, Moser, & Bruns, 2012); Multisystemic Therapy adapted for emerging adult offenders (Davis, Sheidow, & McCart, 2014); and the "common elements" of transition programs (Walker & Gowen, 2011).

The **TIP Model™** is an *evidence-supported practice* based on numerous outcome studies that have demonstrated improved postsecondary progress and/or outcomes for the youth and young adults who were served using the TIP Model™, or at least most of the TIP practices. Several of these outcome studies were conducted by our TIP Institute research team (Clark, Deschênes, Sieler, Green, White, & Sondheimer, 2008; Clark, Karpur, Deschênes, Gamache, & Haber, 2008; Clark, Pschorr, Wells, Curtis, & Tighe, 2004; Dresser, Clark, & Deschênes, in press; Haber, Karpur, Deschênes, & Clark, 2008; Karpur, Clark, Caproni, & Sterner, 2005) and another two outcome studies by other research teams (Hagner, Cheney, & Malloy, 1999; Koroloff, Pullmann, & Gordan, 2008). Four of these studies are summarized below.

Pre/Post Outcome Evaluation and Cost Avoidance Study

To illustrate the types of outcome studies supporting the TIP Model™, we will briefly describe four of these studies. Many years ago, Hewitt B. "Rusty" Clark worked with colleagues in Washington County, Vermont as they were developing a transition system. Dr. Clark and the Vermont team learned much from each other during those early days. Today, the program is operational in communities throughout Vermont, and Clark had an opportunity to assist in an evaluation of the initiative, examining the effectiveness of this TIP-type program (Clark, Pschorr, Wells, Curtis, & Tighe, 2004). This study provided an analysis of pre- to discharge progress for

young adults (16-21 years old). The findings showed substantial improvements in outcomes for young people with EBD, such as increased percentages of young adults being employed and completing educational goals and decreased involvement in the criminal justice system, "intensive" mental health/substance abuse service use, and public assistance. The evaluators also conducted a “cost avoidance analysis” that showed substantial savings as a function of the community-based TIP-type program.

Comparison Group Study of Postsecondary Outcomes

Another study that our TIP Institute research team conducted examined the postsecondary outcomes of TIP program completers in Miami (former students with EBD who had at least 1 year of exposure to TIP) in contrast to the outcomes of other youth and young adults from the same urban school district (Karpur et al., 2005). Comparison groups were matched on age, gender, and ethnicity, and were composed of: (a) former students with EBD classifications who had not had specialized transition services, and (b) former students with no previous disability classifications.

The findings demonstrated statistically better outcomes across postsecondary indicators of education/vocational training and incarceration for the former TIP program group in contrast to those of the comparison group, also with EBD. There was not a statistically significant difference between these two groups on the percentage of young adults employed. One interpretation of these findings is that the TIP program group may have a higher likelihood of achieving future employment that provides a livable wage and meaningful career due to the higher percentage of young adults who continued into postsecondary education. On most of the postsecondary outcome indicators, the TIP program group percentages were more closely approaching the levels of the comparison group of young adults with no disabilities classifications than did the matched comparison non-TIP group with the EBD classification.

National Partnerships for Youth Transition Study

The SAMHSA Partnerships for Youth Transition (PYT) initiative** provided an opportunity for the establishment of five demonstration community sites, focused on examining ways to improve the outcomes of transition-age youth and young adults with EBD (Clark, Deschênes, Sieler, Green, White, & Sondheimer, 2008). The cooperative agreement awards were competitively selected and the communities/counties were to develop, implement, stabilize, and document transition systems to improve the progress of youth and young adults with EBD. In order to influence policy at the national level, SAMHSA leadership involved several national partners for this initiative. Some of these partners included the U.S. Department of Education, the Jim Casey Youth Opportunities Initiative, the TIP Institute, and the Annie. E. Casey Foundation. Representatives from these and other organizations became a part of the community of learning that emerged from the PYT initiative. To achieve the goal of developing transition systems for youth and youth adults, each of the PYT sites in Washington, Pennsylvania, Maine, Minnesota, and Utah undertook efforts to provide community-based transition services and supports for youth with EBD and their families, in a manner consistent

with the community culture and state and local policy. A TIP Model™ fidelity assessment found three of the community sites adopted the TIP Model™ fully, with the other two largely incorporating most of the TIP guidelines and practices. Although the federal funding for these sites ended in September 2006, as of two years later, four of the five communities (i.e., WA, PA, MN, UT) had sustained all, or at least a substantial portion, of their transition services and supports for serving youth and young adults with EBD and their families.

The TIP Institute research team conducted a cross-site analysis of the PYT projects. The preliminary findings from a group of 192 young people involved with services for at least one year are encouraging (Clark, Karpur, Deschênes, and Gamache, 2007). The findings revealed that an increasing proportion of the transition-age youth improved over time in six major outcome areas. The young people were more likely to be employed and to be pursuing high school or postsecondary education. They were less likely to have dropped out of high school and less likely to experience interference in their lives from their mental health conditions or from drug or alcohol use. These improvement trends were statistically significant across the year of enrollment in the PYT programs. Although involvement in the criminal justice system showed a slight decrease from the initial assessment, this trend over subsequent assessments was not statistically significant – possibly due to an initial low level of involvement in this system.

