DOCUMENT RESUME

ED 364 618 UD 029 590

AUTHOR	Jarvis, Sara V.; Robertson, Robert M., Jr.
TITLE	Transitional Living Programs for Homeless Adolescents.
INSTITUTION	Georgetown Univ. Child Development Center, Washington, DC. CASSP Technical Assistance Center.
SPONS AGENCY	Substance Abuse and Mental Health Services Administration (DHHS/PHS), Rockville, MD. Center for Mental Health Services.
PUB DATE	93
NOTE	127p.
AVAILABLE FROM	CASSP Technical Assistance Center, Georgetown University Child Development Center, 3800 Reservoir Road, N.W., CG-52 Bles, Pediatrics, Washington, DC 20007.
PUB TYPE	Guides - Non-Classroom Use (055) -- Reports - Descriptive (141)
EDRS PRICE	MF01/PC06 Plus Postage.
DESCRIPTORS	Acquired Immune Deficiency Syndrome; *Adolescents; Annotated Bibliographies; Developmental Disabilities; Disadvantaged Youth; Early Parenthood; Economically Disadvantaged; *Homeless People; *Outreach Programs; Pregnancy; *Program Development; Program Implementation; Subcultures; *Transitional Programs; Urban Problems; *Youth Programs
IDENTIFIERS	Streetwork

ABSTRACT

This report presents a conceptual framework for developing, reviewing, and evaluating transitional living programs (TLPs) for homeless adolescents. It is designed to be used by those in the field who are or will be developing such programs. All TLPs share basic elements and each of these is described so that TLP providers can understand what their programs need. Chapters examine special populations whose emotional, medical, or life situations present unique obstacles to their successful transition to independent living. Information is presented on these special subgroups in order to identify the issues and needs relevant to the provision of transitional living services to these populations. Program considerations are discussed for adolescents with developmental delays, for youth who are infected with the human immunodeficiency virus, and for pregnant and parenting adolescents. In addition, the report provides a 24-item annotated bibliography of "practitioner friendly" articles or works that are current, easily accessible, and significant to the development, understanding, or review of transitional living services for homeless adolescents. Finally, program profiles are offered that exemplify various aspects of "ideal" transitional living programming. (Contains 40 references.) (GLR)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED 364 618

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☒ This document has been reproduced as received from the person or organization originating it

☐ Minor changes have been made to improve reproduction quality

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

S. K. Goldman

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

CG 029590

BEST COPY AVAILABLE

TRANSITIONAL LIVING PROGRAMS FOR HOMELESS ADOLESCENTS

Sara V. Jarvis
Southeastern Network of Family Services

Robert M. Robertson, Jr., M.S.W.
Valley Youth House

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Substance Abuse and Mental Health Services Administration
Division of Demonstration Programs
Child and Adolescent Service System Program (CASSP)

This report is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), Division of Demonstration Programs, Child and Adolescent Service System Program (CASSP). The authors wish to thank Janice Gasker, M.S.W., for the chapter on developmentally delayed adolescents. All material appearing in this volume is in the public domain and may be reproduced or copied without permission from SAMHSA, CASSP, or the authors. Citation of the source is appreciated.

Copies are available from:

CASSP Technical Assistance Center
Georgetown University Child Development Center
3800 Reservoir Road, NW
CG-52 Bles, Pediatrics
Washington, DC 20007
202-687-8635

Printed 1993

FOREWORD

This monograph presents a conceptual framework for developing, reviewing, and evaluating transitional living programs for homeless adolescents. It is designed to be used by those in the field who are, or will be, developing such programs.

The report is a joint effort of the Southeastern Network of Youth and Family Services and the Mid-Atlantic Network of Youth Services. Both Networks are membership organizations of community-based agencies serving runaway, homeless, and other troubled youth and their families. The Southeastern Network operates in the eight Southeastern States (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee). The Mid-Atlantic Network operates in the mid-Atlantic region (Virginia, West Virginia, Pennsylvania, Delaware, Maryland, and the District of Columbia).

Youth service agencies throughout the country are grappling with the difficulties of assisting troubled youth through their transition to adulthood. Even those agencies who have operated transitional living programs for years often find the task daunting.

While the number of programs serving such youth has increased in the past few years, the documentation of their efforts is limited. Accordingly, providers are forced to piece together programming based upon their own experience, the materials they come across in their work, and the advice of those operating programs. This publication, including details on a variety of types of programs, is an attempt to consolidate some of the knowledge in the field. It is not a comprehensive review of all programs, all materials, or all resources. Rather, it is an attempt to pull together examples of working programs and to draw from the assembled information a conceptual framework for delivery of services to youth in transition to adulthood. The ultimate test of its worth will be its usefulness to agencies struggling to design or improve their programming.

Diane L. Sondheimer
Chief, Child and Adolescent Studies Program
Child, Adolescent, and Family Branch
Division of Demonstration Programs
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration

CONTENTS

	Page
FOREWORD	iii
CONCEPTUAL FRAMEWORK	1
Program Structure	1
Mission Statement	2
Goals and Objectives	2
Client Population	2
Staff Composition	2
Program Process	3
Physical Setting	5
Institutions/Residential Treatment Centers	6
Group Homes	6
Shelters	6
Foster Homes	7
Supervised Apartments	7
Host Homes	7
Live-In Roommate	8
Boarding Home	8
Family Home	8
Unsupervised Apartment/Room	8
Geographic Context	8
Cultural Aspects	11
Theoretical/Clinical Base	13
Intake Assessment	14
Counseling Services	15
Family Involvement	16
Service Linkages	16
Training	17
Staff Training	17
Client Training	17
Conclusion	18
References	18
SPECIAL POPULATIONS	19
PROGRAMS FOR ADOLESCENTS WITH DEVELOPMENTAL DELAYS	21
Defining the Issues	21
"Normal" Development	22
Developmental Delays	23
Program Planning	25
Physical Setting	25
Location	25
Culture	26
Service Linkages	27
Theoretical/Clinical Base	27
Advocacy	29
References	29

Page

PROGRAMS FOR HIV-INFECTED YOUTH 31
HIV and AIDS: An Overview 31
Background and Definitions 31
Routes of Transmission of HIV 31
Numbers of AIDS Cases 32
Testing for HIV 32
From HIV Infection to AIDS 35
AIDS by Age and Gender 35
AIDS by Race 35
AIDS and Adolescents 36
Adolescent Characteristics Placing Them at Risk 37
Adolescent Sexual Risk 37
Runaways, Homeless, and Other At-Risk Youth 38
Adolescent Drug Risk 38
Behavior Change 39
Program and Agency Issues 40
Client Issues 40
Staff Issues 41
Confidentiality 41
Infection Control 41
Education for Staff and Clients 41
Serving HIV-Infected Clients 43
Summary 44
References 44

PROGRAMS FOR PREGNANT AND PARENTING ADOLESCENTS .. 45
Adolescent Pregnancy: An Overview 45
Homelessness 46
Contributing Factors 46
Costs and Benefits 47
Program Provider Issues 48
Summary 50
References 50

SELECTED ANNOTATED BIBLIOGRAPHY 53

RESOURCES 61

PROGRAM PROFILES 71
Collection of the Profile Information 71
Findings and Observations 71
Profiles 77

CONCEPTUAL FRAMEWORK

There is no ideal model for providing transitional living services to homeless adolescents. Likewise, no single variable will make a program exemplary. A successful transitional living program (TLP) is composed of a constellation of interrelated characteristics, factors, and values. These programs share several basic elements:

- Program Structure
- Physical Setting
- Geographic Context
- Cultural Aspects
- Theoretical/Clinical Base
- Service Linkages
- Training

Each component in this conceptual framework is important in its own right. Each represents a specific dimension that must be considered when both developing and evaluating transitional living programs. The interrelatedness of the components will determine whether the program is successful when fully implemented.

This chapter describes the characteristics of each of these components. The aim is to help potential TLP providers understand what their programs need; it is not a how-to manual. Each program will face different problems, have different resources, and choose different clients. There is no perfect transitional living program; there are only programs that, depending on a variety of factors, look different from and work better than others.

Program Structure

Any program must be thoroughly planned before it can be implemented. Funding sources generally require complete written documentation of the program's mission, goals, objectives, client population, staff, and program process. Addressing these elements will help program developers and their advisors clarify their own thinking and help both planning and ongoing implementation of the program.

Mission Statement

A clear and concise mission statement is the essential foundation on which the program is built. It defines the general scope and boundaries of the client population and services or activities. It is usually one of the first concepts communicated to funders, staff, clients, and interested others.

Goals and Objectives

Program goals and objectives should be formulated during the planning process, before a program is funded or implemented. They should be clear, specific, and measurable and should describe what the program believes it should and can accomplish. Once the program has started, these goals and objectives will be used as outcome measures to determine whether the program is achieving what is said it would.

Client Population

The client population should be defined specifically, including age range and criteria for eligibility (e.g., discharge from foster care, nonadjudication as dependent or delinquent, parental permission). Special populations (e.g., teenaged parents, youth with disabilities) and geographic catchment areas to be served should be identified. Additional considerations include physical or mental health status and level of commitment to program expectations.

Definition of the target population is frequently dictated by the funding source. Federal guidelines for runaway and homeless youth identify the population range as 16-21 years of age. In general, State guidelines are consistent with Federal guidelines.

Staff Composition

A TLP program may include professional, paraprofessional, clerical, and administrative staff. All staff at all levels should be fully defined, including the minimum qualifications (e.g., education and experience) necessary to fill the respective positions and the primary responsibilities of each position. Clear, complete job descriptions should be developed before any staff actually begin work. Other staff-related issues include establishing a clear supervisory hierarchy and method or format for staff evaluation. These should be consistent with established agency personnel policies.

TLPs often use mentors. Their main function is to serve as transitional figures who can project a positive image that can be emulated by the youth they serve (Mech and Leonard 1988). Generally unpaid, mentors have life or work experience that demonstrates successful negotiation of the major bumps, pitfalls, and obstacles adulthood has to offer.

Programs usually match youth with a same race, culture, or ethnic origin mentor because it increases the likelihood for successful engagement and adds a dimension of believability to the prospect of successful independence. For example, an inner-city minority youth is more likely to accept and work with a same minority mentor who has experienced similar circumstances.

Mentors should demonstrate a stable and consistent caring attitude. This is particularly important because most TLP clients have expe-

rienced many situations where adults have rejected them or left prematurely. Programs that consider utilizing mentors need to provide orientation and ongoing contact, support, and supervision. This will assist the mentor's understanding and direction in managing those sometimes uncomfortable client-mentor interactions that can arise.

Program Process

In general, a TLP process is similar to any other human service program process and includes identification and referral of clients, screening and/or assessment, implementation of services, termination, and evaluation. Thoughtful attention to each of these components prior to startup should minimize future program restructuring, although implementation of even a well-designed process will usually require fine tuning over time.

A clear and simple *referral process* is the most effective way to develop "referral friendly" contacts. Advance distribution of written materials, including a clear program description, client eligibility criteria, and referral process materials will help to assure a timely startup with a sufficient program caseload. Public child welfare, juvenile probation, and other community agency staff have many different agencies' programs and services to keep straight and may have several options for TLP clients. For that reason, it is important for programs, especially during the startup phase, to maintain regular, ongoing contact with referral sources.

All TLP referrals are *screened* to see if they meet general eligibility requirements. Those who are eligible are then *assessed* to determine whether they will be accepted as TLP clients. An individualized TLP client goal plan is the outcome of the assessment process. This plan generally provides specific goals and timeframes for a client's participation in the TLP program. The goals are in the general areas of skill development (acquisition and practice), education/employment, housing, and treatment.

Implementation of services requires identifying the generic expectations, responsibilities, and consequences for program participants.. Specific stages or phases for increased responsibility and freedom as well as methods for clients to acquire progressively independent status must be spelled out. The program should specify consequences for a client's failure to meet expectations and responsibilities as well as circumstances and criteria for returning clients to earlier phases. These should be consistent for all clients, yet sensitive to circumstances and needs of individual clients.

The program should identify specific tangible and intangible skills to be taught as well as the method for accomplishing and measuring successful acquisition and use. It should have a method for pretesting and posttesting skill levels to document the program's success in preparing TLP clients for independence. Expectations and timeframes for most activities, including employment and education, should be established. The program should define the minimum and maximum lengths of services to clients, where they will live

throughout TLP participation, and the location of independent housing.

Client services may be office based, outreach, or some mix of both. It is also important to thoughtfully consider the use and extent of outreach, the method and amount of client monitoring, and the amount, extent, or balance of individual and group services that will be offered.

The process for closure or *termination* is a natural part of all human services. In its broadest context, termination begins with provision of the first service, since client involvement in the program is really a continuum between entry and exit. Clarity around criteria for what constitutes natural closure (i.e., program completion) and premature closure (i.e., failure to perform or accelerated completion) are as important as considerations for relapse (i.e., client did well throughout program and needs temporary assistance after completion because of an unplanned crisis, etc.) and followup. This is often one of the greatest dilemma's for TLP programs—when to provide additional services and when to terminate the client from the program. A clear procedure for termination and closure should be in place for clients who both successfully and unsuccessfully leave the program. Much of the planning for this involves establishing base or minimum criteria, procedures, and protocols and playing out possible scenarios to assure that the program is prepared to respond in a proactive and supportive manner rather then in a reactive and defensive manner.

Program *evaluation* measures success and conformance to already established goals and procedures. Ultimately, the evaluation should answer two important basic questions: (1) Was the program successful in achieving what it said it would (outcome)? and (2) Did the program operate the way it said it would (process)? A meaningful evaluation depends on developing evaluation standards, tools, and procedures in advance and carefully gathering appropriate data throughout the life of the program.

Another way of conceptualizing the independent living service process is through the Independent Living Service Delivery Continuum (Cook and Ansell 1986). The continuum identifies the acquisition of living skills and experience from its most basic form through independence. Transitional living programs may provide services in any or all of the four phases of the continuum: informal, formal, supervised practice, and aftercare. The informal phase views individuals as acquiring basic living skills through informal observation and trial and error. This phase tends to occur early in one's life and continue through the remaining phases.

During the formal phase, living skills are acquired through formalized instruction and activities designed to provide experience. This phase tends to be the point where many transitional living programs begin through either an organized curriculum or structured practice experiences.

The supervised practice phase places individuals in a nonparenting situation where they can utilize the knowledge and skills they have learned thus far in a setting that allows independence but with a safety net to protect them from mistakes that might have life-threatening consequences (Cook and Ansell 1989). This phase typifies a low-supervision apartment setting.

The aftercare phase is independence without the benefit of a safety net. It is typically the point where TLP clients either continue successful living on their own or relapse to an earlier phase.

Physical Setting

Physical setting options vary on a continuum from maximal supervision and structure to minimal supervision. TLP youth may progress through a variety of settings as they successfully complete program stages or they may remain in a single setting with increasing freedom and responsibility as they progress. Other issues related to the physical setting include staff-to-client ratios, opportunities for transitional living task completion, and access to community resources. Kroner (1988) originally described most of the setting options and their characteristics for TLPs. An enhanced overview with additional settings and characteristics is presented in table 1.

Table 1. Characteristics of physical settings for transitional living programs (TLPs)

Setting	Characteristics				
	Supervision	Structure	Staff to client ratio	Opportunity for TLP task completion	Access to community resources
Institutions/residential treatment centers	High	High	Low	Low	Low
Group homes	High	High	Medium	Low	Medium
Shelters (runaway/homeless)	Medium	Medium	Medium	Medium	High
Foster homes	Medium	Medium	High	Med-High	High
Supervised apartments					
High	Hi-med	Variable	High	High	High
Low	Low				
Host homes	Variable	Variable	High	High	High
Live-in roommate	Lo-med	Low	Medium	High	High
Boarding home	Low	Low	Low	Med-Low	High
Family home	Variable	Variable	Medium	Variable	High
Unsupervised apt/room	Low	Low	Low	High	High

An important consideration when choosing any setting is the cost. Most settings require some type of staffing, either by onsite advisors or contract arrangements with host home owners or live-in roommates. Agencies either own or lease the apartments. Occasionally, houses or apartments have been donated. Programs may also develop special contracts with large apartment complexes or boarding and rooming house vendors.

Several methods have been devised for reducing the overall cost, such as offering free room and board with a small stipend to resident advisors as opposed to using full-time resident staff. Another incentive is to allow resident advisors to maintain full-time day employment when youth are normally involved in educational and employment activities. It is not uncommon for employed program youth to contribute to their own housing costs while enrolled in the program. Parents may also be asked to contribute to their child's costs. Many States use foster care payments to subsidize transitional living services. Just as it is important to be comprehensive in considering the type(s) of setting for a TPL, it is essential to consider who will contribute, and in what form or amount, to the cost of the residential setting.

Institutions/ Residential Treatment Centers

Common examples of institutional settings include juvenile justice detention and correctional facilities and inpatient psychiatric and drug and alcohol rehabilitation centers. In general, these settings accommodate large numbers of residents and patients and are usually very restrictive, with a focus on maintaining a high degree of structure and compliance. Residents rarely have opportunities to participate in activities normally associated with preparation for independent living, although greater freedom and responsibility are often provided as youth near discharge.

Group Homes

Group homes are generally located within the community, and youth residents have opportunities for direct interaction with the activities and individuals they will likely encounter on their own (e.g., employers, schools, mass transit systems, counseling agencies, and support systems). Because group homes generally serve fewer residents than institutional settings, they are able to provide more consistent and individualized interaction, feedback, opportunities for typical transitional living activities (e.g., meal preparation, shopping, laundry, employment). A common outcome for residents upon discharge is situational depression or a feeling of loss for the individuals who provided a daily support system. This most often disappears during the early TL experience as the youth develop new support systems.

A major variation or adaption of the group home is the dormitory setting used by the Neon Street Center in Chicago. This program maintains a 30-unit building where clients have their own sleeping quarters but share common dining, food preparation, and recreational areas.

Shelters

Runaway and homeless youth shelters are not ideal settings for transitional living program youth due to their transitory popula-

tions. Shelters can be used for assessment, orientation, and short-term (emergency) residence until a more appropriate, longer term setting is available. Clear expectations for TLP participants in this setting are important as a means of providing a smooth transition to a more stable setting. The Webster House Transition to Independent Living Program in Muskegon, MI, is an example of a program that provides residential services through its runaway and homeless youth shelter.

Foster Homes

A common alternative for youths engaged with a public child welfare agency and unable to live with their own family, foster homes can provide a more natural transition to independence. This is particularly true for those youth who have lived in the same foster home for an extended period of time and who are being discharged directly to the community. Since foster homes exist within the community, the youth has both opportunity and access to existing resources. The foster home provides a high level of consistent daily supervision/monitoring and can easily accommodate increasing levels of responsibility and freedom for youth moving toward their discharge from care. Like many of the settings yet to be described, the recruitment, training, and support of specialized staff (e.g., foster parent, live-in roommate, resident advisor) are essential for program success.

Supervised Apartments

Supervised apartments provide a very realistic opportunity for youth to experience the normal responsibilities and expectations of independence. Two to four youth generally occupy each apartment with or without an onsite resident advisor. This setting offers two options: a high degree of onsite supervision from a live-in resident advisor or low supervision with no live-in advisor but unannounced apartment visits for monitoring purposes by TLP staff. The apartments may be owned or rented by the agency. Youth in supervised apartments are generally immersed in TLP activities because the setting and the program are closely related.

Variations of the supervised apartment setting include the scattered site approach used by New Life Youth Services in Cincinnati, where clients live in individual apartments within a 10-mile radius of the program office, and the congregate or cluster-site approach, where several client apartments are located in the same building. Examples of the latter approach are the Sasha Bruce Youthwork's Independent Living Program in Washington, DC, and the DIAL-SELF program in Greenfield, MA. The Valley Youth House program (Allentown, PA) has clients progress through a supervised apartment into an unsupervised agency apartment and eventually into one they locate and live in upon program completion.

Host Homes

Host homes are similar to high-supervision apartments in that youth are immersed in the transitional living experience while being supervised and monitored by an adult. In this setting, the youth lives in an established home in one of the bedrooms, with free access to most or all other areas of the house. Rental payments are made directly to the host home owners.

A variation on this setting is the "mentor home" of the Safe Harbor program in Haverhill, MA. This is a modified foster home, where clients live before moving into their own unsupervised apartment.

Live-In Roommate

In this setting, youth share an apartment with an adult. The adult, who is generally a contract program staff person, serves as an appropriate role model with no direct authority over the youth. As the youth nears the end of program services, either roommate may be withdrawn to provide total independence for the transitional living program youth.

Boarding Home

Often used an an interim living arrangement for youth not yet ready for total independence, boarding homes offer access to residents in similar situations, recreational facilities, and prepared meals (since most boarding homes do not have in-room cooking appliances). This setting works most effectively when agencies develop special arrangements with boarding home and large room operators such as YMCAs.

Family Home

While not often thought of as a likely setting, this alternative works well with families willing to provide time-limited residence to their child who is participating in a structured TLP. It has also been helpful in completing successful separations for youth leaving their families. This model is typically one of many choices for programs offering outclient transitional living services, such as many statewide programs like the Maine Department of Human Services Bureau of Child and Family Services.

Unsupervised Apartment/Room

Unsupervised settings are generally reserved for the highest functioning youth who are near or at the end of their program participation. Youth function without supervision, and staff intervention is provided on an as-requested or followup basis. For example, Ozone House in Ann Arbor, MI, has a long history of client self-determination and empowerment. Its clients immediately begin in their own community apartment with little or no supervision or monitoring.

Geographic Context

The location of the program can be an important determinant of client and program success. In general, there are three different contexts: urban, rural, and suburban. Each area raises numerous considerations for program design, including resource availability, economics, and client neighborhood or community of origin.

Urban settings typically offer the greatest range of opportunities and dangers. Youth have more employment options, better public transportation, and more varied and physically accessible education programming. They must also deal with street crime, the temptation to use a variety of easily available drugs, and high living costs.

Most large cities have several TLPs, which may specialize in several, all, or specific types of clients. For example, the Transitional Living

Program operated by Alternatives for Girls in Detroit h/ a strong street outreach to young female prostitutes. The Neon Street Center in Chicago provides extensive services to HIV positive and gay and lesbian clients, and Kaleidoscope in Chicago provides TLP services to severely emotionally disturbed clients.

Suburban settings—bedroom communities of large metropolitan areas as well as small to medium-sized cities lacking the urban core of a major metropolitan area—are similar to urban areas but offer some particular challenges of their own. Depending upon the local economy, these areas may offer good educational and employment opportunities, but few have reliable and efficient public transportation systems. The cost of living is usually lower than urban areas, but there is likely to be greater resistance from community members to establishing housing for youth.

Suburban projects are in many ways hybrid programs that may serve a combination of urban clients who moved out of the city, rural clients who have moved in, and clients who have lived in suburbs for most of their lives.

Rural settings, while they can be idyllic for personal and physical development, often offer the greatest challenge for youth and for program planners. Job opportunities—typically, agriculture or a single local industry is the major employer—are limited to low paying, physically taxing work. There are few opportunities for advancement or for exploration of alternative careers. Educational opportunities are equally limited by the lower tax bases supporting such areas. Transportation poses the greatest problem for TLPs; virtually no public transportation is available. Youth must have cars, arrange for friends or family to transport them to work and school, or depend upon the program staff.

Nonetheless, many transitional living programs operate in rural settings. Some entire States can be characterized as rural. The Maine Department of Human Services, Bureau of Child and Family Services, operates a statewide program that challenges staff with problems such as the high percentage of time spent in transit between locations. The urban and suburban areas, such as Portland, Augusta, and Bangor, tend to be served by private, nonprofit agencies.

Location of the program's residential and nonresidential sites must be carefully considered, whether the program is rural, suburban, or urban. Several questions should be considered when determining the best location for a transitional living program.

- Will youth in the program remain within the program's geographic area or return to their home community or neighborhood?