Outcome and Progress from Initial Implementation of the TIP Model™

A recent outcome study illustrates the level of impact that the TIP Model™ can have when the site is attentive and supported in implementation of the program (Dresser, Clark, & & Deschênes, in press). This site was in a county in the mid-west with small towns and rural areas. Implementation of the TIP Model™ occurred over a 12-month period as the: a) Transition Age Service (TAS) team was established; b) TAS team members were trained and coached in the TIP Model™; and c) countywide collaborative was developed and provided TIP orientation. The TAS team serves youth and young adults ages 14-25 years old. To qualify for the program the young person had to have a severe mental health condition (e.g., major depression, Bipolar I Disorder, post-traumatic stress disorder, attention deficit/hyper activity disorder), a CAFAS score over 80, may have had co-occurring substance use issues (e.g., Cannabis Dependence, polysubstance dependence), and have had a history of multiple-system involvement (e.g., juvenile justice, mental health, out-of-home placement, special education). Some of the participants had borderline IQ scores. The community's initial priority was on referrals with involvement in family court and/or other legal issues. These young people must have resided in Muskegon County and most were from low socioeconomic status, eligible for Medicaid health insurance, have histories of trauma, and out-of-home placements. Criminal behavior ranged from prostitution, larceny, arson, perpetrating domestic violence, being a minor in possession, concealed weapons charges, assault, criminal sexual conduct, and drug possession. For this initial study period, there were 29 participants, with 58% being females, and having an average age at admission of 17.7 years with a range from 14 to 26.9. Thirty-five percent of the participants were Caucasian, 45% African American, 3% Hispanic, 7% Native American, and 10% multi-racial. There were three exiters from the program during this study period: one graduated

from the TAS program, one moved to attend college in another county, and one young person was sent to residential treatment by the court system. These three exiters had an average length of stay of 6.5 months with a range of 3 to 9 months. The other 26 young people remaining in services had an average length of service exposure of about 5.7 months with a range of about 2 months to 12 months.

The evaluation findings showed substantial improvements in most of the progress/outcome indicators across the transition domains related to functioning in home, school, work, and community. For example, the Community Life and Living Situation progress indicators showed the proportion of the young people living in community settings verses treatment/restrictive setting increased from 48% at intake to 93% at discharge or at the end of this 12-month evaluation period. The percent of young people living in family-home type or independent settings increased from 42% to 79%. This included one young person who remained in a stable foster family care setting throughout this period. However, the proportion of young people in detention, jail, residential treatment, or on AWOL decreased from 52% to 7% -- and not being on probation improved from 48% to 66%. Prior to intake, only 3 of the 29 participants had gotten a high school diploma and none of them had completed a GED, a post-secondary certificate, an associates degree, nor graduated a 4-year college. During this 12-month period, the Education and Employment "productivity index" of being employed or attending school increased from 24% to 69% from intake to the end of the evaluation period. Some of the specific progress indicators showed that the proportion of young people attending school or a GED program double (24% to 52%) and the proportion of program participants employed went from 0% to 21%. Although, as stated above, 3 of the 29 of the young people had graduated high school prior to coming into the TAS services, 21% graduated high school or completed their GED during their term with the TAS team. During this same period, attending college went from 0% to 7%.

Summary Discussion and Implications

The array of findings from outcome studies on the TIP Model™ suggest that it is effective in improving the progress and outcomes of youth and young adults with EBD. Some of the outcome indicators include: a) increased enrollment and progress in secondary and postsecondary education or training; b) improvement in gaining and retaining employment; c) less likelihood of interference in functioning related to relationships, school, or work as a function of mental health or substance use problems; d) reduction in restrictive placements; e) lower involvement in the criminal justice system and incarceration; and f) cost savings from reductions in the use of intensive services and restrictive placements , including incarceration.

In addition to the array of outcome research studies that have been completed, each of the TIP Model™ guidelines and core practices has either empirical support or broad professional consensus (Walker & Gowen, 2011). We continue to strengthen the TIP Model™ through research on its programmatic and practice components; such as problem solving (Skelton, Crosland, & Clark, in preparation; Streetman, Crosland, & Clark, in preparation); reducing runaway behavior and stabilizing living settings (e.g., Clark, Crosland, Geller, Cripe, Kenney,

Neff, & Dunlap, 2008); and use of natural supports such as “co-worker mentors” at employment sites (Westerlund, Granucci, Gamache, & Clark, 2006).

The theoretical and research base supporting the TIP Model™, its guidelines, and associated practices is extremely encouraging and continues to expand. We realize that additional research is needed to more fully understand the effectiveness of the TIP Model™ with young people having different diagnoses, different ages (e.g., 14-16-year old vs. 21-24-year old), and/or ethnic/racial/cultural backgrounds (Haber, Karpur, Deschênes, & Clark, 2008). We are collaborating with other sites and researchers in our efforts to strengthen the TIP Model™ as an evidence-based practice and establish additional fidelity and outcome findings on the TIP Model™ (Dresser, Clark, & Deschênes, in press).

Additional Information Available:

- See ***Endnotes*** for the asterisks (*) in the above text.
- See the ***Reference List*** related to the TIP Model™, transition challenges, and outcome research.

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