  If youth are to remain in the area, the TLP must ensure that the necessary facilities and services are available for them when they finish the program. Youth with strong relationships and supports in their own community often feel a strong pull to

return. These pulls must be acknowledged and addressed by both youth and program staff. Together, they must weigh the types of support available from family and friends in their community of origin against the loss of current employment and transitional living program support systems. Depending upon the setting to which the youth are returning, the temptation to backslide into previous nonproductive patterns must also be factored into the equation.

- How available is transportation?

  Since it is unlikely that TLP clients or program graduates will have their own vehicles, the program should be located in an area that has potential employment sites within walking or biking distance or near public transportation.

- How accessible are the stores and services TLP clients will use during and after program involvement?

  Since few youth will have their own transportation, the facilities should be located near essential services.

- Are affordable housing alternatives available for clients after discharge from the program?

  For youths' transition to be truly successful, they must succeed after leaving the program. One essential component of that success is procurement of decent affordable housing. Since most youth will be employed in the general vicinity of the program and will leave while employed, it is crucial that other affordable housing alternatives be explored and identified.

- How safe is the setting?

  For many youth, night work will be a necessity. The residential settings selected should not be located in areas that pose great dangers to youth returning late at night. This will create a dilemma for many programs—particularly those in urban areas—since affordable housing is most frequently found in high-crime neighborhoods.

  If programs have no alternative but to locate in less desirable neighborhoods, they must work with youth to alert them to safety precautions (self-defense classes, mace, traveling with a friend, avoiding areas of particular danger) and provide as much security as is possible (secure door bolts, burglar bars).

- Are there employment opportunities in the area that offer progressively more responsible positions for youth?

  The availability of such opportunities is essential if youth are to escape the status of working poor. Since the program will be seeking employment for a concentrated population of youth who may lack the competitive skills and resources of their

in-school or graduated counterparts, the continuing availability of jobs, particularly those with opportunity to prove oneself onsite and to advance to more responsible and higher paying positions, is crucial.

- Are there other service programs in the area that will refer youth to the TLP?

  When considering the program's geographic area, potential referral sources should be reviewed to determine whether ongoing identification and referral of TLP clients will occur. Program planners should discuss with other agencies their existing or planned TLPs within the same geographic area. Such a review and discussion with similar programs can develop complementary rather than competitive programming for youth.

- Are there qualified individuals in the area who could be tapped for employment in the program?

  Another important consideration is the availability of potential staff within the geographic area. In general, a TLP may need several different levels of staff including professional (therapist, counselor) and contract (houseparents, resident advisors) staff. Agency directors should review the potential employee market as well as their current staff recruitment and retention policies to ensure that they can adequately fill positions.

- What is the general economic condition of the area?

  The general economic condition of the area should be considered in both program costs and the likely impact on clients in and leaving the program. A community experiencing high unemployment during a recession, for example, will present obstacles to youth in a TLP. They will be competing for scarce jobs and affordable housing with unemployed adults possessing more skills and greater responsibilities.

Cultural Aspects

The ethnicity and related cultural aspects of the client population are important considerations in all areas of a program. An understanding and sensitivity to issues related to ethnic origins, gender, cultural traditions, expectations, and values will enhance the staff's ability to engage and maintain TLP clients throughout their participation.

Many cultures operate simultaneously in the program: the cultures of the youth, of the staff, and of the program itself. A program that attends to and respects each of these cultures will find itself better able to serve youth from a broad array of backgrounds and problems than will programs that ignore or give only cursory attention to such issues.

The youth's cultures—in the broadest sense—include their ethnicity, age and development stage, gender, family and interpersonal

dynamics, sexuality and sexual orientation, and problems of the moment. No two youths—even those of the same ethnicity and gender who come from the same neighborhood—will share the exact same cultural background. Recognition and respect for these differences is conveyed through program policies and curriculums, through staff attitudes and behaviors, and through the physical attributes of the program.

Program curriculums should provide for the exploration of the youth's cultural and ethnic heritage as a source of pride and strength. Such explorations could be merged into general education units such as history, social sciences, or reading. They could also constitute a component of the youth's life book or family history. Whatever the context, youth who are urged to connect with their own heritage and encouraged to take pride in it have an opportunity to tap into a personal and social context that can serve as a reservoir of strength and support even after they leave the program.

Staff composition is a key element of cultural sensitivity. To the extent possible, the staff should reflect the client population's race, ethnic origins, gender, and background. Although people of similar backgrounds do not necessarily share the same world view, the presence of a diverse staff conveys a message of acceptance and inclusion that will help youth feel more comfortable in the program. This is not to suggest that staff of a particular background are unable to work with youth who are different. In fact, such cross-cultural connections can actually help youth feel more comfortable dealing with those who are different from themselves. However, for such connections to truly benefit youth, staff must be willing to recognize their own limitations, be willing to involve others in helping the youth, and have a working knowledge of a variety of resources in the community capable of providing help when needed.

If staff members are expected to recognize and acknowledge their own cultural blind spots, they must be assisted through ongoing cultural sensitivity training. Such training should explore the "isms" and phobias that are generated through ignorance and fear and should help staff become more aware of and sensitive to differences. Such training should be a part of every staff person's initial training. Various aspects of cultural sensitivity should also be included in regular inservice training to provide encouragement and support for staff in translating the awareness generated in training into the program's daily activities.

Program policies should provide mechanisms for addressing cultural problems when they present themselves—whether it is among youth, among staff, or between staff and youth. The presence of such problems should be viewed as an opportunity for raising consciousness and for learning new ways to negotiate in situations where anger and prejudice have surfaced. These negotiation skills will be crucial for youth who are likely to face discrimination and prejudice in their work and educational settings. The skills gained

through such a process will help both youth and staff in facing a variety of volatile situations.

The program's physical space says a great deal about the consciousness of the staff. Look at the common areas, the counseling rooms, the spaces used for education, recreation, cooking. Do the pictures on the walls reflect the various cultures represented? Are resources visible and readily available for Latino, white, African-American, and gay and lesbian youth? Would different types of youth walking into these common spaces for the first time see themselves anywhere? Such "microchanges" are low cost and very effective ways to give the message of acceptance and support to youth.

Cultural sensitivity should not be construed as referring only to minority populations, although much of the literature and training focuses on responses to these groups. White, middle-class youth, who predominate in suburban and rural programs, also have specific cultural and rites of passage issues. Programs should consider the rites of passage of all youth, regardless of their race, ethnic origin, religion, or culture.

An excellent example of a transitional living program that provides a high cultural sensitivity is Sasha Bruce Youthworks (Washington, DC), which serves African-American youth. The clients participate in an Afro-Centric Rites of Passage group, which lasts 4-6 months and is based on the traditional rites of passage in the African community. It teaches heritage with the goal of building self-esteem and includes role modeling, a retreat away from the city, and respect for elders. The Urban League of Essex County, NJ, also provides a Rites of Passage-type program for its African-American transitional living clients.

Theoretical/ Clinical Base

The theoretical and clinical base of a TLP influences everything that happens in the program. Clients are perceived, evaluated, treated, and served according to an underlying theory of "normal" development and behavior that determines the core values, beliefs, and understanding of adolescents as a client population. Much of this theory comes from staff who hold human service (social work, psychology, counseling, etc.) degrees and have received basic lifespan or human development education and training.

Transitional living programs generally have an individual psychological orientation, a systems orientation, or some combination. Most commonly, they appear to understand and evaluate clients within a traditional psychodynamic model and to provide planning and services within a systems model. Another important distinction is whether a program is skill-based, clinically based, or some combination. While most programs generally contain elements of both, they usually emphasize one aspect over the other.

A review of existing programs indicates that most TLPs emphasize skill building through teaching and experiencing future skills of

independence. Many also provide clinical counseling to address, manage, and resolve past and present emotional, psychological, and behavioral issues that inhibit client success. While skill-based programs may not provide clinical counseling services, they still use important theoretical and clinically based knowledge in their day-to-day operations for such activities as intake interviews, developing appropriate plans, and managing various types of client behavior.

Intake Assessment

One of the first contacts with the client is through the intake assessment. A major consideration is who conducts the intake interview with referred clients and the format of the interview. Because the intake interview is more than the collection of information, the intake interviewer should be experienced in clinical interviewing. This should serve the diagnostic and planning process well, since the interviewer will have insight in understanding and formulating therapeutic impressions beyond the use of personality inventories and other diagnostic tools.

While the depth of information gathered may differ among TLPs, the intake interview will generally elicit the following information:

- *Referral*—source, contact person, reason for and circumstances at time of referral
- *Client description*—age, gender, ethnic origin, physical appearance and presentation, religion, etc.
- *Presenting problem*—youth's perspective on current status, assets, liabilities, personal goals, and life plans; referral source's perspective on youth's current situation; parent or family perspective on youth status, assets, and liabilities
- *Current functioning*—youth's educational and employment history, extracurricular/recreational activities, hobbies, areas of interests, peer group, nature of interpersonal relationships, drug and alcohol history/assessment, sexual abuse history, sexual activity, use of birth control, etc.
- *Family history*—generational history including marriages, separations, divorces, deaths; drug and alcohol use and mental health; education, occupations, and important childhood, adolescent, and adult events
- *Medical history*—previous illnesses, operations, hospitalizations, allergies to medication, current medication uses, current medical coverages, and significant family illnesses
- *Social service history*—present or past juvenile justice, child welfare, counseling, and psychiatric hospitalization history; reasons for and dates of involvement/hospitalization, and names(s) of probation officers, caseworkers, counselors, or therapists; degree to which youth felt they benefited from involve-

ment; previous psychiatric, psychological, or educational testing

- *Diagnostic impressions*—may or may not contain DSM-III-R diagnosis, thematic overview of primary client issues, assets, liabilities, and recommendations based on what intake information provides and what interviewer diagnostically believes

- *Goal/plan*—This may be separate from the intake and is generally according to the specific requirements, structure, and format of each program; an important outcome may be the need for additional psychiatric, psychological, or educational testing.

Counseling Services

Transitional living clients are older adolescents (aged 16-21) who by and large come from dysfunctional families who have rejected them. They frequently have had prior juvenile justice, child welfare, or counseling involvement and histories of physical and sexual abuse as well as varying drug and alcohol experimentation and use. They generally have had unsuccessful or unsatisfying educational experiences. They frequently are developmentally delayed by varying degrees and often possess poor interpersonal and social skills and are generally not adroit at problem solving and decision-making.

Given those circumstances, most TLPs provide counseling within the program or by referral to an outside agency or individual during the youth's participation in the program. Decisions about whether counseling services will be provided on an individual, group, or combination basis should be considered prior to program startup. If provided in-house, it is important that the designated staff possess the necessary education, training, and clinical skills to successfully work with this special population. Programs choosing outside counselors should apply these same standards to the community agencies or individual practitioners who work with their TLP clients.

Nationally, there is great diversity in the provision of clinical counseling services. Programs such as Sasha Bruce Youthwork (Washington, DC), Lawrence Hall Youth Services (Chicago), and Valley Youth House (Allentown, PA) provide clinical counseling services to clients by designated (therapist or counselor) staff. Programs such as Webster House's Transition to Independent Living (Muskegon, MI) and Mercy Center Ministries (Patchoque, NY) provide those services by referral to another agency.

It is quite common for new transitional living programs to provide clinical counseling services by referral. This frequently occurs for reasons such as reducing program costs and a philosophical belief by many programs that TLP services need to be primarily focused around life skills, employment, and housing.

Some programs provide counseling services by using both program staff and referral to other community agencies. This variation offers

better matching of the unique therapeutic needs of clients with those therapists or counselors who can best meet them.

Family Involvement

Another issue is whether the program will involve the TLP client's parent/families. This is important because it can offer an opportunity for positive separation from the family of origin or allow parents/families to reject or sabotage the youth. Whether a TLP program includes family involvement or not, it should be prepared to deal with family dynamics and issues of separation from the family.

Service Linkages

Service linkages are those individuals, agencies, businesses, or parties who have varying degrees of contact with a TLP, its staff, and its clients. Examples of participants in the service linkage network include other public or community agencies, referral sources, employers, educators, landlords, consultants (who offer training to the program), businesses TLP clients frequent (food and clothing stores, movies, etc.), services TLP clients use (transportation, banking, etc.), businesses who supply goods to the program (office supply, business machine, grocery stores, etc.), and parents, families, important others, and groups or persons with whom clients routinely interact.

Understanding how a TLP fits within an existing agency and within the constellation of community agencies and services is vital for developing ongoing linkages with existing resources. Three important issues to consider are the connectedness of service linkages to the program or client(s), the method of communication to and with other parties, and whether they provide or receive something from the program or clients.

A program should never underestimate the extent and value of its service linkages. Positive relationships help assure smooth and effective program functioning, realistic positive relationships and opportunities for clients, and a variety of other less tangible benefits. Poor relationships distract the program, staff, and clients from the goal of successful preparation for independence. While the squeaky wheel may get the grease, it most assuredly slows, disrupts, or postpones the trip till it is fixed.

Low or subsidized rent is at a premium in most communities, regardless of whether they are in urban, suburban, or rural settings. This presents a unique challenge for transitional living programs. Several have developed noteworthy linkages to meet this ongoing problem. Ozone House (Ann Harbor, MI) participates in a network that identifies appropriate housing for its clients. Kaleidoscope's Youth Development Program (Chicago) has two staff housing coordinators whose primary responsibilities include locating appropriate apartments and developing and maintaining relationships with landlords. Franklin County, MA, DIAL-SELF developed a partnership with a housing authority and community development corporation. The community development corporation rehabilitated a

condemned building, and the housing authority provides subsidized rents for apartments within the building. In addition, their well-developed relationships with landlords includes their participation in the client's orientation process.

Employment is another difficult challenge for transitional living programs to continually meet. As one program director commented, "Every transitional living client cannot work at McDonald's!" Noteworthy employment linkages include the Neon Street Center (Chicago), which has partnered with businesses to develop corporate sponsorships for entry-level positions that have "shadowing" or monitoring features. Alternatives for Girls Transitional Living Program (Detroit) maintains an ongoing job development effort with five businesses.

An extremely well developed employment component is provided at Aunt Martha's Youth Service Center's Transition to Independence Project and Project On Your Own (Park Forest, IL). Aunt Martha's Center has a Youth Employment Unit that operates as an in-house employment agency. It also has a Try Out Employment program that pays the client's first 6 weeks of wages for employers to "try out" their clients as employees. They have successfully maintained an 85-percent placement rate.

Training

Training builds and maintains competency for both TLP staff and clients. Serious consideration and implementation of training ensures a greater preparedness to accomplish the mutual goals of teaching and competency skills.

Staff Training

Training preparedness is part of the staff recruitment and selection process. Base levels for each position's level of competency are established prior to the first candidate interview. The goal of the staff selection process is to find those individuals with high levels of training, experience, and likelihood of success in working with a transitional living client population.

Staff training is an ongoing process. The program's responsibility is to identify individual and program training needs and determine measurable goals and strategies for meeting those needs. It is also important to establish a method for measuring achievement of those goals. Strategies for achieving individual and program staff training goals include supervision, inservice training, out-of-agency training (workshops, seminars, conferences), subscriptions to related professional journals and newsletters, and networking with other TLPs.

Client Training

Client training involves identifying the specific, tangible, and intangible skills to be taught and devising methods for teaching or opportunities for learning and using the skill. This includes the development or identification of curriculums and relevant instructional materials. A comprehensive pretesting and assessment of

client skill levels will help establish individual training needs and direct the depth of the group skills training process.

Numerous prepared transitional living courses and curriculums are available from a variety of sources (see "Resources"). In addition to prepared materials, TLPs use community consultants who contribute their time and expertise in their specialized areas (e.g., credit, landlord relations, job interviews). These experts can help develop appropriate curriculums and may be used as actual presenters or trainers.

Audio and video equipment have been successfully used in training activities with TLP clients. Clients' role playing has been videotaped and then critiqued by both professional staff and TLP peer group members. This group process has been effective in teaching independent living skills and in managing problematic or disruptive behavior.

Conclusion

Transitional living programs are simultaneously concrete, abstract, and complex. Individual components of the Transitional Living Conceptual Framework generally speak to identifiable, observable, and documentable pieces of information. The process of successfully thinking through the program involves understanding the nature and scope of each component, brainstorming alternatives, intellectually playing out scenarios to avoid surprises and unplanned outcomes, and making choices that best fit the specific needs of a program's unique client population, mission, goals, and objectives.

Programs begin as abstractions and become grounded with implementation. Experience highlights the interactive nature of the framework's components. While they appear very complex and unclear initially, they eventually yield a comprehensive, well thought out TLP.

References

Cook, R., and Ansell, D.I. *Independent Living Services for Youth in Substitute Care*. Prepared for the Administration for Children, Youth, and Families, U.S. Department of Health and Human Services, Rockville, MD: Westat, Inc., 1986.

Cook, R. Trends and needs in programming for independent living. *Child Welfare* 67(6):497-514, Nov.-Dec. 1988.

Kroner, M.J. Living arrangement options for young people preparing for independent living. *Child Welfare* 67(6):547-561, Nov.-Dec. 1988.

Mech, E.V. Preparing foster adolescents for self-support: A new challenge. *Child Welfare* 67(6):487-495, Nov.-Dec. 1988.

Mech, E.V., and Leonard, E.L. Volunteers as resources in preparing foster adolescents for self-sufficiency. *Child Welfare* 67(6):595-608, Nov.-Dec. 1988.

SPECIAL POPULATIONS

Under ordinary circumstances, a successful transition into adult independent living requires the attitude, maturity, and life and problem-solving skills necessary to locate and maintain ongoing housing, employment, and significant relationships. The absence of successful life experiences and consistently appropriate adult role modeling creates unique challenges for the learning of skills and attitudes that most older adolescents and young adults acquire through normal family living.

Even more challenged are those subgroups whose emotional, medical, or life situations present unique obstacles to their successful transition to independent living. Developmentally delayed, HIV-infected, and pregnant and parenting adolescents have unique issues and needs for transitional living programs.

The following chapters examine these special populations through the presentation of information necessary to understand the specific subgroups and the identification of issues and needs relevant to the provision of transitional living services to these populations.

PROGRAMS FOR ADOLESCENTS WITH DEVELOPMENTAL DELAYS

Defining the Issues

The main goal of adolescence is individuation, the process of molding a self that is separate from family and unique to its world. Essentially, the goal is "to make an initial separation from the family and to consolidate an identity and value system" (Norman 1980, p. 23). Note that this separation speaks to an emotional transition. For many youths in transitional living programs, physical separation from family occurs at an early age.

The purpose of this section is to clarify the similarities and differences between developmentally delayed adolescents and the "normal" population and to use those similarities and differences to highlight effective treatment strategies for the developmentally delayed population.

This goal of achieving independence is well served by transitional and supportive living programs for homeless adolescents. The transition to individuation and independence is often fraught with difficulties in this culture, particularly for homeless youth. But to the developmentally delayed adolescent, it presents additional challenges.

What exactly is meant by the term "developmentally delayed?" This is a difficult question to answer, as the terms "developmental delay," "developmental disability," and "developmental difference" have been used in a variety of contexts, in some cases synonymous with learning disabilities, mental retardation, conduct disorders, and a wide range of physical problems (e.g., Barkley 1990; Schalock 1990). Thompson and O'Quinn (1979) presented the following general description:

> Wherever an aspect of functioning is not demonstrated by an individual at an age when the majority of children of similar age demonstrate it, the individual is considered to be exhibiting a developmental delay. (p. 16)

In this monograph, the terms "developmentally delayed" and "developmentally different" are used in a general sense to include the above conditions. Developmentally delayed persons follow an alternate route to independence. For each person, the route is unique. The challenge for transitional living service providers is to

assist discovery of ways to navigate each unique path to the ultimate goal—independence.

"Normal" Development

To understand the impact of developmental delays or differences, it is important to grasp the way "normal" development is understood. Erik Erikson (1963), the pioneer developmental theorist, was the first to view development as a phenomenon occurring throughout the entire lifespan. He proposed that personality develops through a sequence of phases or stages. Each phase presents a person with a challenge. That is, each phase represents a point at which a person may grow and develop or become emotionally "stuck." The degree to which a person is stuck, or has not met the developmental challenge, corresponds with maladaptive personality traits in that particular area. But stuck or not, everyone advances through the same stages in the same order, at roughly the same chronological age.

For example, a girl developing normally finds herself facing the fifth of Erikson's eight stages at adolescence. This stage, "identity versus role confusion," is particularly challenging in our society. This challenge represents the difficult transition from dependent childhood to the individuation and independence of healthy adulthood. Mildred Eisenberg (1975) noted:

> The young person attempting to cope with sociological and cultural upheaval . . . is developmentally at Erikson's fifth of the eight stages of man . . . At this stage anxiety indicates role confusion and a realization that "time is running out," that one must terminate [dependence], and that binding choices must be made. (p. 187)

Finding the answers to questions such as "Who am I?", "Must I be like my parents?", and "Why am I here?" in a personally satisfactory way is central to resolving this transition in a healthy, adaptive way.

The storm and stress of adolescence is not universal (Roediger et al. 1991), but our society presents no clear rites of passage to adulthood. For example, a 16-year-old is considered to be old enough to drive a car but not old enough to secure a loan. Two 17-year-olds may be parents, but they may not sign an apartment lease until they are 18.

In addition, the adolescent is coping with a myriad of physical changes—mood-altering hormones, changing body characteristics and, for some, abstract thinking. Abstract thinking, or "thinking about thinking" is the ability to reason in an abstract sense. This ability, experienced for the first time in adolescence, opens up whole new vistas of thought—and frustration.

This, then, is ordinary development—a combination of environment, physical changes, and cognitive growth that allows "normal" people to develop "normal" personalities. These are regular people facing regular life challenges all in the same order, all at about the

same time of life. For the "normal" adolescent, the challenge is gaining independence.

Developmental Delays

For the developmentally different person, the challenge is also gaining independence, but the process does not occur in the same way. While it was initially postulated that persons with disabilities progress through the same sequence of cognitive stages as "normal" persons, only slower (Zigler 1969), there is some evidence that this is an overly simplistic view of persons who are disabled (Clements 1988).

The alternate theory is that developmentally different persons may pass through those same stages, but in a different order. Stark and Goldsbury wrote (1990):

> Individuals in this age span with disabilities may be much more likely to show progression/regression in their development by alternating back and forth between stages of development. That is, they may show far greater discrepancies between levels of function in different areas of development. (p. 78)

Therefore, development for developmentally delayed persons is *fundamentally different* than for other persons. In order to plan effective treatment strategies to assist in the transition from adolescent to adult for developmentally delayed persons, it is essential to understand this difference.

To illustrate this confusing phenomenon—developmental difference—consider an analogy. Symbolize the transition to adulthood as a horse race. Each person has four horses, representing the following areas of development: physical, cognitive, social/emotional, and environmental. In order to reach adulthood, all the horses must reach the finish line.

For most people, the horses are evenly matched in terms of speed and stamina. They all come out of the blocks at the same time, reach the first corner at about the same time, and usually arrive in a photofinish at the gate to adulthood.

This corresponds to Erikson's fifth stage. The physical, cognitive, social/emotional, and environmental development all work together through the same sequence of events to produce a situation that holds the potential for a healthy transition to adulthood.

For developmentally different persons, the race may be a bit different. One of the horses may be much slower than the rest. One of the horses may bolt and actually begin running down the track in the wrong direction. A poorly trained horse may stumble into another racer, causing a perfectly healthy horse to stumble and lose time, or perhaps to sustain an injury and stop entirely.

For example, imagine a wheelchair-bound adolescent (slow physi-

cal horse). This physical disability may result in limited mobility (due in part to a slow environmental horse, which symbolizes poor access), thus hindering socialization opportunities. The physical horse has effectively tripped the social/emotional horse, which had normal potential but now represents delayed socialization skills. Due to this slowed social/emotional development, this adolescent may not be ready to separate emotionally from significant others.

On the other hand, this same adolescent may have average or above average intelligence (a fast cognitive horse). This person may be well aware of the individuation needs of his chronological age peers. He may intellectually desire independence, since that is the age-appropriate stage of development. In other words, his cognitive horse is impatiently waiting at the finish line for the rest of the racers.

In another example, a female, 19-year-old adolescent suffers from developmental expressive language disorder (a learning disability symbolized by a lame cognitive horse). The learning disability, in combination with an unresponsive school environment (a poorly trained environmental horse), has resulted in school failure.

The school failure causes poor self-esteem, which manifests itself in self-destructive behaviors. This may be symbolized by a perfectly healthy social/emotional horse being run into the rails by its environmental colleague. Meantime, this young woman's physical horse has finished the race. While she physically looks like an adult and may already have children, she lacks the cognitive, social, and emotional development necessary for a healthy transition to independence.

Developmental delays, or developmental differences, can be caused by a disability in any of the vital developmental areas:

- Physical (e.g., chronic illness, physical handicap)
- Cognitive (e.g., learning disability, mental retardation)
- Social/emotional (e.g., social rejection, attention deficit hyperactivity disorder)
- Environmental (e.g., low socioeconomic status, dysfunctional family system, trauma—including physical or sexual abuse)

Consequently, a concrete definition of developmental delay may be: a disability in the physical, cognitive, social/emotional, or environmental area that results in a change in the sequence and timing of personality development.

For the developmentally different adolescent, facing the main task of adolescence—independence and individuation—is a complicated challenge. Deficits in development are unique to each individual, based on the level of each area of development. *The goal of successful TL programming is to assist in all phases of development, paying special*

attention to the possible inequities among them and the conflicts those inequities may engender.

Program Planning

A high percentage of youth entering any TLP are likely to be developmentally disabled to some degree, since they have been unable to develop residential resources in their family or among friends. Because the various areas of development may be affected differently, a number of issues need to be considered in planning an effective TLP.

Physical Setting

Physical setting options, such as supervised apartments or group homes, which provide a high level of structure and supervision are important for this population, particularly in the initial phase of treatment. It is important to obtain an accurate diagnosis or assessment of which developmental areas are delayed. For youth with social/emotional delays, specialized foster homes may be most appropriate in order to provide a family setting and to avoid forcing individuation before the youth is socially and emotionally ready.

Because persons with developmental delays may have vastly different needs, it is often beneficial to group persons with similar needs together. Many young people benefit greatly from having peers of similar abilities as roommates, and genuine friendships may develop. On the other hand, some programs purposely choose not to have youth room together, as the deficiencies they have in common (for example, anger management programs) can be compounded. Supervisors or active mentors can resolve some of these problems, but this issue speaks clearly to the need for accurate diagnosis and program policy that allows for individualized programming to the greatest extent possible. During the evaluation of an independent living skills training program in Minnesota, youth reported that the flexibility of the program to meet individual needs was very important (Johnson 1988).

Smith (1988) highlighted the need for accurate diagnosis with disabled youth. She reported that youth:

> . . . need assistance in doing the detective work to discover which approaches, methods or techniques work for each individual and then help in explaining to others how they learn.
>
> The more they know about themselves, the better they can advocate for themselves, and the more likely they are to be successful. (p. 9)

Location

Geographically, an urban setting would offer this population more employment opportunities. A well-developed resource network of employers is likely to be necessary for several reasons. First, program youth are likely to have a wide range of functioning levels, necessitating a wide range of employment opportunities. For example, a youth with extremely poor social skills may require solitary

work while someone who suffers from extreme performance anxiety may require constant supervision. Some developmentally delayed persons may need to "fail" at several job positions before settling comfortably into success.

There are numerous implications for programs here. Employers must have appropriate expectations. The more involved they are in the program as a whole, the more realistic their expectations will become. They must understand the program and know the youth. Most importantly, staff must be available on an ongoing basis for consultation. A program that can employ a well-qualified job developer or job coach is at a distinct advantage in its ability to provide youth with work experience.

For programs committed to providing valuable work experience, the decision to be an active advocate for youth is as important as finding an urban setting conducive to employment opportunities. However, this benefit must be carefully weighed against the maladaptive peer influences that may be present in urban neighborhoods. Adolescents who are delayed in social and emotional development are more susceptible to peer influence than others. Developmentally delayed youth frequently engage in behaviors which, on a social level, are immediate indicators of their susceptibility to victimization of all kinds. They are frequently the antithesis of "street smart." For this reason, programming should include street survival skills, with both role play and real life practice in assertiveness, refusal skills, and conflict resolution. In addition, urban neighborhoods must be carefully screened, since these adolescents are at higher risk for substance abuse and other dangerous behaviors than other homeless youth (Hawkins et al. 1985).

Some developmental delays (e.g., physical handicap, mental retardation) are obvious to the eyes of misunderstanding neighbors. In this case, the anonymity of an urban neighborhood may be an important consideration. In addition, urban settings may provide more sophisticated access for youth with physical handicaps. All in all, geographic considerations are similar to all program planning for persons with developmental delays—the needs of each individual must be weighed.

Culture

In some ethnic groups (e.g., Hispanic) in which the extended family is intrinsic to the culture, developmentally delayed youth may find themselves firmly established in a permanent dependent position, whether they reside within the family home or not. In these situations, work with the entire family is required.

In addition, a large group of cousins and other young family members may provide powerful peer influence, be it appropriate or inappropriate. Inappropriate peer influence, whether its source be family or not, can be counteracted with a residential culture that seeks to create a group feeling within the residential setting. In other words, well-trained staff can facilitate a cohesiveness that produces a positive peer influence among residents. Staff must be

aware of the strong ties to family culture held by many developmentally delayed youth. This is a very real difference from the "normal" adolescent's rebellion from family beliefs. For those who have not begun the individuation process, the culture and opinions of significant family members are central to their belief system. Consequently, family members should be engaged as active participants in programming whenever possible.

Having experienced a physical but not emotional separation from family is frequently the underlying cause of client failure when family members sabotage program efforts or when the client returns to a dysfunctional family environment. These failures can be prevented through family intervention and a program policy with a strong therapeutic emphasis in addition to teaching life skills. In a very concrete sense, this means establishing program policies which encourage—rather than tolerate—visitation by family members. In addition, the individual program-planning process should include the active—as opposed to passive—participation of both youth and significant family members.

The importance of any available family involvement is also highlighted by the acute aftercare needs among this population. Developmental delays may take decades to resolve, and for some, will never be resolved. Ideally, funding availability and resources should be based on accurate needs assessment, *not* chronological age. Since this is seldom possible, responsible programming should include forging strong links to ongoing community resources, mentors, and family.

Service Linkages

In addition to formulating an active partnership among the treatment team, employers, parents (when possible), and teachers (where applicable), a wide range of community resources are required by this population. For example, in a study of youth receiving State social services (Association for the Advancement of the Mentally Handicapped 1988), a significant group was found to have emotional, physical, or developmental disabilities, which resulted in a greater than normal need for community resources. Nearly all of these youth had educational deficits requiring educational or vocational programs, and nearly half required mental health services.

Theoretical/ Clinical Base

An effective program requires a staff well grounded in normal developmental theory as well as developmental difference. This is essential and related to program policy regarding staff orientation, ongoing staff training, and supervision.

Group work as a modality is significant in any programming for adolescents and is even more so for this population. Developmentally different youth often have strong socialization needs and underdeveloped socialization skills, and many have experienced social rejection. Youth who have been socially rejected will fall into their usual interaction patterns when placed in a loosely supervised setting. That is, the socially rejected student will quickly become the

socially rejected Girl Scout. For this reason, the social skills training provided in a transitional living program is best employed in conjunction with cooperation from staff, teachers, parents, and other residents. Guevremont et al. (1990) reported:

> . . . in addition to the transitional social skills training procedures, active interventions in the natural environment using behavior change agents (e.g., parents and teachers) and behavior management procedures are absolutely essential to support changes in social behavior and promote improvements in social status. (pp. 543-544)

Note that parents and teachers often have a history of rescuing these youth, of "doing too much" (Smith 1988, p. 5). This means that many developmentally delayed adolescents have few or no experiences in planning for themselves and need to be taught explicitly to organize a project. But, more importantly, parents, teachers, and staff need to be taught the value of allowing them the opportunity to fail and to learn from their failures. Fortunately, highly supervised TLPs are uniquely suited to providing the necessary comprehensive programming required to address this social/emotional developmental delay.

Effective transitional living programs for developmentally delayed adolescents must provide a foundation for the facilitation of independence to the greatest extent possible. Bearing in mind that developmentally delayed persons have experienced disability in some area of development—and are conscious of that disability—a program that did not, for example, formally solicit participation by consumers in program planning would become another environmental deficit and source of frustration.

It has been found, for example, that learning disabled youth need to achieve a comfort level with their own abilities and disabilities that allows them to speak for themselves (Smith 1988). Once they have created a list of strengths and disabilities, they are capable of becoming their own best advocates. In illustration, a youth with auditory perception problems who is able to say, "Please speak more slowly," and to hold up an index finger while preparing an answer, is a youth on the way to independence.

The goal of transitional living programming for adolescents is to facilitate the initial separation from the family and to consolidate an identity and value system. In a word, the goal of programming for adolescents is independence, relative to emotional development as well as physical residence. For developmentally different youth, this goal is best facilitated by identifying areas of developmental delays and assisting growth in those areas. Development may not progress along a typical sequential and chronological course. However, the youth can be assisted in reaching the goal of a healthy transition to adulthood. To continue the previous analogy, all of a developmentally delayed persons horses will not reach the finish line to adulthood simultaneously, but the slow ones can be assisted in making a much more productive race.

Advocacy

Independence is not only key to all adolescent development but is central to normalization and its roles in quality of life measures (Bellamy et al. 1990). Concerning the measurement of quality of life in residential treatment for developmentally delayed persons, Goode (1988) wrote:

> Quality of life is a matter of consumer rather than professional definition. Quality of life issues should be defined by consumers and other citizens rather than by professionals in the field. Ultimately, it is how the individual perceives and evaluates his own situation rather than how others see him that determines the quality of life he or she experiences. (p. x)

Connie Martinez, a member of People First Capital Group, a self-advocacy group for persons with developmental disabilities, gained her own independence through a transitional living program. She sums up the needs of young adults with developmental disabilities in the following way:

> So, the first thing for the professionals and the parents to understand is that we can have a good quality of life if we have control over our own lives and if we have the help we need to keep that control and independence in our own lives. We don't need KEEPERS, we need TEACHERS. (Martinez 1990, p. 4)

The most significant question for program planners to ask themselves is "Does this program effectively teach self-advocacy?" Many persons with developmental disabilities perceive self-advocacy as synonymous with manipulation of others—something "bad" people do to get what they want. For others, attempts to manipulate other people are inappropriate and maladaptive. If a program can teach appropriate self-advocacy, or "healthy manipulation," it will be facilitating a skill that will be of lifetime use. Teaching self-esteem, assertiveness, and concrete advocacy skills may not feel as productive to a staff person as going out and doing the advocating, but it is infinitely more valuable.

In all then, transitional living programming for developmentally delayed adolescents requires careful attention to the individual and assistance in the growth of whatever area is needed to reach every adolescent's ultimate goal—independence.

References

Association for the Advancement of the Mentally Handicapped. Youth in transition from foster care system to independent living. *Children Today* 2(Mar.-Apr.):2-3, 1989.

Barkley, R.A., ed. *Attention Deficit Hyperactivity Disorder.* New York: Guilford Press, 1990. pp. 222-223.

Bellamy, G.T.; Newton, J.S.; LeBaron, N.M.; and Horner, R.H. Quality of life and lifestyle outcomes: A challenge for residential programs. In: Schalock, R.L., ed. *Quality of Life: Perspectives and Issues.* Washington, DC: American Association on Mental Retardation, 1990. pp. 127-138..

Clements, J. Early childhood. In: Matson, J., and Marchetts, A., eds., *Devel-*

opmental Disabilities: Lifespan Perspective. New York: Grune & Stratton, 1988.

Eisenberg, M. Brief psychotherapy: A viable possibility with adolescents. *Psychotherapy: Theory, Research, and Practice*, 12(Summer):187, 1975.

Erikson, E.H. *Childhood and Society*. 2nd ed. New York: Norton, 1963.

Goode, D.A. Quality of life for persons with disabilities: A look at the issues. In: Schalock, R.L., ed. *Quality of Life: Perspectives and Issues*. Washington, DC: American Association on Mental Retardation, 1988. p. x.

Guevremont, D.; DuPaul, G.J.; and Barkley, R.A. Diagnosis and assessment of Attention Deficit Hyperactivity Disorder in children. In: Barkley, R.A., ed. *Attention Deficit Hyperactivity Disorder*. New York: Guilford Press, 1990. pp. 543-553.

Hawkins, J.D.; Lishner, D.M.; and Catalano, R.F. Childhood predictors and the predictors and prevention of adolescent substance abuse. In: Jones, C.L., and Barrjes, R.J., eds. *Etiology of Drug Abuse: Implications for Prevention*. Washington, DC: National Institute on Drug Abuse, 1985.

Johnson, L.K. Teaching independent living skills in Minnesota. *Children Today* 17(Nov.-Dec.):19-23, 1988.

Martinez, C. A dream for myself. In: Schalock, R.L., ed. *Quality of Life: Perspectives and Issues*. Washington, DC: American Association on Mental Retardation, 1990. pp. 3-7.

Norman, J.S. Short-term treatment with the adolescent client. In: Turner, F.J., ed. *Differential Diagnosis and Treatment in Social Work*. New York: The Free Press, 1980. pp. 23-36.

Roediger, H.L.; Capaldi, E.D.; Paris, S.G.; and Polivy, J., eds. *Psychology*. 3rd ed. New York: Harper Collins, 1991.

Schalock, R.L., ed. *Quality of Life: Perspectives and Issues*. Washington, DC: American Association on Mental Retardation, 1990.

Smith, S.L. Preparing the learning disabled adolescent for adulthood. *Children Today* 17(Mar.-Apr.):4-9, 1988.

Stark, J.A., and Goldsbury, T. Quality of life from childhood to adulthood. In: Schalock, R.L., ed. *Quality of Life: Perspectives and Issues*. Washington, DC: American Association on Mental Retardation, 1990. pp. 71-83.

Thompson, R.J., and O'Quinn, A.N. *Developmental Disability: Etiologies, Manifestations, Diagnoses, and Treatment*. New York: Oxford University Press, 1979.

Zigler, E. Developmental versus difference theories of mental retardation and the problem of motivation. In: Schalock, R.L., ed. *Quality of Life: Perspectives and Issues*. Washington, DC: American Association of Mental Retardation, 1969. pp. 77-78.

PROGRAMS FOR HIV-INFECTED YOUTH

HIV and AIDS: An Overview

This chapter offers a very brief overview of human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS): background and definitions; how the virus is transmitted; numbers of people currently diagnosed with the disease and the estimated number believed to be infected; varying rates of infection within different age, sex, and racial groups; and projected infection rates in the future. This information is current as of January 1992. However, this disease is still new, and the numbers and percentages change frequently. Local AIDS service organizations or health departments can provide up-to-date statistics as needed.

This section is designed to offer easy access to the basic information needed to understand the virus, to inform staff, and to answer the most common questions about the disease. It is not an extensive or exhaustive review of information. It is important that human services professionals continue to educate themselves and their staff members by reading newspapers and journal articles, by watching television specials, and by attending training and information sessions.

Background and Definitions

AIDS, first recognized in the United States in 1981, has been reported in all States and on all continents of the world except Antarctica. AIDS is a serious infectious disease that undermines the body's immune system and leaves the affected persons susceptible to a variety of fatal opportunistic infections and diseases, including cancers, pneumonia, dementia, and wasting syndrome.

The causative agent, HIV, was isolated in 1984. In 1988, the National Academy of Sciences suggested the term "HIV disease" to describe the entire spectrum of diseases caused by the virus. Four stages are typically described: acute infection, asymptomatic infection, symptomatic infection (previously known as AIDS-related complex or ARC), and AIDS. Although these stages may be viewed along a continuum, individuals will not necessarily experience all of them.

Routes of Transmission of HIV

Although the numbers and percentages of those diagnosed with AIDS change from year to year, the routes of transmission—the way people get infected—have not changed. There are only three ways to get the virus:

- Through *unprotected sexual contact* in which there is an exchange of infected body fluids

- Through injection of *contaminated blood or blood products* via the sharing of drug injection equipment (works), the use of unsterile instruments in tattooing or ear piercing, and accidents in health care settings such as needle sticks. Infection through blood transfusions is now rare—approximately a 1 in 150,000 chance in 1990.

- From *infected mothers to fetuses* in the uterus before birth, during the birth process, or possibly to nursing infants through breast milk.

Numbers of AIDS Cases

As of January 1992, 209,693 cases of AIDS had been diagnosed; of those diagnosed since June 1981, 135,434 (or 65 percent of those diagnosed) have died (Centers for Disease Control 1992). Using the standard multiplier of 10-15 persons infected with HIV for each one diagnosed with AIDS, an estimated 1.5 million-2.2 million individuals are infected with the virus who have not yet developed AIDS.

The highest numbers of AIDS diagnoses are in New Jersey, New York, California, Florida, and Texas. However, as the numbers increase in the other States, the percentage of the total represented by these States will shrink.

Testing for HIV

A blood test is used to determine if a person has developed antibodies to HIV. Those with antibodies are infected with the virus.

A positive HIV test means a person has been infected with the virus and can transmit it to others. It does not mean the person has AIDS or any other symptomatic manifestation of HIV disease. A person who has tested positive for HIV may be healthy for many years. A person who tests positive on the screening test (the ELISA) is usually administered a second, more sensitive test (the Western Blot) to confirm the results and to help screen out false positives.

A negative HIV test means that the person has not developed antibodies to the virus. This does not necessarily mean the person is virus free. Of those who have been infected, 85 percent seroconvert (test positive for the virus) in 2-12 weeks; 15 percent seroconvert before or after that time. This means that in a some cases—and especially immediately after infection—a person may NOT test positive even though infected and capable of infecting others.

Clearly, the test for HIV is not a good screening mechanism for future sexual partners. Testing negative is not a guarantee of non-infection and offers no protection against future infections.

Confidentiality of Test Results

Since laws vary from State to State, it is important to be familiar with State and local laws before being tested. It is also important to know the difference between anonymous and confidential testing.

Anonymous testing means that people are not required to provide their names and that no record of their results is on file. Generally, they choose or are assigned a code number that they use to obtain their results. This type of testing offers the best protection against unwanted disclosure of test results.

Confidential testing means that a person's name is given, but rules limit who may have access to the information. Just as with other medical records, a person must give permission for the information to be released. Unfortunately, mistakes can be made and information released without permission.

Getting a Test

In most States, the local health departments provide HIV testing. Private physicians can also test for the virus. There is generally a waiting period (from a few days to a couple of weeks) from the time of the test until results are known.

The decision to be tested is not to be taken lightly. The waiting period can be very difficult, and hearing the results can be traumatic. It is essential that those considering testing be tested in a facility that offers pretest and posttest counseling. Many health departments, AIDS service organizations, and other health agencies offer such services free of charge.

People may decide to be tested or not for a number of reasons. Individuals must make the determination based upon their own circumstances. Some considerations are outlined below.

Reasons to consider getting tested for HIV

- To begin medical treatments

  Treatments are now available which, though they do not cure HIV disease, have helped those infected stay healthier longer.

- Worry about HIV is interfering with regular life

  If school, work, friendships, and dating relationships are suffering from a concern about HIV, testing may provide some resolution.

- If pregnant, considering becoming pregnant or fathering a child, or breastfeeding

  HIV may be transmitted to the fetus (current estimates are that about 25–30 percent of babies born to HIV-infected mothers are infected with the virus). There have been 12 documented cases to date of transmission through breastfeeding.

- If the information would provide motivation for adopting safer behaviors

  Learning one is HIV positive could provide impetus for protect-

ing others; learning one is HIV negative could motivate one to ensure against the future transmission of infection.

- If required to undergo mandatory testing

  The military and job corps currently require HIV testing prior to acceptance. The results of these tests become part of a person's medical record. Since a positive test will disqualify an individual from the military, it may make sense to be tested prior to application.

Reasons to consider NOT getting tested for HIV

- Anonymous testing in not available in the community

  The social, legal, and economic consequences of having others know of one's HIV infection can be devastating. Some with HIV infection have been rejected by family and friends, physically and mentally abused, and denied housing, medical care, jobs, and health insurance. If anonymous testing is not available, individuals may decide to avoid the risk of having others learn of their HIV status by electing not to be tested. Or they may choose to go to an anonymous test site in another area.

- All possible precautions against infection are already in use

  If a person is already doing everything possible to protect against infection, a positive test would not necessarily result in any behavior change.

- Coping with a positive test would be impossible

  Some people are convinced they would kill themselves or would refuse to practice safer behaviors to protect others if they knew they were infected.

One approach to assisting youth in making decisions about testing, known as the "Three Plus" approach, focuses on three key questions plus a discussion and role play. The questions are:

- Why do you want to be tested?
- Who are you going to tell?
- What are you going to do when you get the results?

Counselors and direct-care staff can assist youth in their decisionmaking by asking these basic questions and, if the youth and counselor feel comfortable, introducing a short role play exercise to help the young person explore motivations and feelings about the test.

The role play is set up by asking the young person to imagine that he/she is about to receive the test results. The counselor plays the

role of the clinician providing the results. They then act out scenarios in which the young person receives both positive and negative results. This allows the youth to explore reactions to both outcomes and opens the way for further discussion of the testing decision.

From HIV Infection to AIDS

HIV infection is still a relatively new disease. At this point, it seems that about 50 percent of those testing positive for HIV develop AIDS within 10 years. Some who test positive may never develop AIDS. It is too early to know for certain how the disease may progress.

Early in the epidemic, there were no effective treatments. AIDS was seen as a terminal illness; once diagnosed, it was just a matter of time. However, with the new drug therapies now being introduced, that perspective has changed. HIV disease is now being viewed by the medical profession as a chronic disease—much like diabetes. It cannot be cured and requires lifelong treatment, but it is not a death sentence.

This is an important breakthrough. It provides those who are infected with a new source of hope. It also signals the need for a change in attitudes and approaches of those providing services. Those infected with HIV need support and encouragement to adopt healthy life styles, to seek early treatment, and to think positively about their prognosis.

AIDS by Age and Gender

More males than females are diagnosed with AIDS. The overall male to female ratio is 9 to 1, but there is great variation in that ratio by geography, age, and race. In a study done in New York City, the ratio of males to females was much closer: 2.8 to 1 (Hein 1990). Even more dramatic was the finding that, among the youngest armed forces recruits, more females than males were infected (Hein 1990). The ratio was 1 to 2, one male for every two females. Several reasons for this have been suggested:

- The virus is more effectively transmitted from males to females than the reverse.
- Females tend to have partners who are 3 years older and older males have had more opportunities for exposure to the virus.
- There are more infected males than females in the population, so females are more likely to have contact with infected partners than are males.

AIDS by Race

The rate of AIDS diagnosis in the United States among Blacks and Hispanics is twice their representation in the general population. The overall population of the country is 80 percent white, 12 percent Black, 6 percent Hispanic, and 2 percent other. The percentages of those diagnosed with AIDS are 54 percent white, 29 percent Black, 16 percent Hispanic, and 1 percent other (Centers for Disease Control 1992). Given that drug use and unplanned teen pregnancies are endemic among those suffering from poverty and given the overrepresentation of Blacks and Hispanics in the lower echelons of our

society, it should come as no surprise that this disease is ravaging these populations.

The overrepresentation of AIDS among minority groups is even more dramatic among women. For Black women, AIDS occurs at four times their population rate; for Hispanic women, the rate is three times their population rate. The general population of women in the United States comprises 81 percent white, 11 percent Black, 6 percent Hispanic, 1 percent Asian, and 1 percent Native American. The percentages of women diagnosed with AIDS are 26 percent white, 52 percent Black, 21 percent Hispanic, and 1 percent other (Centers for Disease Control 1992).

The rates among children (up to age 13) are similar to those among women—not surprising when you realize than many children are exposed to HIV prenatally from an infected mother. The general population of children in the United States is made up of 73 percent white, 15 percent Black, 9 percent Hispanic, 2 percent Asian, and 1 percent Native American. AIDS cases among children are 21 percent white, 52 percent Black, 25 percent Hispanic, and 1 percent other (Centers for Disease Control 1992).

AIDS and Adolescents

To date, all reported AIDS cases among adolescents have resulted from the same routes of HIV transmission as with the adult population, although with different proportions. Adolescents are less likely than adults to be infected through homosexual contact and more likely to be infected via heterosexual contact.

Since the advent of blood screening, blood donor self-referral, and heat treatment of clotting factors, the risk of HIV exposure to infected blood or blood products in transfusions has been virtually eliminated. New HIV infections among adolescents will therefore come almost exclusively from sexual or drug-use exposures (Gayle and D'Angelo 1990).

It is difficult to identify the number of adolescents who have been infected with the virus. As of June 1991, the Centers for Disease Control reported only 695 adolescents between the ages of 13 and 19 with AIDS. Among the 20- to 29-year-olds, 36,266 cases were reported. Although the numbers for adolescents appear low, many of those in the 20- to 29-year-old age group must have been infected as teenagers because of the long latency period (up to 10 years) between infection and HIV-related illnesses.

AIDS cases in adolescents have been reported from 41 States, Puerto Rico, and the District of Columbia. Fifty-three percent of all adolescent cases have been reported in Florida, California, New York, Texas, New Jersey, and Puerto Rico. Fourteen percent of cases are from New York alone (Gayle and D'Angelo 1990). Such information can create a false sense of security among youth outside these areas. Youth need not reside in these areas to be at risk. Ours is a very

mobile culture, and the virus travels in the bodies of those who are infected.

Adolescent Characteristics Placing Them at Risk

Adolescents are at particular risk for HIV infection. This is especially true for those adolescents who lack the typical supports of family, friends, and school. Several general characteristics place most adolescents at risk:

- *Impulsiveness*—Not thinking through consequences of behaviors before acting
- *Sense of invulnerability and immortality*—Feeling they could not possibly be affected by AIDS
- *Sexual exploration and experimentation*—Trying out new behaviors
- *Dysfunctional beliefs and attitudes toward health care services and disease prevention*—Concerns about confidentiality and accessibility of care and discomfort introducing contraceptives that would protect them from HIV infection
- *Reliance on peers rather than adults for information*—Peers may be misinformed themselves.
- *Use of perceived peer group standards rather than actual norms to determine behavior*—Believing that "everyone" is sexually active and, therefore, they need to be, when, in fact, many are not sexually active.
- *Focus on the immediate rather than the long term*—Thinking rooted in the present and current experience rather than in the long-term consequences of their behavior.
- *Concrete versus abstract thinking*—This is particularly important when dealing with a disease with an incubation period of 10 years or more—how are adolescents to feel it is of immediate concern to them?
- *Fear leading to denial*—If frightened too much, they may simply deny the risk of unprotected sexual and drug behavior altogether.

Adolescent Sexual Risk

A 1986 Harris Poll found that 50 percent of youth were sexually active by the age of 17. Other studies have placed that figure anywhere from 59 to 90 percent.

Not only are many teenagers sexually active, most are not monogamous. Many believe they are monogamous because they engage in serial monogamy; they have only one sex partner at a time. However, since adolescence is a time of experimentation and exploration, most of these relationships last only a few weeks or months.

Through a series of these relationships and the resultant exposure to the partners of their partners, youth greatly amplify their risk.

They are already experiencing the consequences of that behavior. When the rates were adjusted for the percentage of individuals who are sexually active, adolescents were found to have the highest rates of gonorrhea of any age group. Their infection rate was two times that of 20- to 24-year-olds (Hein 1986).

Even though they are suffering the consequences of inadequate protection, these youth are not protecting themselves. In a study of youth who were users of health clinic services and who were considered at high risk for sexually transmitted diseases, almost half reported that they never used contraception of any kind. Fewer than 20 percent of the youth reported using condoms (Stiffman and Earls 1989).

Runaways, Homeless, and Other At-Risk Youth

Runaway and homeless youth have more problems than their nonrunaway peers. In a study of youth served in runaway centers in the eight Southeastern States (Southeastern Network 1991), these youth reported problems with:

- Low self-esteem (44 percent)
- Depression (39 percent)
- Drug/alcohol abuse (19 percent)
- Suicide attempts (23 percent)
- Abuse: Physical (38 percent)
  - Neglect (29 percent)
  - Emotional (30 percent)
  - Sexual (19 percent)

These youth are likely to engage in high-risk sexual and drug behaviors to alleviate distress. Sex and drugs become an escape from pain for some. For others, the sale of drugs and prostitution become primary means of survival.

They are also likely to be out of school. Most are attending irregularly if at all and, as a result, do not have access to the HIV/AIDS education programs offered through schools. They are likely to know even less about the disease, its transmission, and how to protect themselves than other, in-school youth.

Adolescent Drug Risk

Clearly, those using injectable drugs—and sharing needles—are at a high risk for exposure to HIV. These are not the drugs of choice for the majority of youthful drug users. Unfortunately, those are not the only drugs of concern.

Youth, especially runaway and homeless youth, are high users of drugs like alcohol and marijuana. These drugs, called gateway drugs because they often precede the use of other drugs, lower

inhibitions and cloud rational thinking. When under the influence of these drugs, youths may make poor decisions—about sexual activity or about drug use—that put them at increased risk for acquiring HIV.

A recent study of runaway and homeless youth in the Southeast compared the self-reported usage rates of various drugs with the self-reported rates of drug use by in-school youth (Southeastern Network 1990). Usage rates by runaway and homeless youth were higher for every substance (table 2).

Table 2. Self-report of drug use in past month (in percentages)

	School youth	Runaway/homeless
Beer	26	33
Liquor	16	18
Wine	17	2
Marijuana	9	19
Stimulants	4	10
Depressants	4	8
Narcotics	2	6
Coke/crack	3	8
Cigarettes	17	54
Sold drugs	3	10
Drunk	14	23

Behavior Change

Behavior change for youth is parallel to that of adults. Health educators tell us it depends upon three basic factors:

1. *Identification as a personal threat*—Youth must see AIDS and HIV infection as a disease that has meaning for them, not just for adults or for gay men. Unless they can identify their own risk, they are unlikely to make any change.

2. *Understanding the reasons for taking preventive measures*—Youth must clearly understand why certain precautions are important. If they do not understand what "body fluids" are, they are unlikely to understand why a condom should be used.

3. *Sense of personal efficacy in taking necessary precautions*—Even if they understand that the disease affects them and that using condoms can offer protection, they will not use them if they do not know how. Simply looking at a diagram of how condoms are put on or watching someone else put one on a banana is insufficient. Though it is better than no information, it is less likely to result in use of condoms than is actual hands-on practice.

Program and Agency Issues

Agencies cannot afford to ignore HIV and AIDS. They must address client- and staff-related issues directly to develop comprehensive policies, procedures, and educational activities that create a positive, accepting, and caring organizational climate. Agencies operate within a confusing and constantly changing legal environment. They must have agency policies and procedures that adequately protect staff and clients. They must educate staff and clients and be prepared to address a variety of service issues related to HIV disease and its prevention.

Client Issues

HIV-infected clients cannot by law be denied services based only on their HIV status. Two Federal laws, Section 504 of the Rehabilitation Act of 1973 and the Education for All Handicapped Children of 1975, prohibit recipients of Federal funds from discriminating against a handicapped individual who is otherwise qualified to participate, unless bona fide efforts at reasonable accommodation are unsuccessful (Lloyd 1987).

The U.S. Supreme Court held in the case of *School Board of Nassau County, Florida* v. *Arline* that an individual who has contracted a contagious disease may be "handicapped" and, therefore, protected by Section 504 of the Rehabilitation Act of 1973. The definition of "handicapped" under the Education for All Handicapped Children Act of 1975 has always included "health conditions" (Lloyd 1987).

A third and more recent piece of Federal legislation expected to influence agency HIV policies is the American Disabilities Act of 1990. The impact of this law and its specific application to HIV-infected individuals will likely be far reaching, but, as yet, it is untested in the courts.

In addition to Federal regulations, agencies must also be aware of State and local regulations that affect the delivery of service, hiring and supervision of staff, and education of clients and staff. Local and State health officials as well as local AIDS services organizations can provide updates on and interpretations of such regulations.

Agencies need a clear policy on service eligibility for HIV-infected clients. Since HIV is difficult to transmit (i.e., ordinary and reasonably good hygiene practices and infection control practices will prevent transmission), an agency would have difficulty making a case that it cannot make a reasonable accommodation (Lloyd 1987).

Agencies already have a responsibility to prevent sexual activity (whether consensual or assaultive) and drug use among clients in an agency's residential setting. Outside of its own residences, it has a responsibility, at a minimum, to promote safer sex and educate its clients regarding the nature and transmission of HIV. Although agencies may be unable to adequately serve clients who are in need of extensive medical care, they should have no difficulty serving clients who are asymptomatic or are able to care for themselves.

A number of resources are available to assist agencies in the devel-

opment of policies and protocols for serving HIV-infected youth. In 1985, the Centers for Disease Control published guidelines regarding services to HIV-infected children in foster care and educational settings. Additional guidelines and resources are available from the Child Welfare League of America and the National Network of Runaway and Youth Services.

Staff Issues

Agencies must also address the issue of HIV infection among staff. Agency staff must educate themselves about Federal and State legislation that affects the organization's ability to hire, fire, and supervise employees with HIV.

Agencies need personnel policies that address HIV as well as other life-threatening illnesses. Issues to be addressed include: use of sick and annual leave, extent of unpaid leave permitted for illnesses, health insurance coverage, leave for care of seriously ill family or partners, job security, and confidentiality of medical information.

A good resource for employer assistance in this area is the National Leadership Coalition on AIDS in Washington, DC. They have materials on policy development, legal issues, and employee education that are specifically designed for use by small businesses. Another resource for policy development and staff education is the *Safe Choices* program of the National Network of Runaway and Youth Services (see Resources).

Confidentiality

An important component of both staff and client HIV policies is the issue of confidentiality. Agencies must be aware of State and Federal restrictions and requirements. Within that context, the agency must struggle with the concept of "need to know." Who needs to know of a client's or staff member's HIV status? Why must they know? Is it necessary for the provision of good services? What repercussions will likely ensue for the HIV-infected person? Are adequate protections in place?

Unfortunately, these questions have no easy answers. Each agency must develop its own policies as it sees fit. Involving other community resource people (legal experts, HIV educators and treatment staff, State/local health officials, and representatives from local AIDS/HIV service organizations) in the process will help ensure that policies reflect the current and best thinking in the field.

Infection Control

It is essential that agencies practice universal precautions in the handling of all body fluids (blood, semen, and vaginal fluids) to avoid infection. This requires the use of latex gloves when handling potentially infected materials and the practice of carefully cleaning potentially infected areas with a chlorine solution. Contact your local health department for written materials and onsite training in universal precautions.

Education for Staff and Clients

HIV education should be ongoing for both staff and clients. Program staff need to have a clear and usable knowledge base in HIV prevention, transmission, and education. It is important that such infor-

mation be offered initially as part of staff orientation training or in the early stages of a staff member's tenure with the program. Regular updates and more indepth training in specific HIV-related issues should be provided as part of inservice education programming.

Such training will help reduce the potential for emotionality among staff around HIV issues. Without such training, staff may decide to leave the program when required to work directly with HIV-infected clients.

Independent living curriculums for clients should include similar information and training. A variety of local, State, and national organizations provide training and educational materials appropriate for use with adolescents.

Programs may also consider distributing condoms to their clients as part of educational programming. For some programs, this presents ethical dilemmas; for others, it represents the only responsible option for a youth service agency. Regardless of the program's decision on the distribution issue, it should inform youth about the proper use of condoms and where they can purchase them or get them free.

Agencies may choose to involve outside resource people for specific topics (e.g., infection control, epidemiological updates, legal issues). These outside experts should not be the sole source of information, however, particularly since agency staff are better prepared to work effectively with adolescents than most outside resource people.

Total reliance on outside resources presents three problems. First, the agency has no control over the availability of such resources. If the external resource experiences funding cuts and can no longer provide services or can only provide services on a limited basis, the agency's clients and staff will suffer.

Second, the agency is not developing its own expertise in HIV. Agency staff will be fielding questions from clients about HIV outside of formal presentations by outside speakers. They must be prepared to respond with accuracy and sensitivity to client concerns. They are more likely to do so if they have been educated themselves and are actively involved in educating clients.

Third, and perhaps most insidious, is the underlying message conveyed: the problem is "out there," not "in here," and can only be addressed by "experts." In fact, the problem is very much "in here," and most of the issues (except for the most technical ones) are best dealt with by those closest to the clients. By involving staff in active HIV education with clients, the agency sends a message that HIV is like many of the other challenges faced by clients—not easy, but not impossible. And staff can help them develop the necessary knowledge and skills.

Serving HIV-Infected Clients

Transitional living programs have an important responsibility to meet the emotional and psychological needs of their HIV-infected clients. All staff need to have a good understanding of HIV-related issues. Those staff, either in-house or by referral, who provide counseling services to HIV-infected clients need to be especially sensitive to the therapeutic issues involved in serving adolescents in these programs.

Those clients who are awaiting their HIV test results may manifest varying degrees of anxiety, depression, or acting out behaviors. Many clients in TLPs have already experienced rejection and failure in many areas of their lives. The possibility of a positive test—and the client's concern about rejection by friends, family, and the program—may trigger many of those feelings. On the other hand, a negative test result may reduce or eliminate the clients' fear and anxiety or may leave them alone to face painful issues raised by the testing process.

Those who test positive are likely to deal with a constellation of issues, including possible rejection by the few supports they have managed to amass, a social stigma separating them from other youth, their own real or anticipated illnesses, issues related to sexuality and sexual behaviors, and the possibility of an untimely and painful death. Such issues may be exacerbated for those clients who are already experiencing mental health problems.

Counseling services for HIV-infected clients should include suicide risk assessment, peer support groups, HIV risk-reduction strategies for the client, and family intervention whenever appropriate and possible (Athey 1989). A sense of personal control and hope is important to the client's emotional well-being. These feelings can be fostered through education in the promotion of good general health and the importance of self-care in delaying the onset of illnesses.

Programs should be aware of and have established service linkages with other agencies that provide medical or counseling services to HIV-infected clients. Youth service programs routinely providing transitional living services to HIV-infected clients should consider designating a liaison person to access the community's system of care of HIV-infected clients.

An additional clinical issue to consider includes an awareness of the possibilities of infection through sexual abuse. Because sexual abuse, date rape, and sexual assault continue to be largely unreported, program staff must remain alert for signs of sexual trauma (Burgess and Hartman 1989).

Programs providing transitional living services to pregnant and parenting clients must be sensitive to pregnant clients who are HIV infected and to those with HIV-infected children. Special education and assistance in procuring medical services for such clients and their children is essential.

Summary

Transitional living programs serve adolescents with a wide range of needs. Their lives have been marked by failures—with family and friends, in school and work, by self-destructive behaviors, and by limited opportunities and disappointments. Added to this is the prospect of infection with a virus—a virus that can result in even further rejection and ostracism from society.

Programs should help clients understand two important, overriding issues:

- We are not helpless in the face of this disease. Being at high risk for HIV infection does not mean a person is necessarily infected. Actions can be taken to avoid infection if clients are educated and supported in their efforts to remain virus free.

- HIV infection is not a death sentence. There have been great strides in the past few years in the medical management of those infected with HIV. Many of those who are infected are leading productive and meaningful lives.

Programs serving these youth have a responsibility and a unique opportunity to assist them in changing the direction of their lives. In these times, those responsibilities must include HIV education and support and caring for those who are infected.

References

Athey, J.G. Emotionally disturbed adolescents and AIDS: An introduction. In: Woodruff, J.O.; Doherty, D.; and Athey, J.G., eds. *Troubled Adolescents and HIV Infection: Issues in Prevention and Treatment.* Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center, 1989.

Burgess, A.W., and Hartman, C.R. AIDS and the sexually abused adolescent. In: Woodruff, J.O.; Doherty, D.; and Athey, J.G., eds. *Troubled Adolescents and HIV Infection: Issues in Prevention and Treatment.* Washington, DC: CASSP TA Center, Georgetown Univ. Child Development Center, 1989.

Centers for Disease Control. AIDS cases by sex, age at diagnosis, and race/ethnicity reported through January 1992 in the United States. *HIV/AIDS Surveillance Report* July:1-18, 1992.

Gayle, H.D., and D'Angelo, L.J. Epidemiology of AIDS and HIV infection in adolescents. In: Pizzo, P.A., and Wilfert, C.M., eds. *Pediatric AIDS: The Challenge of HIV Infection in Infants, Children, and Adolescents,* Baltimore, MD: Williams and Wilkins, 1990.

Hein, K. AIDS in adolescents: A rationale for concern. *New York State Journal of Medicine* May, 1987.

Hein, K. AIDS in adolescents: Exploring the challenge. In: *Safe Choices Guide.* Washington, DC: National Network of Runaway and Youth Services, 1990.

Lloyd, D.W. Legal issues for child welfare agencies in policy development regarding HIV infection and AIDS in children. *Children's Legal Rights Journal* Spring, 1987.

Southeastern Network of Youth and Family Services. *Drug Use Among Runaway and Homeless Youth: A Southeastern Perspective.* Durham, NC: the Network, 1990.

Southeastern Network of Youth and Family Services. *Profile of Youth: July 1989-June 1990.* Durham, NC: the Network, 1991.

Stiffman, A.R., and Earls, F. High risk youths who use health clinics: A profile of a population accessible for AIDS-related interventions. In: Woodruff, J.O.; Doherty, D.; and Athey, J.G., eds. *Troubled Adolescents and HIV Infection: Issues in Prevention and Treatment.* Washington, DC: CASSP TA Center, Georgetown Univ. Child Development Center, 1989.

PROGRAMS FOR PREGNANT AND PARENTING ADOLESCENTS

Adolescent Pregnancy: An Overview

The 1989 report of the Carnegie Council on Adolescent Development warned:

> . . . by age 15, substantial numbers of American youth are at risk of reaching adulthood unable to meet adequately the workplace, the commitments of relationship in families and with friends, and the responsibilities of participation in a democratic society. These youth are among the estimated 7 million young people—one in four adolescents—who are extremely vulnerable to multiple high risk behaviors and school failure. Another 7 million may be at moderate risk. (Hersh 1990, p. 21)

Approximately half of all adolescents are at some risk for serious problems like dangerous lifestyles, early unprotected sexual intercourse and pregnancy, substance abuse, and school failure.

The adolescent pregnant and parenting population has continued to draw increasing attention, research, and speculation regarding current effects and projected costs and impacts. During the 1950s and 1960s, the choices surrounding an unplanned pregnancy seemed both traditional and clear: the couple married or the child was placed for adoption, often following the mother's 6- to 12-month absence from the family home to a relative out of the area or a home for unwed mothers.

Things changed. Families became less intact and more dysfunctional. Divorce rates are now approaching 60 percent. Sexuality became more open and acceptable. Adolescent pregnancy became less a shameful event, with few feelings of guilt, and more a badge of honor and rite of passage away from the family.

There are conflicting statistics and notions about adolescent pregnancy. Each year, more than 1 million adolescents become pregnant; more than 800,000 of those pregnancies are reportedly unintended. Half of the unintended pregnancies occur to girls under 18 years of age; 30,000 of those occur to girls under 15 (Children's Defense Fund 1986, p. 16). There is also an important relationship between pregnancy and homelessness, which is frequently one of the primary characteristics of clients referred for

transitional living services. Robertson (1989) stated that an unknown number of homeless adolescents are pregnant and have become homeless because of their pregnancy or have become pregnant while homeless. Athey (1990) identified most pregnant adolescents as being homeless first and becoming pregnant later.

The proportion of births to unmarried teenagers has been increasing rapidly. Within the Black community, the vast majority of teenage births are to single mothers. Ninety percent of Black adolescent mothers are single, although the birth rate among unmarried Black women has been going down. Four out of ten white adolescent mothers are single, and the birth rate for this unmarried population is rising (Children's Defense Fund 1986, p. 7).

Homelessness

As a special population served by transitional living projects, it is important to understand the situations and circumstances that lead to both pregnancy and homelessness. Athey (1990) identified four primary pathways to adolescent female homelessness. The first is system related, in which the youth has been placed, often multiple times, in foster care, hospital, emergency shelter, residential school, and juvenile justice settings. This is often marked by little stability, which harms rather than helps the youth. Youth often leave the system with a history of multiple placements, feeling that the street offers a more consistent opportunity to meet their needs. The system often chooses not to locate them after they leave their placements.

A second pathway to homelessness is that of "throwaway," in which the adolescent is evicted by the caretaking parent or family. This often follows extensive parent-child conflict. Females are often evicted as a result of pregnancy while living at home.

Physical and sexual abuse is a common pathway for adolescent females, who run away to escape the problem. For them, the street is often safer than their homes. Athey (1990) cited several studies showing that from 21 to 60 percent of runaway and homeless adolescent females had been exposed to admitted sexual abuse and between 16 and 40 percent had suffered physical abuse. A fourth pathway to homelessness is through parental homelessness, which often places the adolescent female prematurely on her own.

Contributing Factors

There are multiple opportunities and resources for adolescents to become pregnant. These may include their lack of experience of unconditional love, which may create a desire to fill that void with a baby. Situations such as this produce little motivation to avoid pregnancy or use contraception. Only 20 percent of sexually active 15- to 19-year-old females report the use of condoms the last time they had sexual intercourse (Furstenberg et al. 1990).

Abrahamse and associates (1988) described other factors that make adolescent females receptive to single parenthood. These factors, which manifest themselves in different ways in different individuals, include rebelliousness, (mis)calculated thinking, and a bleak

outlook for future prospects. These three factors may be helpful for programs in constructing profiles to help identify prospective single mothers.

A large body of psychological literature supports the notion that rebelliousness, risk taking, and problem behaviors are related to adolescent pregnancy. The adolescent's willingness to consider nonmarital childbearing is one instance of a broader resistance to social norms and a tendency toward nonconforming behavior (Abrahamse et al. 1988). This may be associated with their struggle to separate themselves from their parents. In some cultures, this may be the social norm.

Costs and Benefits

The economic perspective of adolescent pregnancy emphasizes the costs and benefits of single parenthood as they appear to the adolescent. What does she stand to lose (or gain) by forming a single parent family? That is, what opportunity costs would she incur? This perspective implies that the irrational behavior of becoming a parent without marriage or support may indeed be logical and reasonable within the adolescent's own perception (Abrahamse et al. 1988).

Premature parenthood is widely believed to jeopardize the overall life chances of young mothers and their children. It contributes to the impoverishment of many already disadvantaged lives. A 20-year followup study (Furstenberg et al. 1990) of Baltimore girls under 18 years of age who had never had a child prior to their initial interview sought to explore the link between teenage parenthood and long-term welfare dependency. This study provided evidence of an "intergenerational transmission of disadvantage" and indicated that today's teenage parents may be less likely to overcome the handicaps associated with early childbearing than were their own teenage parents. It showed that a greater percentage of second generation teenage mothers were at risk of long-term welfare dependency, and their offspring, in turn, were more likely to be raised in more disadvantageous family circumstances.

According to participants' pregnancy histories, about the same proportion of each generation became pregnant within the first several years after the birth of their first child, but more of the younger generation obtained abortions. That is, the number of children subsequently born to the younger generation was less, even though the pregnancy rates were relatively the same. The study also found that 60 percent of both mothers and daughters were neither working nor in school at a comparable stage in their lives. Without some positive life-changing event or intervention, it appears likely that the prospects for escaping poverty remain unchanged at best.

Teenage motherhood is also associated with an increased probability of homelessness among public assistance families. It is one of many factors that impede financial independence (Wertzman 1989), although its overall effect probably subsides as the women get older.

Athey (1990) categorized three basic types of activities that lead to adolescent pregnancy—rape, survival sex, or a love relationship. Rape or sexual assault of homeless women is 20 times that of women in general (Kelly 1985). Fifty percent of rape victims are less than 18 years of age. Since homeless girls have double risk factors, it can be assumed that rape has been a common experience for many of the young women participating in transitional living programs. Sexual abuse at home has also been related to adolescent pregnancy because it leads to sexual acting-out and increased promiscuous behavior (Brown and Findelher 1986).

Homeless adolescents, particularly those who have been on the street for some time, use sex to acquire food, shelter, or other material items. Such survival sex may lead to systematic prostitution. While the love relationship in its ideal sense is the least damaging, it often leads to premature parenthood.

Early premarital childbearing is known to be far more common among Blacks than whites, although in the past 15 years, the incidence of teenage childbearing has risen most rapidly among young unmarried whites (Furstenberg et al.). Abrahamse and colleagues (1988) found that 50 percent of Black and 25 percent of white female adolescents expressed a willingness to consider single adolescent motherhood. This willingness can be traced to three sources: (1) a small, well-defined (19 percent) segment who rank high in problem behaviors that are part of a recognizable pattern of nonconforming behaviors, (2) the opportunity to avoid education by becoming a single mother, and (3) among white and Hispanic adolescents, a link to self-reported depression (which may be a proxy for low self-esteem).

Other problems associated with the pregnant teenage population include mental health problems with a high incidence of self-reported suicide attempts, poor diet, unsatisfactory prenatal care, the presence of sexually transmitted diseases, and varying degrees of substance abuse (Athey 1990). Transitional living programs seeking to develop and provide services to this population are likely to discover any combination of the factors discussed. While the general TLP client pool comprises primarily at-risk and high-risk youth, the pregnant and parent population has an additional layer of risks and challenges to be met.

Program Provider Issues

While all prospective clients come to transitional living programs somewhere on the at-risk to high-risk continuum, pregnant or parenting clients bring the unique dimension of a single-parent family. One of the first decisions a program must consider is whether it will serve this population. Will it serve a client who already knows she is pregnant? Will it serve a client who presently has a child or children and will it limit the number of children it will serve? Will it continue to serve a nonparenting client who becomes pregnant while participating in the program? Will it offer

services to fathers of clients' children or clients' current partner or boyfriend?

The answers are simpler for programs that offer only outclient educational and training services than for residential programs. The physical setting becomes particularly important for meeting the ongoing needs of parenting clients and those nearing delivery of a child. Programs may choose to provide a high level of supervision through a group home, congregate apartments, shelter setting, various forms of host homes, or live-in options. These are effective alternatives for managing prenatal, postdelivery, and child care issues. This is easier to accomplish if the residential setting is owned or operated by the program or sponsoring agency. Many TLPs have difficulty in helping parenting clients locate suitable housing due to landlord reluctance to rent to young, single women with children. Because these clients are, or will be, functioning on a very low income, their options are frequently limited to properties or neighborhoods that pose real safety issues.

An additional consideration is the geographic context in which the program operates. While urban settings may offer greater availability of various housing opportunities, they may also present the greatest safety risks. Urban settings may also offer greater anonymity and a larger pool of other resources such as employment opportunities, day care, and medical services.

Suburban settings frequently offer greater safety, but have greater limitations of other resources such as public transportation and affordable and available day care. Different communities also offer different levels of support for both clients and programs that serve the pregnant and parenting population.

While rural programs have the same general client needs (housing, employment, medical services), they often have comparatively less to offer in terms of resources and opportunities. These limitations can often be overcome with strong networking and service linkage development.

Transitional living programs serving the pregnant and parenting population will probably have to address clinical issues. Pregnant and parenting clients bring physical and emotional stresses other clients do not have to manage. Childbearing often triggers old issues with the client's family of origin. It intensifies ongoing problems of self-esteem and may deepen client depression. Clients with histories of abuse and mental health problems may present greater resistance to engagement.

Babies of parenting TLP clients are frequently at risk for developmental and emotional handicaps. Athey (1990) reported on a Boston shelter study that found a majority of children from similar backgrounds suffering developmental delays, severe anxiety and depression, and learning difficulties. This highlights the importance of counseling services and parent education for both generations.

Program staff need to be well trained in working with both therapeutically difficult clients and pregnant and parenting clients. Their knowledge base should include an understanding of child development issues. Programs also need to be sensitive to staff age and life experience. While young, nonparenting staff may have acquired theoretical foundations in child development, they may be experiencing their own new independence at the same time they are teaching it. Their lack of birth, life, and parenting experience may actually be unsettling to both clients and program functioning. Programs seeking to serve this population should reach a philosophical decision on the kind of staff they want prior to actually hiring staff.

Programs that do not offer day care services need to consider the extra time, transportation, and cost clients will require to get their child to an alternative day care site and themselves to work. The pregnant and parenting population requires additional service linkages, particularly in the area of medical care for the mother and child. Unless programs have a special linkage with a hospital, medical group, or individual practice, services will probably be provided through a clinic, which clients often experience as demeaning and detached. Medical practices often will not accept Medicaid payment because of its low reimbursement rate.

Linkages with businesses and schools are important. Many employers are reluctant to hire pregnant individuals because they know their initial tenure will be short or because young parenting mothers may occasionally be late or absent due to child illness or day care issues. Established and properly maintained positive relationships with businesses and schools are important to educate and sensitize present and potential employers to the sometimes unpredictable situations experienced by young single mothers.

Summary

The pregnant and parenting population brings a special challenge to transitional living programs that seek to serve them. While each client has her own unique life history, which is often filled with limited success, low self-esteem, and various forms of victimization, they share common issues that are predictable and workable.

Services to this population need to be well thought out, with a clear understanding of the developmental, physical, and emotional issues common to them. Program staffing and linkages with other providers are important to making their transition to adult living a successful one.

References

Abrahamse, A.F.; Morrison, P.A.; and Waite, L.J. Teenagers willing to consider single parenthood: Who is at greatest risk? *Family Planning Perspectives* 20(1):13-18, 1988.

Athey, J. Pregnancy and child bearing among adolescents: A report of a workshop. Pittsburgh, PA: University of Pittsburgh, 1990.

Children's Defense Fund. *Welfare and Teen Pregnancy: What Do We Know? What Do We Do?* Washington, DC: Adolescent Pregnancy Prevention Clearinghouse, 1986.

Furstenberg, F.F., Jr.; Levine, J.A.; and Brooks-Gunn, J. The children of teenage mothers: Patterns of early childbearing in two generations. *Family Planning Perspectives* 22(2):54–63, 1990.

Hersh, P. The resounding silence. *The Family Therapy Networker* 14(4):18–29, 1990.

Robertson, M.J. *Homeless Youth: An Overvi? v of Recent Literature*. National Conference on Homeless Children ar Youth. Washington, DC: Institute for Policy Studies, Johns Hopkin. Jniversity, 1989.

Wertzman, B. Pregnancy and childbirth: Risk factors for homelessness. *Family Planning Perspecitves* 21(4):175–178, 1989.

SELECTED ANNOTATED BIBLIOGRAPHY

This bibliography is included to provide "practitioner friendly" articles or works that are readable, current, easily accessible, and significant to the development, understanding, or review of transitional living services for homeless adolescents. The articles were selected by a computerized literature search of the Psych Lit Database, which contains annotated summaries of serial literature in psychology and related disciplines and covers 1,300 journals in 27 languages from approximately 50 countries. Relevant materials were also solicited from existing transitional living resource agencies, clearinghouses, and independent authorities.

The summaries are designed to highlight the essential concepts or information of the article or book so that practitioners may determine its relevance to their specific needs. A general recommendation for a consolidated and comprehensive overview is to obtain the November/December 1988 issue of *Child Welfare*, which was devoted exclusively to the topic of independent living preparation for at-risk adolescents, and *Daily Living: The Best of 1987-1989*, which is a 3-year compilation of the quarterly transitional living journal.

The books and articles in the bibliography are coded to assist in identifying their primary content. More than one code may be attached when several areas are covered. The codes are:

CLI - Clinical

CUR - Curriculum

EVL - Evaluation

HIS - Historical

LEG - Legal

MOD - Model/Program Design

POL - Policy

THE - Theoretical

Allen, M.; Benner, K.; and Greenan, L. Federal legislative support for independent living. *Child Welfare* 67(6): 515-527, 1988.

Describes the Federal legislative background, development, and outlook and current activities by the States in relation to establishing services to help adolescents in foster care prepare for independent living. Initiatives undertaken in Illinois illustrate one State's design for accommodating its particular needs. Suggestions are given for future legislation.

Code: HIS

Altorfer, J. *Report of Independent Living Subsidy Program Review.* Eugene, OR: Oregon Children's Service Division, 1980.

The purposes of the Independent Living Subsidy Program (ILSP) Review are to obtain information about the success or failure of participants, to determine the program's strengths and weaknesses, and to determine if changes are needed in the present policies. Major findings of the review are provided by caseworkers who worked with the program participants. Included is the worker's assessment of program effectiveness, suggested ILSP changes, and other salient issues regarding the program. This review may be helpful to professionals planning to create independent living programs or exploring how to improve existing programs.

Code: EVL

Anderson, J.L., and Simonitch, B. Reactive depression in youth experiencing emancipation. *Child Welfare* 60(6):383-390, 1981.

Youth in the process of moving from substitute care such as residential placement or institutionalization to independent living as adults generally go through a series of emotional changes resulting from the emancipation process. Reactive depression is a common response to a sense of loss or disappointment, both of which are likely to occur as an adolescent moves into independent living. The Oregon Independent Living Subsidy Program (ILSP), developed in 1973, uses casework to help individuals move through the sequential reactions of anxiety, elation, fear and loneliness, and quiet confidence as the emancipation process develops. The article is significant for those considering a transition model for disturbed adolescents in that it examines the affective issues of moving into adulthood. Although ILSP has its drawbacks, it provides a model for the development of an affective component of a transition program.

Code: CLI

Ansell, D., and Griffin, W., eds. The best of 1987-1989 [Special Issue]. *Daily Living.* Edenten, NC: Independent Living Resources, 1989.

A compilation of the first 3 years of *Daily Living* containing more than 40 articles within 5 sections including independent living program development; residential independent living programs; nonresidential independent living programs; youth clubs, conferences, and foundations; and reports and personal perspectives. Also includes resource, video, and computer software sections.

Code: CLI, CUR, EVL, HIS, LEG, MOD, THE

Barth, R.P. Emancipation services for adolescents in foster care. *Social Work* 31(3):165-171, 1986.

This article reviews studies on the likely social and educational futures for adolescents who are discharged from foster care when they reach the age of majority. It also looks at the range of services that may promote adolescents' successful transition to independent living, including (1) foster-parent training, (2) supervised group home, (3) independent living subsidy programs, (4) scholarship programs, and (5) pre- and postemancipation services. Changes in practices, programs, and policies are suggested.

Code: CUR, MOD, THE

Clarren, J. *Project Stepping out.* Towsen, MD: Baltimore County Department of Social Services, 1985.

The purpose of this federally funded research and demonstration project was to address the issues relating to the preparation of foster care youth for independent living. The authors believe that many youth in foster care leave by falling out, sliding out, dropping out, or being pushed out. Therefore, planning and coordination are needed among agency social workers, administrators, supervisors, foster parents, the community, and the youth themselves. The report provides information on the developed model as well as recommendations.

Code: EVL, MOD

Cook, R. Trends and needs in programming for independent living. *Child Welfare* 67(6):497-514, 1988.

Summarizes national trends in independent living services for foster adolescents with an emphasis on a philosophical framework. Also includes concepts, ideas, and program elements that can be useful to planners, administrators, and practitioners. Discusses the Westat, Inc., Study (1986), the Citizen's Committee for Children of New York Study (1984), and American Public Welfare Association (1985) work regarding current statistics and status of foster care youth in care and discharged from care. Outlines a continuum of independent living preparation (informal learning, formal learning, supervised practice living, and self-sufficiency).

Code: HIS, MOD, THE

Cook, R., and Ansell, D. *Independent Living Services for Youth in Substitute Care.* Contract no. 105-84-1814. Rockville, MD: Westat, 1986.

Reports on a study of independent living programming for dependent youth that addresses the differences between youth who received independent living services and those who did not; programs and services provided to prepare and support adolescents in transition; and recommendations for improved service delivery. The study provides useful frameworks for viewing services within a continuum correlated with youths' developmental phases and provides examples of programs and services at each level.

Code: EVL, HIS, MOD, THE

Cook, R.; McLean, J.L.; and Ansell, D. *A National Evaluation of Title IV-E Foster Care Independent Living Programs for Youth—Phase 1.* Contract No. 105-87-1608. Rockville, MD: Westat, 1989.

The Independent Living Initiatives (Public Law 99-272) authorized funding to assist youth 16 years and older to make the transition to independent living. This study was designed to assess the influence of the Initiative on the policies, programs, services, training, and funding provided by State and local foster care agencies to prepare and support adolescents in their transition to independent living. It also looks at the characteristics of these youth, the number and types of services they received, and the outcomes for those youth.

Phase I reviews State policies; demographic, case history, and family characteristics and service needs of youth discharged from care between 1987 and 1988; and number and type of services they received. Phase II, when completed, will assess the effects of independent living programs on the adaption of these youth after leaving the foster care system.

Code: HIS, MOD, POL

Euster, S.D.; Ward, V.P.; Varner, J.G.; and Euster, G.L. Life skills for adolescent foster children. *Child Welfare* 63(1):27-36, 1984.

Adolescent foster children frequently experience gaps in their personal development resulting from the issues that led to the placement and from a sense of impermanence or not belonging to a group or family. Taking these issues into consideration, a model for a Life Skills Group for Foster Adolescents was developed in South Carolina. The purpose of the program is to teach adolescents skills that will result in more positive interactions with peers and better relationships with those in positions of authority. In addition, the program targets skills necessary in making a successful transition to adulthood. The program is based on five principles: the need for stability and security, a lack of pressure on the adolescents to self-disclose, the provision of activities that allow individuals to decide on their level of participation, an awareness of appropriate responses to sensitive issues, and consideration of the developmental level of the group when planning activities. Topics in the curriculum include foster care issues, development of friendships, sex and sexuality, substance abuse, and problem solving.

Code: MOD, THE

Furrh, E., Jr. Emancipation: The supervised apartment living program. *Child Welfare* 62(1):54-61, 1983.

Material is based on author's experience developing the Supervised Apartment Living Program of Hope Center for Youth in Houston, TX. Describes a program model to prepare delinquent or emotionally disturbed adolescents for independent living. Includes a skill development outline for many independent living training activities.

Code: CUR, MOD, THE

Hardin, M. New legal options to prepare adolescents for independent living. *Child Welfare* 67(6):529-546, 1988.

Discusses existing legal alternatives (agency legal custody and emancipation) for older adolescents living apart from their families and proposes two new alternatives to allow mature older adolescents to practice limited independence and continue receiving aid and supervision from child welfare agencies. Article reviews issues of independent living arrangements and agency liability in providing independent living services. Charts summarize highlights of existing and proposed legal options for young persons in the foster care system moving toward independence in most States.

Code: HIS, LEG, THE

Irvine, J. Aftercare services. *Child Welfare* 67(6):587-594, 1988.

Discusses services and resources for youth (aged 16-21 years) who have been discharged from a foster care setting and live in an independent arrangement. Aftercare services include supervised apartment living, independent living subsidy apartments, transitional housing, counseling, employment services, vocational training, medical care, and financial assistance.

Code: MOD

Jones, M.G. The design evolution and operation of an independent living program. *Residential Treatment for Children and Youth* 7(2):89-102, 1989.

Children in residential treatment centers, while accomplishing important and even vital tasks, often fail to acquire skills necessary to become independent, productive adults. Independent living programs (ILPs) offer a solution to this problem. Described are the design, development, and operation of an ILP for adolescent boys. Residents progress through three levels that contain a number of specific, measurable tasks and corresponding privileges. The article addresses myths and realities as well as problems about developing similar ILPs.

Code: MOD

Kroner, M.J. Living arrangement options for young people preparing for independent living. *Child Welfare* 67(6):547-561, 1988.

This article discusses 12 living arrangement options, including institutions, residential treatment centers, community-based group homes, foster homes, supervised apartments, shelters, live-in roommates, host homes, boarding homes, shared homes, semisupervised apartments, and subsidized support programs. On a continuum of most to least restrictive, the important features of each are described with respect to practical independent living issues. Screening factors, training, licensing, and funding are also briefly discussed.

Code: MOD

Mauzerall, H.A. Emancipation from foster care: The Independent Living Project. *Child Welfare* 62(1):46-53, 1983.

Adolescents in foster care do not come from backgrounds characterized by loving, stable environments. Emancipation may be particularly difficult for this population, as their low self-esteem and conflicting feelings interfere with the formation of identity and purpose as they enter adulthood. The Casey Family Program in Idaho uses a group work approach to initiate the educational process directed toward emancipation. This component is followed by a halfway house approach via a small group home. During their stay in this setting, the adolescents further refine and then apply the skills introduced during the group work stage. Upon completing 6 months in the halfway house, the youths are generally ready to move into the community. Although the techniques used in the emancipation program described would require revision for work with emotionally handicapped adolescents, the basic philosophy and curriculum are useful in considering transition issues.

Code: Mod, THE

Mech, E., and Leonard, E. Volunteers as resources in preparing foster adolescents for self-sufficiency. *Child Welfare* 67(6):595-608.

Summarizes current usage of volunteers nationwide by profiling their use in selected independent living programs. Details specific roles for volunteers and where weaknesses lie and specifies recommendations for strong volunteer programming.

Code: MOD

Meston, J. Preparing young people in Canada for emancipation from child welfare care. *Child Welfare* 67(6):625-634, 1988.

Discusses basic child welfare structure in Canada and describes program models presently in existence, including nonresidential program/living skills training, independent camps/weekend retreats, semi-independent living programs, and phased independent living programs.

Code: MOD, THE

North, J.; Mallabar, M.; and Desrochers, R. Vocational preparation and employability development. *Child Welfare* 67(6):573-586, 1988.

Discusses how youth learn independent living employment skills and the development of overall independent living plans that spell out specific goals, activities, and responsible participants. Presents specific strategies and general resources to meet employment and training needs. Emphasizes the critical role agencies play in developing individualized case plans and skill training.

Code: CUR, MOD, THE

Ryan P.; McFadden, E.J.; Rice, D.; and Warren, B.L. The role of foster parents in helping young people develop emancipation skills. *Child Welfare* 67(6):563-572, 1988.

Asserts that programs designed to prepare youth for emancipation from foster care have ignored the critical role foster parents have and can play. The advantages and problems of using foster parents as primary teachers of independent living skills are presented. The development of materials that can assist foster parents to develop home learning programs for the youth in their care is discussed. It is suggested that those materials can be used as part of a systematic foster parent education program and provide additional resources on the continuum of services an agency provides youths leaving care.

Code: MOD

Schinke, S.P., and Rose, S.D. Interpersonal skill training in groups. *Journal of Counseling Psychology* 23(5):442-448, 1976.

Two approaches to interpersonal skills training are compared and contrasted in terms of short-term effectiveness and longer term maintenance of behaviors. The group using a rehearsal contracting approach (including modeling, practice, verbal instructions, and feedback) was found to be more effective than a behavioral discussion group in learning specific responses, although the discussion group demonstrated an increase in the skill acquisition as well. The rehearsal contracting group had a greater ability to maintain the behaviors over time than the discussion group. This study supports other research validating the use of behavioral techniques in social skills training.

Code: MOD

Shacter, B. Treatment of older adolescents in transitional programs: Rapprochement crises revisited. *Clinical Social Work Journal* 6(4):293-304, 1978.

According to Margaret Mahler, a toddler often goes through a stage of development characterized by push-pull, such as "leave me but don't go too far." During adolescence, this rapprochement crisis occurs again to some extent as the adolescent simultaneously views his childhood and impending emancipation. The author recommends societal support and increased funding for treatment of these issues.

Code: CLI, THE

Tatara, T.; Casey P.R.; Nazar, K.L.; Richmond, F.K.; Diethorn, R.; and Chapmond, T. Evaluation of independent-living programs. *Child Welfare* 67(6):609-624, 1988.

Presents precise information on how States may adapt their information systems to produce comprehensive program and evaluation data. Uses Pennsylvania and Texas systems as examples. Defines objective and structure of systems, timing of data collection, data sets and elements, and data analysis strategy. This article is also useful for individual programs seeking to design in-house evaluations.

Code: EVL

Wood, W.D. A cognitive perspective applied to emancipation problems. *Adolescence* 60(60):879-885, 1980.

A cognitive perspective toward emotional stress and behavior disorders is described and applied to developing a classification of emancipation problems and a plan for intervention. Problems described include overdependency, vacillation about dependency, and resistance to authority. The plan for intervention is geared toward minimizing complications, which are often intensified by use of confrontive intervention methods.

Code: CLI

RESOURCES

The process of seeking consultation, information, and support requires an ability to identify and access individuals and organizations who either have what you need or can direct you to someone else who can be helpful. Individuals and organizations identified in the resource directory are organized into four general categories: national organizations, Federal agencies, technical assistance and resource centers, and other organizations and individuals.

This directory does not include all the individuals and organizations who have knowledge and experience in transitional living services. It provides the primary resources whose publications and other materials have been reviewed for quality and relevance to the homeless adolescent population.

Additional resources not specifically identified within this directory includes each State's office for children and youth services, which funds transitional living programs, and the 10 regional coordinated networks (funded through the Administration for Children, Youth, and Families, Family and Youth Services Bureau). Both resources can be extremely helpful in identifying individuals and programs with independent and transitional living expertise within specific geographic areas. Networking opportunities through established networks or organizations can be extremely helpful in accessing and obtaining at low or no cost unpublished materials including training materials, program manuals, uncopyrighted assessment instruments, forms, and program-friendly consultation.

National Organizations

National Network of Runaway and Youth Services
1400 I Street, NW
Suite 330
Washington, DC 20005
202-682-4114

A membership organization of over 500 youth services programs, the Network provides advocacy for youth issues as well as training and information on issues of concern to member programs. It distributes one publication of particular interest:

> *Doing What We Do Best: A Guide to Replication of an Independent Living Project*, June Bucy and Cynthia Klotzbach, May 1986.

This report on a joint project of the National Network and Big Brothers/Big Sisters focuses on linking adult volunteers with youth in transition. It identifies characteristics of youth in transition, describes roles for volunteers, and discusses how local agencies can work together to replicate the project.

While the report focuses on a specific project, its findings have broad applicability. It outlines principles for interagency collaboration that apply to any sort of linkage (e.g., it takes time, different styles of operation must be considered, programs may have different mandates and legal considerations). It also builds a strong case for interagency linkages that programs may find useful in promoting local collaborations. The planning process described would fit any sort of volunteer mentoring program.

Council on Accreditation of Services for Families and Children
520 Eighth Avenue
Suite 2202B
New York, NY 10018
212-714-9399

The Council is the largest, most comprehensive independent accreditor of social services and mental health agencies in the United States and Canada. The Council publishes its accreditation requirements as the *Provisions for Accreditation*. The *Agency Accreditation Manual* is a companion document that includes the provisions, interpretations of the provisions, compliance measures, rating indicators, and the weighting systems. Standards and criteria for compliance are painstakingly developed by panels of experts in the field.

The Council is currently publishing standards for transitional living services for youth. The services and criteria outlined can provide agencies with a template for program development and program evaluation. While agencies may strive to do more than is outlined in the standards, meeting these basic criteria would ensure that the program is addressing the major components of a transitional living program.

Federal Agencies

Administration for Children, Youth, and Families (ACYF)
Family and Youth Services Bureau
330 C Street, S.W.
P.O. Box 1182
Washington, DC 20013
202-205-8102

ACYF coordinates funding for services for runaway and homeless youth, including community-based programs for youth, coordinated networks designed to share information and expertise among service providers, a toll-free 24-hour switchboard for runaway youth and their families, and the transitional living program for homeless youth. The transitional living program coordinates fund-

ing for programs providing shelter (up to 18 months) and related services to homeless youth in order to promote a successful transition to self-sufficient living. Services are provided to youth aged 16 through 21 who are not currently under the jurisdiction of the juvenile justice or child welfare system.

Department of Housing and Urban Development
451 7th Street, S.W.
Washington, DC 20410

HUD provides transitional and supportive housing funds for homeless and hard to serve populations in the form of competitive block and discretionary grants. Technical assistance is also provided through HUD regional offices.

Technical Assistance and Resource Centers

National Institute of Mental Health-Funded Centers

In 1984, in response to the gaps in service options and the failure of present systems to meet the needs of seriously emotionally disturbed children, the National Institute of Mental Health (NIMH) developed the Child and Adolescent Service System Program (CASSP). CASSP supports States in the development of interagency efforts to improve the systems under which the most troubled children and youth receive services.

CASSP Technical Assistance Center
Georgetown University Child Development Center
3800 Reservoir Road, NW
Washington, DC 20007
202-625-7033

The CASSP TA Center at Georgetown was established by NIMH to plan and coordinate all the components of the CASSP technical assistance program and to conduct a wide range of technical assistance activities. The Center's special areas of emphasis include the development of systems of care for children and their families, community-based service approaches, cultural competence, services for special populations of high-risk youth, and strategies for financing services.

To assist States in the development of a system of care, the Center initiated a two-phase process in collaboration with the Florida Research and Training Center (see below). In phase one of this effort, the Center solicited and compiled materials related to systems of care from 15 States and distributed those materials to all States and territories to provide a sampling of system of care models. Phase two involved building upon the compilation of materials to develop generic guidelines for systems of care for severely emotionally disturbed children and adolescents.

This conceptual model is outlined in *A System of Care for Severely Emotionally Disturbed Children and Youth* (1986), Beth A. Stroul and Robert M. Friedman (available from the Georgetown Center). The

model focuses on State-level care for youth but is equally applicable to local areas. It provides descriptions and a discussion of each of seven service dimensions (mental health, social, educational, health, vocational, recreational, and operational) representing areas of need for youth and their families. These dimensions could form the basis for an agency's program planning and/or as an assessment and planning guide for development of a local service continuum. Independent and transitional program directors may find the theoretical framework and the concrete programming descriptions helpful in their conceptualization, design, and delivery of program services.

Florida Research and Training Center for Improved Services for Seriously Emotionally Disturbed Children
University of South Florida
Florida Mental Health Institute
13301 Bruce B. Downs Boulevard
Tampa, FL 33612-3899
813-974-4500

The Research and Training Center is funded by the National Institute on Disability and Rehabilitation Research and NIMH. The Center's mission is to improve services for children with serious emotional disturbances and their families by increasing the knowledge base for such services through a focus on epidemiological and service system research. As part of its commitment to this mission, the Center provides a variety of training, consultation, and dissemination activities. An annotated bibliography describing materials prepared by Center staff is available upon request. Copies of material or further information can be obtained by contacting the Center.

The Center is currently engaged in a 7-year longitudinal study (the National Child and Adolescent Study) of emotionally disturbed youth in public school and publicly funded residential mental health treatment centers. The study, which began in 1985 with youth aged 9 to 17, is specifically designed to examine outcomes of emotionally disturbed youth who are making the transition from adolescence to young adulthood. Information on findings thus far are available from the Center.

The National Child and Adolescent Study findings provide some critical information about the differing outcomes for nonhandicapped and disabled youth. The study offers information on educational, employment and earnings, and independent living outcomes among emotionally disturbed youth. It also provides insights into the links between substance abuse, psychiatric diagnoses, and early childbearing. These are all critical issues for providers of transitional living services. Such information can be extremely useful in demonstrating the cost savings of transitional living programming to funders and policymakers.

Research and Training Center on Family Support and Children's Mental Health
Portland State University
P.O. Box 751
Portland, OR 97207-0751
503-464-4040

The Center puts a special emphasis on improving services to families whose children have emotional disorders. Research and training activities focus on family support issues, family-professional collaboration, diverse cultural groups, and enhancing the training of professionals to provide community-based services.

A list of materials and publications is available from the Center. Three publications are of particular interest for those providing independent and transitional living services:

> *Youth in Transition: Resources for Program Development and Direct Service Intervention*, A. Christina Rutland, Sept. 1986.

An annotated bibliography designed to provide information to practitioners and program planners about a variety of approaches to address the transition needs of emotionally handicapped and developmentally disabled adolescents. Because the literature on the transition of emotionally disturbed youth to adulthood was found to be so limited, the authors expanded their search to include children and youth who are developmentally disabled. While the bibliography provides reviews of several articles of general interest to those providing independent living services, the listings will be most useful for programs serving youth who are developmentally disabled.

> *Transition Policies Affecting Services to Youth With Serious Emotional Disturbances*, Nancy M. Koroloff and Matthew J. Modrcin, Sept. 1989.

An examination of the ways in which State-level policies have facilitated the orderly planning and delivery of transition services for youth with serious emotional disorders. Included are summaries of transition policies collected from 17 States as well as a discussion of the components necessary for a comprehensive transition policy.

The materials focus on the development of State-level policies and, as such, will prove only marginally useful for local providers attempting to develop or improve independent living services for youth. The general concepts of service planning are similar to those in *A System of Care for Severely Emotionally Disturbed Children and Youth*. However, providers will find applying the principles and findings of this document a more difficult task.

> *Youth in Transition: A Description of Selected Transition Programs Serving Adolescents with Emotional Disturbances*,

Matthew J. Modrcin, Connie Coleman, and Judy Robison, Sept. 1989.

An overview of the program components necessary to meet the long- and short-range goals of adolescents in transition. Includes detailed descriptions of transition programs offered through traditional 7-day residential programs, hospital-based programs, school-based programs, case management programs, and transition programs that are components of multiservice agencies targeting youth.

This publication provides a brief but valuable overview of the concept of transition from both developmental and contextual perspectives. It also reviews five different service components necessary for youth in transition (specialized educational curriculum, community survival and living skills, vocational preparation, vocational placement, and transition planning and residential services). The key findings are useful in program development/improvement. The program listings will assist programs in identifying those in the field who are providing similar services.

ACYF-Funded Resource Center

The National Resource Center for Youth Services
The University of Oklahoma
202 West Eighth
Tulsa, OK 74119-1419
918-585-2986

The focus of the Resource Center is to increase the coordination and level of professional services to adolescents and their families. The Center provides experience-based, professional training, publications, and video materials to those who work with and care for adolescents. Particular publications of interest include the following.

For Program Directors and Staff

Pathways to Adulthood: Creating Successful Programs to Prepare Teens for Independence, Kris G. Mayne, Editor, 1988.

A collaborative effort by authors from 11 different programs that highlights the philosophy, structure, and components of program success. This monograph provides a quick overview of several approaches to transitional and independent living programming. The authors are unflinching in their honest assessments of their program strengths and weaknesses. This document provides an excellent introduction to the field as well as a broad overview of programming options.

Independent Living Strategies: A Program to Prepare Adolescents for Their Exit From Foster or Group Care, William V. Griffin, 1987.

Offers a practical model of successful independent living program-

ming for adolescents; defines logical steps for youth's transition out of care, the management of that transition, and the necessary followup. The publication provides a useful framework for design of a model program. Although focused on youth within the foster care system, the components of the model program design presented are equally applicable to youth who are outside the child welfare system.

Independent Living Strategies: An 8-Day Training Curriculum, Raymond Kirk, 1987.

A comprehensive training packet for public child welfare agencies assisting youth in transition from foster care to independence. Consists of four 2-day training modules based on the eight critical skills identified in *Independent Living Strategies* (above).

Pass It On: Helping Staff to Share Knowledge and Skills With Youth, William V. Griffin and Dorothy I. Ansell, 1990.

A trainer's manual and participant's workbook designed to help child welfare workers, youth workers, and foster parents prepare youth for independence. Based on 18 hours of instruction addressing tangible and intangible skills, using the team approach, self-esteem, decisionmaking, and assessment tools.

Volunteer Mentor Training Program: To Promote Independent Living Skills in Youth Preparing to Leave Foster Care, Janet L. Walters, Mary E. Furnas, and Dorothy Renstrom, 1990.

A program designed to assist older youth move from foster care to independence by linking them with an adult role model who is not part of the foster care system. Materials include a *Volunteer Coordinator's Handbook* and *Participant's Manual*.

Meeting Life's Challenges: Three Manuals for Helping Youth Workers to Empower Adolescents and Their Families, Oasis Center, Nashville, TN, 1988.

Manuals are designed to facilitate teaching independent living skills to youth in foster care. Manuals cover survival skills (sex, drugs and alcohol, shopping, money management), youth employment (job seeking and placement), and independent living skills (decisionmaking and problem solving).

Transition to Independent Living: A Selected Annotated Bibliography and Resource Listing, Peter R. Correia III, 1986.

A survey of 30 articles and publications addressing various aspects of independent living. Includes a listing of life skills resources as well. Although somewhat dated, this bibliography provides a useful overview of independent living programming and service issues. Program directors and staff will find it a useful guide to resources in the field prior to 1986.

For Youth in Transitional Living Programs

Your Plan for Adult Living: Life Skills Profile Handbook and Planning Index, Marc Jacobs and Lenore Gilrane, 1988.

The Planning Index is designed for supervised completion by youth. It targets facts and feelings in six major areas: school and work, money and shopping, relationships and family, health and medical care, where to live, and moving on. The *Life Skills Profile Handbook* is a profiling tool and partner to the *Index* that challenges youth to identify the skills they need.

Decisions, Decisions, Decisions! Preparing for Young Adulthood: A Guide to Making Decisions That Work for You, Steven Brion-Meisels, Marc Jacobs, and Elizabeth Rendeiro, 1988.

Presents activities centered on interpersonal decisions essential to independent functioning. Includes a five-step decisionmaking model.

Lifebook, Susie W. Kaylor and Theresa A. Cote, 1989.

A personal guidebook for youth transitioning to adulthood. Includes practical advice as well as special places to put important papers.

Other Organizations and Individuals

Independent Living Resources (ILR)
P.O. Box 1013
Edenton, NC 27932
919-482-2937 and 919-489-1351

ILR provides training seminars and serves as a clearinghouse for information on adolescent independent living. Since 1987, it has produced a quarterly publication for the adolescent independent living-child welfare field that includes articles, reviews of programs, written texts, curriculums, videos, and computer software geared to the independent living movement. Its president, William V. Griffin, has worked in the field of public/private human services and child welfare since 1974. He is an adjunct faculty member of the Graduate School of Social Work, University of North Carolina at Chapel Hill. Dorothy I. Ansell, Vice-President, has been developing and providing training and independent living services for youth since 1979. Pertinent materials available to other providers include the following.

Assessment Packet

A collection of 31 different forms for use in independent living programs, organized into five sections: applications, behavioral assessments of candidates, contracting and youth agreements, behavioral and narrative assessment of youth, and program evaluation and after-discharge assessments.

Mentoring: What's It All About?

A handbook, written in a question and answer format, for foster parents and volunteers who spend time with youth in foster care. Provides practical information to enhance training sessions and workshops for volunteer mentors.

Speak out!

A two-volume curriculum (*Group Leader's Guide* and *Participant's Guide*) for teaching communication skills to youth in a group setting. Provides instructions for conducting 40 different activities related to communication and relationship skills necessary for successful transition to independence.

Ansell and Associates
Dorothy I. Ansell
919-482-2937
Joan M. Morse
718-793-2356

Provides training and consultation in independent living programming for program administrators, foster parents, child care workers, social workers, independent living coordinators, and volunteer coordinators.

Brendan Associates
4324 Thetford Road
Durham, NC 27707
919-489-1351

William V. Griffin is president of Brendan Associates, a human service consulting group that offers training, technical assistance, program development, and onsite consultation and evaluation for independent living programs.

Child Welfare Institute
1365 Peachtree Street, Suite 700
Atlanta, GA 30309
404-876-1934

The Child Welfare Institute provides training and consultation in all aspects of interdependent living. It also publishes training materials and sponsors two major conferences each year on independent living issues.

Daniel Memorial's Institute for Independent Living
7555 Beach Boulevard
Suite 102
Jacksonville, FL 32216
904-724-4200

Daniel Memorial is the oldest child-caring institution in the State of Florida. Its Institute for Independent Living was created in response

to a community need to assist youth in their transition from dependency to independence. The Institute's primary objective is to serve as a guide in the development of transitional living skills programs within the present child care/foster care/group care system.

Materials and publications include the following.

Moving Out and Making It

A 16-chapter training curriculum that provides behavioral practice opportunities for youth aged 13 to 21 in social, independent living, and job-seeking skills.

Independent Living Assessment for Life Skills

A comprehensive assessment that covers 16 categories, including tangible and intangible skills that an adolescent needs to become independent.

Independent Living Skills Plans

A computer-generated individualized skill plan based on assessment results.

Independent Living Skills Instructional Manual

Outlines components of an ideal independent living program model and provides instruction in the use of assessments, skills plans, the curriculum "Moving Out and Making It," and the computer-generated plans.

Independent Living Skills Center
One Fordham Plaza
Suite 800
Bronx, NY 10458-5871
212-295-5501

Created in 1985 by the South Bronx Human Development Organization, the Center operates an information clearinghouse, resource library, and referral center for New York City's voluntary foster care agencies and community-based service providers. It collects, organizes, and disseminates program models, educational materials, training resources, and youth-oriented materials. It also promotes and facilitates training and staff development around independent living issues. Since 1989, State funding has supported the replication of the Center's services in three other locations (Albany, Buffalo, and Stony Brook).

PROGRAM PROFILES

The following compilation represents an attempt to identify programs across the country that exemplify various aspects of "ideal" transitional living programming. The list is by no means comprehensive or all inclusive, but is merely a sampling of quality programming and services in this emerging field.

The purpose of the compilation is to provide current and potential service providers with a resource that includes a variety of program types and approaches. It is the authors' hope that providers will use the document and the expertise of the providers listed in the development and revision of their own transitional living programs.

Special thanks to all the programs who participated in this effort and who willingly gave hours of their time for discussion of their programs' successes and limitations. Without their candor and commitment to this issue, this document could never have been produced.

Collection of the Profile Information

Programs were identified through both general youth services literature and the more limited literature specific to independent and transitional living services. In addition, contacts were made with State independent living services coordinators, regional coordinated network staff, and consultants in the field.

Those programs identified were contacted and interviewed by phone using a four-page data collection instrument. The instrument was developed to correspond with the conceptual framework defined by the authors in a previous project. The questions and information requested reflect the various components of that framework and offer providers concrete examples of programming within those components.

Findings and Observations

All those interviewed were very committed to transitional living programs. Many had been involved in providing services to youth in transition for 10 or more years and had moved through a number of phases in their attempts to design services that fit youths' needs. Others, in operation for a shorter period of time, had made exten-

sive use of existing resources and knowledge and were energetically pursuing their own best response to needs of youth in their area.

Geographic Context

Programs were asked to identify themselves as urban, suburban, or rural. There was much overlap; many urban programs also served suburban areas, suburban programs often served rural areas, and rural programs often reached into suburban areas. The area identified on the profile is the primary area of service for the program.

Urban programs tended to be of two types: the inner-city model or the suburban model. In the inner-city model, clients were poor and extremely disadvantaged. As a result, services focused on basic survival skills, breaking the cycle of poverty, and ameliorating harm inflicted by substance abuse, dysfunctional family settings, and early pregnancy and parenting. The suburban model clients were less disadvantaged. As a result, these programs were able to address basic skills and to move beyond survival issues to offer more opportunities for clients. The model of choice was, to a great extent, determined by the economics of the area. Poorer, more problematic cities tended to choose the urban model, while cities with more stable economies and more opportunities for youth used a suburban model.

In rural and some suburban areas, transportation was very difficult for clients and for staff. Staff time with clients was more limited because of the amount of time spent traveling. As a result, these programs tended to provide more individualized interaction and fewer group experiences for clients.

Physical Setting

Programs ran the gamut from shelter to group home to foster home to apartment living. Some offered a continuum of care; in these programs, clients tended to spend less time in each component and moved regularly from more to less structured environments during their tenure. In some of these programs, youth spent only a few months in any given component. These young people were essentially in transition, physically and psychologically, during the entire time they were in the program.

Other programs offered only a single component, relying on the community for other short- or long-term services. In these settings, youth tended to spend longer periods of time within that one program. In some programs, this might mean 18 months or more within a single program setting.

Foster homes, in which families were reimbursed for housing and providing support to youth, were fairly common. Host homes, using volunteer families, were much less common.

Supervised apartment settings tended to be agency owned and/or operated. The agency rented one or more units, and agency staff were on site nearly continuously. Unsupervised apartments tended to be scattered in sites around the area, with units rented by the young people themselves. Staff made announced and unan-

nounced visits on a regular basis, but the agency assumed no liability for the units.

Very interesting rehabilitation projects were being undertaken by a few programs. In general, these involved identifying local properties, owned by the city or county, that had been slated for future demolition and that were currently vacant. Programs worked with the city to rent these properties for minimal fees, with local developers to make cosmetic renovations rendering them fit for habitation, and with volunteer groups to decorate and furnish the units. This community-intensive effort—termed "Re-habitat for Humanity" by the San Diego program—has resulted in more community involvement in the lives and welfare of youth in the program.

Client Population

The racial makeup of a program's clientele tended to reflect the racial makeup of the area served by the program. Most served a mix of clients. However, some, like the Ute Mountain program, were focused on serving very specific populations.

Special Populations

Most programs would accept or have already served youth they knew to be HIV positive. Programs had policies and procedures in place to educate staff about AIDS/HIV and to ensure that clients and staff were not infected by improper handling of blood and body fluids.

Some programs focused services specifically on pregnant and parenting youth, providing a wide range of services (day care, parenting and child development classes, etc.). Many of the programs, though not specifically designed for pregnant and parenting youth, served them as well. When programs specifically denied services to this population, it was because other programs in the area provided those services.

None of the programs interviewed was specifically designed for the developmentally delayed. However, several of those interviewed stated their belief that all the youth they served were developmentally delayed in one or more areas—whether it resulted from years of drug abuse, educational deficits, abuse and neglect from parents, or other causes. Case planning and services were designed to address various developmental needs according to the individual client's needs and skills.

Age Range

Most programs identified ages 16-21 as their eligible range; however, most intakes seemed to occur between 16 and 19. Older youth served tended to be those who had entered the program at an earlier age and had turned 20 or 21 while in the program. Few youths older than 19 were entering programs.

Cultural Sensitivity

Programming around cultural sensitivity tended to be either very well developed or essentially nonexistent. Those with well-developed programming offered ongoing training for staff, incorporated cultural issues into client curriculum, and made concerted efforts to recruit and hire minority staff. This focus tended to reflect the

larger, parent or umbrella agency's attention to this issue. Some of the programs took a broad view, looking at a variety of differences affecting staff and client functioning rather than just racial or ethnic differences and including sexual orientation and class differences in their trainings.

In programs without cultural sensitivity programming, staff identified it as a problem and discussed ways the agency was seeking to address it. Many were in search of good models for use with staff and with clients.

Staff

Information was collected on age, race, and ethnic background of staff in an attempt to discern patterns in hiring among programs. No clear pattern emerged.

Some programs used mostly older staff (30-50 years of age). They found older staff were more mature and experienced, garnered more respect from clients, and were more likely to be parents of youth themselves and to have a better understanding of the various facets of the youth's situation. Other programs used primarily younger staff (under 30 years of age), citing their easy rapport with clients and ability to model independent living skills in a way that clients found acceptable. Most programs had staff of all ages, with older staff serving administrative or clinical positions and younger staff serving in direct care roles.

Most programs made an effort to staff the program with individuals whose ethnic and racial backgrounds matched those of the clients they served. Urban programs tended to have ethnically diverse staff. Many programs cited difficulties in hiring qualified and credentialed minority staff.

Most direct service workers had BA degrees, though some were high school graduates. Some programs, particularly those in the urban areas, recognized service and experience in lieu of formal education.

Program Capacity

The number of youth served each year by program varied a great deal depending upon the number of program components operated and the length of time youth spent in each component. In general, those with very high numbers served tended to have a variety of programs, to offer nonresidential services, and to do outreach to youth who were not served in the residential program. Those with lower numbers served tended to focus services on youth in residential care.

Program Length

Few programs served youth for less than 6 months. Those that did were providing services on a nonresidential basis. Most programs offering residential care worked with youth from 6 months to 2 years.

Counseling Services

Some programs provided in-house counseling services; others referred youth in need to local counseling services. Some worked

very hard to bring in youths' families; other focused their work on the youth only. In general, these different approaches reflected the program's orientation.

Programs with a skills-based orientation tended to focus on the client. They found clients' families to be unavailable and disengaged and chose not to spend limited agency resources on working with them.

Programs with a systems-based orientation tended to be more clinical in their approach. They also viewed the family as disengaged and dysfunctional but felt it was essential that the families be involved to help youth deal with separation issues and to prevent future dysfunctional intervention by the family.

Assessment Tools

Most programs used tools they had developed themselves or had adapted from other programs. Some programs, usually those within a particular State, used standardized tools that had been offered by State trainers or that were required by State funding sources.

Client Eligibility

Though client eligibility was not a specific question posed to program staff, there were some interesting differences in program approaches to selection of clients. Some programs were very careful to select clients who were highly motivated and who were viewed as having the greatest potential for success. These programs tended to use the intake as a screening tool.

Other programs selected those clients viewed as most in need of services and committed themselves to designing a program for that client that made failure difficult. Often, this included built-in activities.

One interesting observation from the interviews was related to the role of the visionary leader. Some programs had a strong leader with a very clear vision of the program's purpose and direction. In these programs, staff spent more time exploring the overall purpose and direction of the program, reviewing and revisiting program services and approaches on an ongoing basis. The unanswered question that emerges from this observation has to do with staff turnover. Do those programs that engage in such intensive self-examination and continual changes experience high staff turnover (because things keep changing around them) or low turnover (because staff are engaged with the program in a different way)?

Evaluation

Most programs found that extensive outcome evaluation was too time consuming and expensive. Many expressed an interest in developing meaningful evaluation measures but were inexperienced and had limited resources to engage others who had the expertise.

The attempts made by programs to evaluate their efforts reflected their agency's emphasis on data. Within agencies focused on col-

lecting and analyzing data, programs tended to make greater use of measurable goals and objectives and to administer pre and post tests. When agencies were less focused on data management, programs tended to take a more qualitative approach to evaluation, using only a few quantitative measures of success (job placements, educational attainments, successful program terminations, etc.)

Termination of Clients From the Program

Most programs had some difficulty identifying general grounds for termination. This probably reflects the efforts made by programs to individualize services for clients and to prevent and avoid termination prior to program completion. Most agreed that law violations—particularly crimes against persons—would be grounds for termination.

Many of those interviewed stated that unplanned terminations never occurred. All conditions and aspects of termination were written into client contracts so that all conditions for termination—successful or unsuccessful—were planned by the client and staff from the outset. Failure to meet the conditions of the contract automatically resulted in termination.

Most programs were aware of and were making attempts to deal with clients' difficulties in separating from the program — difficulties that often resulted in the client's sabotage of jobs or future living situations. Most attempted to deal with this issue by making the process conscious for youth—discussing the reasons it might happen and encouraging them to talk through their concerns about leaving the program—and by phasing out services very gradually so that clients could continue to receive program support after graduation.

Unique Features

Programs were asked to identify unique or particularly strong features—those things that set them apart from other programs. The features identified vary widely but share two commonalities. First, they reflect some aspect of the program that is well developed, ongoing, and has a history of success. Second, the identified feature reflects the philosophy that drives the program, giving it its meaning and direction.

Agency Name: Alternatives for Girls

Program Name: Transitional Living Program

Address: 1950 Trumbull Street
Detroit, MI 48216

Contact Person: Amy Good

Telephone: 313-496-0938

Years TLP in Operation: $2^1/_2$ (since 1989)

Geographic Context: Urban

Physical Setting: Shelter
Unsupervised apartment (low)

Client Population:

Black	75%
White	20%
Other	5% (Latino and Arab American)

How cultural sensitivity is integrated into programming and staff training: Quarterly sensitivity training

Special Populations: HIV
Pregnant
Client and child (Children do not live with them)
Prostitutes

Age Range: 15-20 years

Staff:

Position	Minimum educational requirement	Ethnicity	Full-time equivalent	Age
Dir. of Prog. Svcs	MSW	C	FT	34
Res. Prog. Dir.	BA	B	FT	38
TL Coordinator	BA	C	FT	26
2 Program Dir.	BA/AA	B/B	FT	39/49
Youth Specialists	AA/BA	B/C	FT	25/35

Program Capacity (per year):

In-house	62
Aftercare	20

Program Length: 12 + months

Clinical Counseling: Provided by program and by another agency
Counseling provided to client only

Assessment Instruments/ Tools Used by Program:	Developed in-house
Theoretical/Clinical Base:	Family systems
Service Linkages:	Employers/Businesses: Job development with 5 businesses Landlords: Strong relationships with 3-4 landlords Child Welfare Agencies Probation Agencies Community Agencies: Service agreements
Staff Training:	100 hours per year for shelter staff. Inservice training and out of program training.
Program Structure:	*Planning:* Formal review at conclusion of year, planning for new year, and completing annual report of year's service and activities. *Evaluation*: Outcome evaluation, followups quarterly after graduation. *Logical/natural termination of clients*: Goal planning through program. Goal planning after completion of program. Formalized process for premature discharge.
Unique Features/ Comments:	• Strong street outreach services to homeless/prostituting adolescents in southwest Detroit. • Utilizes vans, team, and volunteers who provide crisis intervention and support to future TLP clients. • Utilizes minority professional women mentors with 10 IL modules completed on an individual basis. • Didactic and highly experiential with pre/post test features. • Residents choose IL skill area where they become the "house expert," which includes research and resource development.

Agency Name: Appalachian Youth Service

Program Name: Independent Living Program (also an IL program for pregnant and parenting)

Address: 205 W. High Street
Ebensburg, PA 15931

Contact Person: Trish Corle

Telephone: 814-472-7874

Years TLP in Operation: 4 (since 1987)

Geographic Context: Suburban: 1 county
Rural: 2 counties

Physical Setting: Group Home
(Client) Family/Outclient
Foster Care

Client Population

Black	2%
White	98%

Special programming around cultural issues and sensitivity: No

Special Populations Served: Pregnant
Client and child

Age Range: 16-21

Staff:

Position	Minimum educational requirement	Ethnicity	Full-time equivalent	Age
Program Manager	BA	C	FT	27
2 Program Aides	BA/HS	C/[illegible]	FT/FT	20-27

Program Capacity (per year): 40

Program Length: 7-12 months
12 + months

Clinical Counseling: Provided by another agency
Counseling provided to: Client only
Parent/Family

Assessment Instruments/ Tools Used by Program: TELS, Test of Adult Basic Education (TABE), Myers-Briggs Type Indicator, Job-O, Slossen Intelligence

Theoretical/Clinical Base: Self-determination/empowerment. Long-term goal setting.

Service Linkages:

Employers/Businesses: Through agency's employment/training division.

Landlords: Member of community network providing information/referral of these resources.

Child Welfare Agencies

Probation Agencies

Community Agencies: County mental health offices, Department of Public Welfare, Birthright/Planned Parenthood

Staff Training:

40 hours training per year. State IL training, etc.

Program Structure:

Planning: Ongoing updating of program. Twice a year conduct program review.

Evaluation: Informal outcome evaluation at conclusion of program.

Logical/natural termination of clients. TELS is pre/post test determining proficiency for program completion.

Unique Features/ Comments:

- Rural setting.
- Three-step program includes: (1) thorough assessment, (2) in-house training curriculum provided on an individual client basis, (3) voluntary aftercare.
- Clients provided services in school.
- Strong emphasis on education including assistance for obtaining grants and loans.
- 70-percent client employment rate.

Agency Name: Aunt Martha's Youth Service Center, Inc.

Program Name: Transition to Independence Project (Cook County)
Project On Your Own (Will & Kankakee Counties)

Address: 224 Blackhawk Drive
Park Forrest, IL 60466

Contact Person: Lonnetta Albright

Telephone: 815-727-3002

Years TLP in Operation: 7 (since 1984)

Geographic Context: Urban, Suburban
Rural: Project On Your Own

Physical Setting: Shelter, Host home (recruited, self-identified by clients)
(Client) Family/Outclient

Client Population:

	TIP	Project On Your Own
Black	15%	50%
White	85%	50%

How cultural sensitivity is integrated into programming and staff training. Part of IL curriculum. Staff attend cultural competence training.

Special Populations Served: Pregnant; Client and child (emergency basis only)
Married couples

Age Range: 18-21 (occasionally serves minors)

Staff:

Position	Minimum educational requirement	Ethnicity	Full-time equivalent	Age
Administrator	BA	B	15%	37
Project Director	BSW	B	40%	36
Coordinator	MA	B	FT	32
Mentor	BA	B	PT	29
Mentor	Exp	B	FT	27
Case manager	BS	C	FT	23
Counselor	MA	C	PT	47
IL Specialist	BA		PT	

Program Capacity (per year): 100

Program Length:

0-6 months
7-12 months Aftercare/Relapse
12 + months Aftercare/Relapse

Clinical Counseling:

Provided by agency's counseling program

Provided by another agency occasionally in rural area

Counseling provided to: Client only
Parent/Family

Assessment Instruments/ Tools Used by Program:

Daniel Memorial assessment package. Other in-house assessment tools depending on program.

Theoretical/Clinical Base:

Reality therapy-natural consequences. Family systems.

Service Linkages:

Employers/Businesses: Through Employers Advisory board. Agency's Youth Employment Unit operates as in-house employment agency. Agency's Try Out Employment program pays clients first 6 weeks at wages for employers who "try out" clients. (85-percent placement rate)

Landlords: Agency's Family First program has arrangements with landlords to waive first month's rent. Also works with landlord who buys building for group residence purpose.

Child Welfare Agencies

Probation Agencies

Community Agencies

Staff Training:

20-hour in-house comprehensive orientation/training. Institute of Reality Therapy certifies staff.

Program Structure:

Planning: Yearly unit reviews. Yearly implementation plans with quarterly reviews.

Evaluation: Outcome goal evaluation including computer client tracking program. Client evaluation surveys. University of Chicago completes evaluation of some units.

Logical/natural termination of clients: Formalized individual discharge planning. Graduation and certificates of completion.

Unique Features/ Comments:

- Program serves clients in urban (S. Chicago), suburban, and rural settings.
- Part of large ($10 million) comprehensive, multiservice agency with 60 program units including counseling, community service, youth employment, residential, health, and 50 foster homes.
- Strong community support and volunteerism.
- Undergraduate/graduate internships in IL program.
- Very strong employment/housing component.

Agency Name: Daymark, Inc.

Program Name: New Connections

Address: 1598-C Washington Street East
Charleston, WV 25311

Contact Person: Sharon Mayes

Telephone: 304-340-3690

Years TLP in Operation: 8 (since 1983)

Geographic Context: Urban (30-50% come from rural to city)
Suburban
Rural

Physical Setting: Shelter
Supervised Apartment (high): Congregate apartments
(Client) Family/Outclient
Foster homes
Street

Client Population: Black 25-30%
White 70-75%
How cultural sensitivity is integrated into programming and staff training. Support groups including gay and lesbian.

Special Populations Served: Pregnant
Client and child
Gay and lesbian

Age Range: 16-21

Staff:

Position	Minimum educational requirement	Ethnicity	Full-time equivalent	Age
Director	BA	C	FT	
Teacher	BA/T.Cert.	C	FT	Entire
IL Case manager	BA/SW Lic.	C	FT	age
JTPA Case manager	"	C	FT	range
General Case manager	"	C	FT	25-55
Sec/Youth Counselor	HS	C	FT	
Relief Staff	BA/Exp.	C	PT	

Program Capacity (per year): 200-250

Program Length:	0–6 months 7–12 months 12 + months
Clinical Counseling:	Provided by another agency as necessary or needed—voluntary by client.
Assessment Instruments/ Tools Used by Program:	In-house developed intake, Cambridge Pre-GED test
Theoretical/Clinical Base:	Reality Therapy/Control Theory (Glaser)
Service Linkages:	Child Welfare Agencies Probation Agencies Community Agencies: Woman's Health Center (Teen mother/support group), State Department of Health and Human Resources
Staff Training:	Reality therapy training. Training to maintain social work and teaching licensure. In-house training.
Program Structure:	*Planning*: Board completes 5-year long-term plans. Ongoing program reviews by staff. Program review by Board every 3 years. *Evaluation:* Performance standards. *Logical/natural termination of clients*: Natural consequences for behaviors depending on severity and chronicity of behaviors. Implemented on an individual.
Unique Features/ Comments:	• Voluntary program. • Strong reality therapy philosophy agencywide.

Agency Name: Franklin County DIAL/SELF

Program Name: DIAL/SELF

Address: 196 Federal Street
Greenfield, MA 01301

Contact Person: Melanie Goodman

Telephone: 413-774-7054

Years TLP in Operation: 9 (since 1982)

Geographic Context: Rural

Physical Setting: Supervised Apartment (high): Cluster
Unsupervised Apartment (low): Scattered site with on-site monitor
(Client) Family/Outclient

Client Population: White 99%
How cultural sensitivity is integrated into programming and staff training. In-house weekly meeting. IL skills workshop in community.

Special Populations Served: Client and child

Age Range: 16-21

Staff:

Position	Minimum educational requirement	Ethnicity	Full-time equivalent	Age
Ex Dir/Prog Dir	MA	C	FT	34
2 Coordinators	BA	C	FT	35/45
Caseworker/Coun.	5BA/2MA	C	FT	21-45

Program Capacity (per year):

Residential	14
Outclient parent	20
Assessment outreach	15/20

Program Length: 0-6 months
7-12 months
12 + months

Clinical Counseling: Provided by another agency
Counseling provided to: Client only
Parent/Family as needed/informal

Assessment Instruments/ Tools Used by Program:	Compilation of many
Theoretical/Clinical Base:	Logical/natural consequences. Reality. Uses different therapists/approaches with different client's depending on need.
Service Linkages:	Employers/Businesses Landlords (See comments) Child Welfare Agencies Probation Agencies Community Agencies: Family planning, D&A
Staff Training:	16-hour IL orientation (Pass It On). Two clinical consultants meet with teams on ongoing basis and provide in-house training. Staff have four professional days for out-of-agency training.
Program Structure:	*Planning*: Strategic planning and ongoing program review. *Evaluation*: Client followup surveys. University of Massachusetts conducting a 3-year statistical and social evaluation. *Logical/natural termination of clients*: "Pink slips, suspensions, and expulsions" when necessary. Program cycle of 12 months includes formal graduation, framed certificate, party, transition to alumni advisory committee, etc.
Unique Features/ Comments:	• Strong housing linkage started in 1982 with housing authority (subsidizes rents) and community development corporation (rehab condemned building). Landlords actively collatorate with program from client start as participant in orientation process. • Staff on call 24 hours. • Aftercare component is formalized with counselor/client meeting and group services for up to 1 year after graduation. • Has also served married client couples in scattered site setting.

Agency Name: Harbor Schools, Inc.

Program Name: Safe Harbor

Address: 88 Essex Street
Haverhill, MA 01832

Contact Person: David Nastasia/Michael Corbett

Telephone: 508-372-7796

Years TLP in Operation: 10 (since 1981)

Geographic Context: Primarily Urban; Suburban; Rural

Physical Setting: Supervised Apartment (high)
Unsupervised Apartment (low): 2nd Phase
(Client) Family/Outclient: 3rd Phase (aftercare services)
1st Phase—Mentor homes (modified foster homes)

Client Population:

Black	25-33%
Hispanic	10-20%
White	45-65%

Special programming around cultural issues and sensitivity: Planning stage

How cultural sensitivity is integrated into programming and staff training. In-house training

Special Populations Served: Pregnant
Client and child
Adolescent sexual offenders

Age Range: 16-22

Staff:

Position	Minimum educational requirement	Ethnicity	Full-time equivalent	Age
Program Director	MA	Caucasian	FT	39
Program Manager	MA	Caucasian	FT	37
Asst. Pro. Mgr.	MSW	Caucasian	FT	27
Resource Develop	MSW	Caucasian	FT	27
20 Caseworkers	BA/MA/MSW	Primarily Ca	Mostly PT	30-40

Program Capacity (per year): 30

Program Length: 12 + months

Clinical Counseling:	Counseling provided by another agency; affiliation with mental health center Counseling provided to client only
Assessment Instruments/ Tools Used by Program:	Developed own in-house version
Theoretical/Clinical Base:	"Normalization", "logical or natural consequences" (includes decisionmaking and predicting, then getting back "together when happens")
Service Linkages:	Landlords Community Agencies: G.E.D. programs, Pregnancy/parenting teens
Staff Training:	PT staff: management training (monthly) curriculum Caseworkers: curriculum in helping youth in decisionmaking/ risk management, other IL skills areas, etc.
Program Structure:	*Planning*: Administrative retreat 3-4 times a year (2-day) to review, revise, and plan ahead. Once a year a goals and objectives planning process occurs. *Evaluation*: Staff retreat on outcomes of cases and factors which led to successes and/or failures. *Logical/natural termination of clients:* Bi-weekly goal review with clients. Graduation dinner/party in which families are invited.
Unique Features/ Comments:	• Monitoring homes with living partners. • High degree of support and highly developed teamwork approach.

Agency Name: Janus Youth Programs

Program Name: Williamette Bridge

Address: 3942 S.E. Hawthorne Street
Portland, OR 97214

Contact Person: Jerry Fest

Telephone: 503-233-8111

Years TLP in Operation: 4 ½

Geographic Context: Urban

Physical Setting: Large home

Client Population

White	75%
Other	25% (Minorities)
	30-40% gay or lesbian identified

How cultural sensitivity is integrated into programming and staff training. Ongoing training

Special Populations Served:
HIV
Pregnant
Client and child
Developmentally delayed

Age Range: 16-21

Staff:

Position	Minimum educational requirement	Ethnicity	Full-time equivalent	Age
Pgm. Supervisor			1	
Pgm. Director			1	
Case Managers	cover 24 hours at home		2	
Support/mentors			3	

Program Capacity (per year): 7

Program Length: 12 + months

Clinical Counseling: Counseling provided by another agency if needed
Counseling provided to: Client only
Parent/Family

Assessment Instruments/ Tools Used by Program: Screen out arsonists and major mental illness

Theoretical/Clinical Base: Creating—with youth—a pathway to independence by encouraging supports and requiring youth to make decisions.

Service Linkages:
Employers/Businesses
Landlords
Child Welfare Agencies
Probation Agencies
Community Agencies

Staff Training:
Ongoing specialized training: outreach, drugs, advocacy
3-hour staff retreats once a month: special trainings, processing program issue.
Weekly staff meeting
Outside training and conferences

Program Structure:
Planning: Ongoing focused on program development.
Evaluation: Process rather than goal-oriented program; hard to document increased self-esteem and decisionmaking skills. Trying to figure it out.
Logical/natural termination of clients: Open door policy—if client must leave because plan is not being worked, can come back as soon as space is available.

Unique Features/ Comments:

- Self government model
  - Program began with three rules (no sex, drugs, violence) and since that time youth in the program have developed rules and structure.
  - Youth receive weekly evaluation of their progress and their continuation in the program is driven by that evaluation—not by staff.
- Extensive staff training and support. The program is very different from most, and staff receive much training and time to meet and process events and issues.

Agency Name: Kaleidoscope, Inc.

Program Name: Youth Development Program

Address: 1279 N. Milwaukee Avenue, Suite 250
Chicago, IL 60622

Contact Person: Bob Devaney

Telephone: 312-278-7200

Years TLP in Operation: 16 (since 1975)

Geographic Context: Urban and Suburban

Physical Setting: (Client) Family/Outclient: All clients have own apartment in community transient hotels(short term for emergencies)

Client Population:

Black	40-60%
Hispanic	X
White	40-60%
Asian	X
Other	X

Special programming around cultural issues and sensitivity: No

Special Populations Served: Accepts any type client: HIV, Pregnant, Client and child, Developmentally delayed, Severely emotionally disturbed

Age Range: 16-21

Staff:

Position	Minimum educational requirement	Ethnicity	Full-time equivalent	Age
Program Admin.	BA	C	FT	29
Asst. Prog. Admin.	MA	C	FT	44
4 Social Workers	Masters	C/H	FT	25-54
2 Adol.Parent Spec.	BA	B/C	FT	32
Youth Workers Supv.	BA	B	FT	32
6 Youth Workers	BA	B/C	FT	24-34
Housing Coord.	BA	B/A	FT	37-25

Program Capacity (per year): Approximately 50

Program Length: 12 + months

Clinical Counseling: Counseling provided by program and by another agency
Counseling provided to client only

Assessment Instruments/ Tools Used by Program:	Developed in-house
Theoretical/Clinical Base:	Unconditional acceptance—nonpunitive discharge Natural consequences
Service Linkages:	Landlords: Two housing coordinators locate apartments and maintain relationships/contacts with landlords. Child Welfare Agencies: Vocational counselor (agencywide) develops positions with employers. Probation Agencies Community Agencies
Staff Training:	Weekly 2-hour staff trainings
Program Structure:	*Evaluation*: Development stage *Logical/natural termination of clients:* Only reason for discharge is reaching age 21 or runaway or incarceration for 2 weeks. Can be readmitted if slot available upon return.
Unique Features/ Comments:	• Program works with any type client regardless of history. • For clients, it is "the last stop of the train." • Strong relationship/trust building. • Strong reality component. • Strong team approach. Each client has a social worker and youth worker. (Parent clients have parent specialist also.)

Agency Name: Lawrence Hall Youth Service

Program Name: Supervised Independent Living

Address: 16 N. Wabash Avenue, 16th Floor
Chicago, IL 60601

Contact Person: Phyllis Shadwick

Telephone: 312-346-3383

Years TLP in Operation: 18 (since 1973)

Geographic Context: Urban
Suburban

Physical Setting: Client's own apartment

Client Population:

Black	80%
Hispanic	3%
White	17%
Other	1%

How cultural sensitivity is integrated into programming and staff training. Consultant worked with staff for 3 months.

Special Populations Served: Client and child—50%
Adolescent fathers

Age Range: 17-20

Staff:

Position	Minimum educational requirement	Ethnicity	Full-time equivalent	Age
Program Director	MSW	C	FT	50
Asst. Prog. Dir.	MSW	C	FT	56
Supv. - Soc. Wk.	MA	C	FT	44
Supv. - Case Asst.	BA	B	FT	41
8 Social Workers	MSW	C/B	FT	30-61
4 Case Assistants	HS/BA	B/C	FT	24-60
Nurse	RN	C	8 hrs./wk.	30

Program Capacity (per year): 110-115

Program Length: 12 + months

Clinical Counseling: Counseling provided by program
Counseling provided to: Client only
Parent/family as many supports as possible.

Assessment Instruments/ Tools Used by Program:	Daniel Memorial, psychological by referral agency
Theoretical/Clinical Base:	Psychoanalytic - Psychodynamic
Service Linkages:	Employers/Businesses: Internal component (project skill) youth employment/job readiness Landlords Child Welfare Agencies Community Agencies: Daycare homes for babies, Substance abuse clients
Staff Training:	1-week orientation program
Program Structure:	*Planning*: Internal case reviews. *Evaluation*: Intervention evaluations. *Logical/natural termination of clients*: Case reviews. Sexual responsibility policy; will not work with clients who have had more than two pregnancies. Annual awards dinner.
Unique Features/ Comments:	• Psychoanalytic/psychodynamic orientation provides focus on developmental stages, traumas, and strengths/deficits in client lives. Includes reparenting. • Pregnancy planning staffing when pregnancy confirmed. • Provides services to adolescent fathers. Includes weekly men's groups. • Special mandatory client seminars (AIDS, drugs, etc.). • Treatment groups.

Agency Name: Maine Dept. of Human Services, Bureau of Child and Family Services

Program Name: IL services for entire State

Address: State House Station II, 221 State Street
Augusta, ME 04333

Contact Person: Nancy Goddard

Telephone: 207-289-5060

Years TLP in Operation: Since 1988

Geographic Context: Urban
Rural Primarily

Physical Setting: Group Home
Shelter
Supervised Apartment (high)
Unsupervised Apartment (low)
(Client) Family/Outclient: Relative's home
Foster home

Client Population:

Black	0.5%
Hispanic	0.1%
White	96%
American Indian	1.3%
Asian	0.5%

Special programming around cultural issues and sensitivity: No

Special Populations Served: Pregnant
Client and child

Age Range: 16-18 (to age 21 in some cases)

Staff:

Position	Minimum educational requirement	Ethnicity	Full-time equivalent	Age
Substitute Care				
Program Specialist	MSW	C	FT	45
5 Supervisors	BA/MA	C	FT	33-45
2 Contract Staff	BA/MA	C	FT	30-35

Program Capacity (per year): 171

Program Length:

0–6 months
7–12 months
12 + months

Clinical Counseling:

Counseling provided by another agency
Counseling provided to client only

Staff Training:

Preservice training. Ongoing training and clinical supervision. Workshops as scheduled in-house.

Program Structure:

Planning: Staff and regional program managers identify needs.

Evaluation: Not implemented statewide yet.

Logical/natural termination of clients: N/A since clients are in the custody of the State.

Unique Features/ Comments:

- Teen conference.
- Mentoring component.
- Provide IL services to rural clients throughout the state.
- Use of outdoor activities (e.g., canoe trips) has been effective in working with rural youth in developing problem-solving, self-esteem, etc.

Agency Name: Mercy Center Ministries, Inc.

Program Name: Mercy Center—TILSP (Transitional & Independent Living Support Program)
Mercy Residence/Mercy House—Pregnant and Parenting Residences

Address: 436 W. Main Street
Patchogue, NY 11772

Contact Person: Sister Mary Waters

Telephone: 516-447-3978

Years TLP in Operation: 8 (since 1983)

Geographic Context: Suburban

Physical Setting: Group Home; Shelter; (Client) Family/Outclient ; TILSP

Client Population:

Black	20%
Hispanic	10%
White	60%
Asian	5%
Other	5%

How cultural sensitivity is integrated into programming and staff training. Inservice by staff and topic experts.

Special Populations Served: Pregnant
Client and child
Runaway/homeless female youth

Age Range: 16-20

Staff:

Position	Minimum educational requirement	Ethnicity	Full-time equivalent	Age
(2) Program Dir.	BA	C	FT	27-49
(3) House Dir.	BA or equiv. life exp.	C	FT	40-55
(3) Asst. House Dir	life exp	B/H/C	FT	21-59
Overnight Staff	life exp	B/H/C	FT	21-59

Program Capacity (per year): Residential 40-45 (not counting kids)
Nonresidential followup 250-300.

Program Length: 12 + months

Clinical Counseling:	Counseling provided by another agency Counseling provided to: Client only Parent/Family
Assessment Instruments/ Tools Used by Program:	In-house tools
Theoretical/Clinical Base:	Natural consequences
Service Linkages:	Employers/Businesses Landlords Child Welfare Agencies Probation Agencies Community Agencies: Schools, churches
Staff Training:	40 hours of training per staff person.
Program Structure:	*Planning*: Administrative planning sessions 4 times a year. *Evaluation*: Exit interviews, followup interviews. Agency/Board of Directors evaluation. *Logical/natural termination of clients*: Individual recognition on completion of program and special events. Residency for 1 year maximum.
Unique Features/ Comments:	• All clients must be voluntary. • House meeting once a month. • Family work is an important component of program.

Agency Name: Middle Earth Unlimited Inc.

Program Name: Turning Point Independent Living Services

Address: 3816 S. First Street
Austin, TX 78704

Contact Person: Mitch Weynand

Telephone: 512-447-5639

Years TLP in Operation: 10 (since 1981)

Geographic Context: Urban

Physical Setting:
Group Home
Shelter
Supervised Apartment (high): Duplex next to group home
Unsupervised Apartment (low): Scattered site

Client Population:

Black	5%
Hispanic	30%
Biracial	5%
White	60%

How cultural sensitivity is integrated into programming and staff training. Looking at that issue now; interested in finding materials and resources.

Special Populations Served:
HIV
Pregnant
Client and child

Age Range: 16-21

Staff:

Position	Minimum educational requirement	Ethnicity	Full-time equivalent	Age
Program Director	BA	Hispanic	FT	33
Counselor #1	M.Ed.	White	FT	26
House Manager	BA	Hispanic	FT	38
Counselors (5)				

Program Capacity (per year):

Group home (2-3 months)	8
Duplex (2-3 months)	4
Apartments (3-6 months)	40-50

Program Length: 7-12 months

Clinical Counseling:	Counseling provided by program Counseling provided to: Client only Parent/Family—Very Limited
Assessment Instruments/ Tools Used by Program:	Some use of standardized assessment tools—some tools adapted/developed by program.
Theoretical/Clinical Base:	Not clinically oriented: reality therapy, crisis intervention, brief treatment model
Service Linkages:	Employers/Businesses Landlords Child Welfare Agencies Community Agencies
Staff Training:	Staff trained in-house on related issues and through attending conferences.
Program Structure:	*Planning:* Informal; staff consensus model *Evaluation*: Informal mechanisms. Primarily measure units of service (# services delivered, # days of care, # of jobs had, etc.) *Logical/natural termination of clients*: Have experienced client sabotage of success as client nears program exit date. Try to address this by discussing it beforehand and providing support through the transition.
Unique Features/ Comments:	• Continuum of care within agency—from emergency shelter to group home to duplex to apartments. • Well-developed job training program—job readiness, computer-based GED program.

Agency Name: New Life Youth Services

Program Name: New Life Youth Service Independent Living Program

Address: 4931 Steward Road
Cincinnati, OH

Contact Person: Mark Kroner

Telephone: 513-561-6946

Years TLP in Operation: 10 (since 1981)

Geographic Context: Urban
Suburban
Rural

Physical Setting: Unsupervised Apartment (low): Scattered site
(Client) Family/Outclient: Outclient IL preparation

Client Population:

Black	49%
Hispanic	X
White	49%
Asian	X
Other	X

How cultural sensitivity is integrated into programming and staff training. Groups and inservice training

Special Populations Served: Pregnant
Client and child
Developmentally delayed
Character disorders

Age Range: 16-19

Staff:

Position	Minimum educational requirement	Ethnicity	Full-time equivalent	Age
Program Director	BA*	C	FT	40
2 Social Workers	BA/BA	B/C	FT/FT	44-38
2 Advocates	MSW/BA	C/C	PT/PT	24/28
Mover			PT	

*Licensed Social Worker

Program Capacity (per year):

Apartments	45
IL Preparation—outclient	50

Program Length:	7–12 months
Clinical Counseling:	Provided by another agency Counseling provided to client only
Assessment Instruments/ Tools Used by Program:	Developed in-house. Psychologist completes vocational testing and mini MMPI.
Theoretical/Clinical Base:	Reality
Service Linkages:	Employers/Businesses Landlords Child Welfare Agencies Probation Agencies Community Agencies: Medical, Pregnancy Clinics, Counseling Agencies, etc.
Staff Training:	All staff receive 40 hours per year.
Program Structure:	*Planning*: Annual systems review of components. *Evaluation*: Client and referral source. Feedback/followup. *Logical/natural termination of clients*: Provided on a case by case basis. Annual party and recognitions.
Unique Features/ Comments:	• Developed "Progress and Setbacks," IL board game. • Print materials available for purchase include *We Gotta Get GROWIN'!*, *Doing Their Best When Out of Your Nest*, and *100 Questions*. • Well developed "scattered-site" approach where clients "learn by doing and when they have to."

Agency Name: Oneida County Community Action Agency

Program Name: Transitional Living Program

Address: 207 N. James Street
Rome, NY 13440

Contact Person: Bonnie Joslin/Carol Northrup

Telephone: 313-339-0259 FAX 315-339-2981

Years TLP in Operation: 1 (since 1991)

Geographic Context: Rural

Physical Setting: Supervised Apartment (high)
Host Home: Shelter for 2-4 months
Client rents apartment in senior citizen residence

Client Population White 95%
Special programming around cultural issues and sensitivity: No

Special Populations Served: Pregnant
Developmentally delayed

Age Range: 16-21

Staff:

Position	Minimum educational requirement*	Ethnicity	Full-time equivalent	Age
Program Director	H.S.+	Caucasian	FT	50
Program Coordinator	H.S.	Caucasian	FT	46
Case manager #1	H.S.	Caucasian	FT	42
Case manager #2	H.S.	Caucasian	FT	41

*Oneida County Community Action Agency, Inc. has no educational requirements.

Program Capacity (per year): 20

Program Length: 12 + months

Clinical Counseling: Provided by another agency

Assessment Instruments/ Tools Used by Program: In-house version

Theoretical/Clinical Base: Reality, Problem solving

Service Linkages: Community Agencies: Life Skills, G.E.D., Preemployment training, Mental Health

Staff Training:	Community workshops, relevant conferences
Program Structure:	*Planning*: Development stages *Evaluation*: Development stages
Unique Features/ Comments:	• Developed residential component where clients rent apartment in a senior citizen residence.

Agency Name: Ozone House

Program Name: Miller House (residential) & Ozone House (nonresidential)

Address: 508 Miller Avenue
Ann Arbor, MI 48103

Contact Person: Joan Kauffman

Telephone: 313-668-8484

Years TLP in Operation: 7 (since 1984)

Geographic Context: Urban

Physical Setting: Group Home
Unsupervised Apartment (low): Own apartment with low/no monitoring
(Client) Family/Outclient

Client Population:

Black	15%
Hispanic	1%
White	80%
American Indian	1%
Asian	1%
Other	2%

How cultural sensitivity is integrated into programming and staff training. Classes within IL skills curriculum. Inservices for staff.

Special Populations Served: HIV
Client and child: Short-term crisis

Age Range: 16-19

Staff:

Position	Minimum educational requirement	Ethnicity	Full-time equivalent	Age
2 Program Coord.	BSW	C	FT	40
Clin. Case Admin.	MSW	C	FT	28
Skills/Ed. Coord.	MEd.	C	FT	28
Licensing Coord.	MSW	C	½ FT	30
Miller Case Coord.	BA	C	FT	25
5 Group Home Coun	HS/BA	C/H/B	FT	22-30
Tutor	BA	C	Contract	24

Program Capacity (per year):

Residential	24
Nonresidential	20

Program Length:	7-12 months 12 + months
Clinical Counseling:	Provided by program and by another agency Counseling provided to: Client only Parent/Family
Assessment Instruments/ Tools Used by Program:	Referral for various evaluations (educational, psych., etc.) IL Skills Assessment (Daniel Memorial), in-house materials
Theoretical/Clinical Base:	Self-determination and empowerment.
Service Linkages:	Employers/Businesses: Business Internship Program—part of network for job placement Landlords: Part of network that identifies availability Probation Agencies Community Agencies: Corner House Center for Teens, Planned Parenthood, Catholic Social Services (Assessments/ Psychotherapy), Courts, Alcohol-Drug Treatment Center
Staff Training:	Out of agency training benefit, inservice
Program Structure:	*Planning*: Quarterly retreats for review/planning purposes. *Evaluation*: Outcome evaluation from statistics. Aftercare log to track clients. *Logical/natural termination of clients*: Graduation ceremony. Housewarming party when they get their own apartment.
Unique Features/ Comments:	• Long history of client self-determination/empowerment. • Substance-free activities every other Friday. Staff-client volley-ball every Tuesday. • IL start-up kit (dishes, sheets, pots, pans, silverware, umbrella, etc.) for clients entering their own apartment. • Each client has a staff advocate.

Agency Name: San Diego Youth & Community Services

Address: 3878 Old Town Avenue, Suite 200B
San Diego, CA 92110

Contact Person: Liz Shear

Telephone: 619-297-9310

Years TLP in Operation: 12 (since 1979)

Geographic Context: Urban

Physical Setting: Shelter
Unsupervised Apartment (low): In small cottages
Host Home: Specialized foster care

Client Population:

Black	33%
Hispanic	33%
White	33%

How cultural sensitivity is integrated into programming and staff training. Ethnic diversity task force (includes sexual orientation) of agency coordinates ongoing training program. Two mandatory trainings per year.

Special Populations Served: HIV
Pregnant
Client and child

Age Range: 16-21

Staff:

Position	Minimum educational requirement	Ethnicity	Full-time equivalent	Age
Program Director				
40 Foster Homes		40% of agency are minority.		
8 Social Workers				
8 Case managers	Staff are culture & language appropriate.			
1 IL Trainer			PT	
1 Recreation Ther.				
Respite Care Workers			⅕ time	

Program Capacity (per year):

Foster care	30
Cottages	8
Shelter	500
Outreach	1,000

Program Length:	12 + months
Clinical Counseling:	Provided by program and by another agency Counseling provided to: Client only Parent/Family
Assessment Instruments/ Tools Used by Program:	Youth must self-refer. Youth in cottages participate in screening decisions.
Theoretical/Clinical Base:	Community development approach to service (building intentional communities, working with individuals within their context, empowering); client-focused, systems, networking.
Service Linkages:	Employers/Businesses Landlords Child Welfare Agencies Probation Agencies Community Agencies
Staff Training:	Culture sensitivity, HIV prevention, drug and alcohol treatment, advocacy, empowerment, youth participation, clinical consultation, ILS.
Program Structure:	*Planning*: Participatory planning process. *Evaluation*: Treat client's achievement of goals—immediate and through followup. *Logical/natural termination of clients:* Anticipate potential for sabotage and make it conscious. Support youth through termination.
Unique Features/ Comments:	• Building intentional communities—teaching clients to live together and to participate in the creation of positive environment. • Team approach to service with clients as part of the team. All team members have roles and all know their own and others' roles; this helps keep everyone on track. • "Re-habitat for Humanity" Agency has leased building slated for demolition for 1-2 years. It does cosmetic renovation and, through donated services of developers, rents to clients. The program links government, service providers, and business; makes use of local housing stock which would otherwise be vandalized; and uses donors and volunteers for the program.

Agency Name: Sasha Bruce Youthwork

Program Name: Independent Living Program

Address: 1312 E. Capital Street, N.E.
Washington, DC 20003

Contact Person: Brian Carome

Telephone: 202-675-9375

Years TLP in Operation: 4 (since 1987)

Geographic Context: Urban

Physical Setting: Unsupervised Apartment (low): 6 units in building
(Client) Family/Outclient
Agency foster homes

Client Population: Black 100%
How cultural sensitivity is integrated into programming and staff training. Afro-Centric Rights of Passage group. Contemporary film group.

Special Populations Served: HIV
Pregnant

Age Range: 16-18

Staff:

Position	Minimum educational requirement	Ethnicity	Full-time equivalent	Age
Program Director	BA	C	FT	28
Clinical Director	MSW	B	FT	50
2 Counselors	MSW/BA	C/C	FT/PT	28/33
Night Manager	BA	B	FT	30
2 Skills Counselor	BA/BA	B/C	½T—½T	45/26
Contract	BA Level	B	PT	23-50

Program Capacity (per year): 41

Program Length: 7-12 months
12 + months

Clinical Counseling: Provided by program
Counseling provided to: Client only
Parent/Family

Assessment Instruments/ Tools Used by Program:	Assessment packet developed in-house.
Theoretical/Clinical Base:	Competency based
Service Linkages:	Community Agencies: D&A Treatments
Staff Training:	2-day initial staff training. 8 hours per month for all staff. 10 hours per month for management.
Program Structure:	*Planning*: Completed by management team. *Evaluation*: Annual reporting. *Logical/natural termination of clients*: Utilizes level system with incentives to proceed through program. Utilizes suspensions and terminations.
Unique Features/ Comments:	• Afro-Centric Rights of Passage Group (4–6 months in length) is based on traditional rights of passage in African community. Teaches heritage with goal of building self-esteem. It includes retreat away from city, role modeling, and respect for elders. • Contemporary Film Group meets 2 times a month. Discussion group follows relevant film. • Focus on learning constructive ways of heritage and building self-esteem. • Program also provides art therapy once a week to clients.

Agency Name: Travelers and Immigrants Aid

Program Name: Neon Street Center

Address: 1110 W. Belmont Avenue
Chicago, IL 60657

Contact Person: Barry Steele

Telephone: 312-528-7767

Years TLP in Operation: 5 (since 1986)

Geographic Context: Urban

Physical Setting: Institution/residential treatment setting: 10 beds
Supervised Apartment (high): 30 unit dormitory type setting
Drop-in Center
Relative Foster Care

Client Population:

Black	80%
Hispanic	3%
White	15%
Other	2%

Special programming around cultural issues and sensitivity: No

Special Populations Served: HIV
Gay/Lesbian

Age Range: 14-21

Staff:

23 Position	Minimum educational requirement	Ethnicity	Full-time equivalent	Age
Senior Director	MSW	C	½	39
New On-Site Dir.	HS	B	FT	35
2 Administrator	M/HS	C/B	FT/PT	43/29
3 Supervisors	BA	C	FT	25-30
4 IL Specialists	BA/MA	C	FT	26-34
12 Counselors	BA	C/B	FT	22/42

Program Capacity (per year):

Group Home	20
TL Housing	65
Relative Foster Home	55
Drop-In	350

Program Length: 12 + months

Clinical Counseling:	Provided by program and by another agency Counseling provided to: Client only Parent/Family occasionally
Assessment Instruments/ Tools Used by Program:	Developed in-house
Theoretical/Clinical Base:	Logical/natural consequences
Service Linkages:	Employers/Businesses: Corporate sponsorship for entry level position (shadowing/mentoring) Landlords: Ongoing relationship with real estate community Child Welfare Agencies Probation Agencies Community Agencies: Relationships with medical community/ hospital (mental health, substance abuse)
Staff Training:	Weekly individual supervision Monthly staff training
Program Structure:	*Planning*: Management by objective *Evaluation*: Data collection, anecdotal *Logical/natural termination of clients*: Discharge planning. Followup for unplanned terminations.
Unique Features/ Comments:	• AIDS Services Program provides outreach and education to community. • Provides men's/women's groups regarding gay/lesbian/sexual identity issues. • Service origin from adult housing/homeless services rather than traditional child welfare.

Agency Name: Urban League of Essex County

Program Name: Independent Living Skills Program

Address: 3 Williams Street, Suite 300
Newark, NJ 07102

Contact Person: Anthony Taylor

Telephone: 201-624-6660

Years TLP in Operation: 3 (since 1988)

Geographic Context: Urban
Suburban

Physical Setting: (Client) Family/Outclient
Foster Home (Division of Youth & Family Services)

Client Population:

Black	79%
Hispanic	19%
White	2%

How cultural sensitivity is integrated into programming and staff training. Rites of Passage specific to client's own ethnic background.

Special Populations Served: Client and child

Age Range: 14-21

Staff:

Position	Minimum educational requirement	Ethnicity	Full-time equivalent	Age
2 Coordinators	BA	B	FT	26

Program Capacity (per year): 60

Program Length: 7-12 months

Clinical Counseling: Provided by program and by another agency
Counseling provided to: Client only
Parent/Family

Assessment Instruments/ Tools Used by Program: Developed in-house, others as needed

Service Linkages: Employers/Businesses
Landlords
Child Welfare Agencies
Probation Agencies
Community Agencies

Staff Training:	In-house/out of agency training
Program Structure:	*Evaluation*: Pre/post tests, 3-month followups *Logical/natural termination of clients*: 2 notifications for disciplinary reasons; 3rd is termination. Graduation on program completion.
Unique Features/ Comments:	• Experimental apartment module for IL clients where they live in apartment setting for a weekend to practice and reinforce skills learned.

Agency Name: Ute Mountain Ute Reservation

Program Name: Sunrise Youth Shelter

Address: P. O. Box 56
Towroc, CO 81334

Contact Person: Rita Arnett

Telephone: 303-565-9634

Years TLP in Operation: 1 (since 1990)

Geographic Context: Rural

Physical Setting: Group home

Client Population: American Indian 100%
How cultural sensitivity is integrated into programming and staff training. Currently reworking program to reflect new emphasis on culture. Program director is rewriting to integrate Indian culture/spiritually/values into all aspects.

Special Populations Served: Pregnant
Client and child

Age Range: 16-21

Staff:

Position	Minimum educational requirement	Ethnicity	Full-time equivalent	Age
Program Director	Low Deg.	Native Am.	FT	32
Living Counselor	HS	Native Am.	FT	21
Living Counselor	HS	Native Am.	½ T	32

Program Capacity (per year): 4

Program Length: 12 + months

Clinical Counseling: Provided by program and by another agency
Counseling provided to: Client only
Parent/Family: in the future

Assessment Instruments/ Tools Used by Program: Client needs assessed through social history interview.

Theoretical/Clinical Base: Developing individual responsibility and self-esteem within the context of Indian culture and values.

Service Linkages:

Employers/Businesses
Landlords
Child Welfare Agencies
Community Agencies

Staff Training:

House meeting 2-3 times per week to identify issues and problems. Other training is hands-on on the job. Staff attend related conferences (Native American spirituality and healing; substance abuse and cultural sensitivity).

Program Structure:

Evaluation: Tracking clients' programs through tasks; follow up on progress after leaving the program; and participation in Nebraska Department of Social Services evaluation survey.

Unique Features/ Comments:

- Strong emphasis on integrating cultural context into program activities.
- Focus on individual and community responsibility.
- Very strong linkages with community. Clients work in tribal enterprises primarily and stay within community; they are involved in community events and in planning for those events.

Agency Name: Valley Youth House

Program Name: Independent Living Program

Address: 524 Walnut Street
Allentown, PA 18101

Contact Person: Joan Haldeman

Telephone: 215-432-6481

Years TLP in Operation: 13 (since 1978) Several model variations within this time period.

Geographic Context: Suburban

Physical Setting: Supervised Apartment (high)
Unsupervised Apartment (low)
(Client) Family/Outclient
Foster Homes

Client Population:

Black	10%
Hispanic	10%
Biracial	20%
White	50%

How cultural sensitivity is integrated into programming and staff training. Developing.

Age Range: 16-18

Staff:

Position	Minimum educational requirement	Ethnicity	Full-time equivalent	Age
Program Director	MSW	C	FT	44
Therapist	M.Div.	C	FT	34
(2) Counselor	BA	C/C	FT/FT	44/23
(2) Res. Advisor	HS/MEd	C/C	Contract	48/25

Program Capacity (per year): 20

Program Length: 12 + months

Clinical Counseling: Provided by program
Counseling provided to: Client only
Parent/Family

Assessment Instruments/ Tools Used by Program: TELS (Test of Everyday Living Skills); Coping Skills Assessment; JOB-O (career assessment); D & A Risk Scale; Suicide Risk Scale; Conflict Resolution Scale

Theoretical/Clinical Base: Psychodynamic, natural consequences

Service Linkages:
Employers/Businesses
Landlords
Child Welfare Agencies
Probation Agencies
Community Agencies

Staff Training: 2-3 day orientation, weekly (clinical) supervision; inservice training, out-of-agency training benefit.

Program Structure:
Planning: 3-year long-range program plans, yearly internal audit, yearly program evaluation by Program Committee (Board of Directors).

Evaluation: Pre/post test, completion of individual goal plans, exit interview, 1-year followup.

Logical/natural termination of clients: Natural consequences regarding behaviors which if progressive may result in suspension/dismissal. Graduation upon completion.

Unique Features/ Comments:

- Empowerment through clients serving as program team members in goal plan and level evaluation meetings and as advisors to program in staff meetings.
- Provides outclient and residential service.
- Structured (but flexible) IL skill and interpersonal skill curriculums; all clients participate in volunteer experiences.
- Has utilized and developed various IL models since program inception in 1978.

Agency Name: Webster House

Program Name: Transition to Independent Living

Address: 125 Delaware
Muskegon, MI 49442

Contact Person: Julie Maschino

Telephone: 616-722-2694

Years TLP in Operation: 3 (since 1988)

Geographic Context: Urban

Physical Setting: Runaway/homeless youth shelter

Client Population:

Black	28%
White	67%
Other	5% (mix of Indian, Hispanic, Asian)

Special programming around cultural issues and sensitivity: No

Special Populations Served: Pregnant

Age Range: 16-19

Staff:

Position	Minimum educational requirement	Ethnicity	Full-time equivalent	Age
Program Coord.	BA	C	FT	34
2 Counselors	BA	B/C	FT/FT	35/23

Program Capacity (per year): 35

Program Length: 12 + months

Clinical Counseling: Provided by another agency
Counseling provided to: Client only
Parent/Family

Assessment Instruments/ Tools Used by Program: In-house compilation

Theoretical/Clinical Base: Natural consequences

Service Linkages: Community Agencies: Substance abuse prevention/education groups & assessments, nutrition, etc.; other IL skill areas; Girl Scouts

Staff Training:	Out-of-agency training allowance; 50 hours during first year, 25 hours each additional year, 12 inservice trainings/year 40-hour crisis intervention/empathy training in first 3 months on the job.
Program Structure:	*Planning*: Yearly goal setting and planning, long-range planning, client/parent evaluations *Evaluation*: 6–12 month followup upon closure. Client feedback. *Logical/natural termination of clients*: 5 levels—assessment at each level, leaving is fourth level.
Unique Features/ Comments:	• Ongoing IL skill-based groups; several run by outside agencies, other by staff

Agency Name: Wyandotte House, Inc.

Program Name: TLP - Neutral Ground

Address: 726 Armstrong Suite 202
Kansas City, KS 66101

Contact Person: Clarence Small

Telephone: 913-621-4641

Years TLP in Operation: 6 months

Geographic Context: Urban

Physical Setting: Group Home: Females only—not monitored by staff 24 hours, but staff provides some support and guidance.
Supervised Apartment (high)
Host Home
YMCA: Contract rooms for older males

Client Population:

Black	70%
White	30%

How cultural sensitivity is integrated into programming and staff training. Individual work with staff by program director. Training about new cultures (Laotian) in the area. Agency is also working on positive community development in gang-involved areas of the city.

Special Populations Served: Pregnant
Client and child

Age Range: 16-21

Staff:

Position	Minimum educational requirement	Ethnicity	Full-time equivalent	Age
2 case managers	BA	1 Blk./1 Wht.	2	
1 nurse	RN		1	
Therapist	MA	White	1	
Couns. Case Man.		Hispanic		
Program Director		Black		
Teacher	BA	White		

Program Capacity (per year): 15-20

Program Length: 12 + months

Clinical Counseling:	Provided by program and by another agency, if necessary Counseling provided to client only
Assessment Instruments/ Tools Used by Program:	MMPI (upon entry); life plan—two interviews prior to entry; assessment team does monthly reviews of clients.
Theoretical/Clinical Base:	Reality therapy; values clarification.
Service Linkages:	Employers/Businesses Child Welfare Agencies Probation Agencies Community Agencies
Staff Training:	In-house, on the job.
Program Structure:	*Planning*: Year end review. Visited other programs to gather ideas/approaches prior to starting. *Evaluation*: Now trying to develop evaluation methods. *Logical/natural termination of clients*: Anticipate sabotage, make it enticing to complete the program, let youth know they always have access to services through aftercare.
Unique Features/ Comments:	• Comprehensive array of services. • Network of services within community made available to clients. • Liberal way of offering services—easy access, firm entry requirements. • All youth served care from the streets.

Notice of Nondiscrimination

In accordance with the requirements of Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, and Section 504 of the Rehabilitation Act of 1973, and implementing regulations promulgated under each of these federal statutes, Georgetown University does not discriminate in its programs, activities or employment practices on the basis of race, color, national origin, sex, age, or disability. The University's compliance program under these statutes and regulations is supervised by Rosemary Kilkenny-Diaw, Special Assistant to the President for Affirmative Action Programs. Her office is located in Room G-10, Darnall Hall and her telephone number is (202) 687-4798.