

**DBHS Practice Protocol  
Transition to Adulthood<sup>1</sup>**



**Developed by the  
Arizona Department of Health Services  
Division of Behavioral Health Services**

**Effective Date: 1/1/2008  
Amended 11/4/2008**

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<sup>1</sup> Formerly known as Practice Improvement Protocol #7

**NOTE:**

**This Clinical Practice Protocol has required implementation elements. Providers are required to implement the identified Service Expectations, as clearly identified in this document.**

**Title**

Transition to Adulthood

**Goal/What Do We Want to Achieve Through the Use of this Protocol?**

- Ensure that an individual's transition from childhood to adulthood is supported and reinforces resiliency and recovery.
- Ensure that an individual's transition from the children's service system into the adult service system is smooth and seamless.
- Foster the understanding that transitioning into adulthood does not occur at eighteen but is a process that continues through early adulthood, and that services delivered need to be person-centered and involve the young adults, their families and natural supports whenever possible.

**Target Population(s)**

All eligible adolescents and young adults, between the ages of 16 and 24, enrolled in the Tribal and Regional Behavioral Health Authority (T/RBHA) systems.

**Attachments & References**

[\*Attachment A: Frequently Asked Questions\*](#)

[\*Attachment B: Housing\*](#)

[\*Attachment C: Resources\*](#)

[\*Attachment D: Social Security and Transition\*](#)

[\*ADHS/DBHS Provider Manual 3.17 Transition of Persons: 3.17.7-A\*](#)

**Definitions**

[\*Child and Family Team\*](#)

[\*Adult Clinical Team\*](#)

[\*Special Assistance\*](#)

[\*Peer/Recovery Support\*](#)

[\*Person Centered Planning\*](#)

[\*Guardian\*](#)

## **Background**

Young adults preparing to move into the world of legally recognized adulthood must successfully complete a number of developmental tasks. Typically, the young adult will experience successes and challenges as he or she moves toward a more independent and self directed life. Many young adults being served within the behavioral health system have not developed support systems and contacts to assist and guide them through planning and preparation for adulthood. It is the responsibility of the behavioral health system to ensure young adults are provided the opportunity to experience a positive transition into an adult world. This process should support independence, interdependence and recovery, and help ensure young adults are given the support, skills and connections needed to experience future success. Further, it is essential that young adults have the skills needed to identify their support needs and advocate for themselves as adults. Planning for transition into adulthood is an important aspect of ensuring that youth become stable and productive adults.

## **Areas of Consideration**

*The following areas must be considered when assisting young adults with transition:*

### **Team Coordination**

It is critical the behavioral health system, through Child and Family Team practice, address skill areas that will help the young person successfully transition to adulthood. When a young person reaches age 17 it is important to coordinate between the Child and Family Team and adult teams. This includes orienting the youth and his/her family to the adult system and preparing the adult team to make the transition from the Child and Family Team. The youth provider, coordinating with the adult provider, should encourage a liaison (e.g. Family and Peer Mentors) in the adult system to act as an ambassador for the incoming young adult and their involved family and/or caregiver.

### **Medical/Physical Healthcare**

Assist the youth to plan for:

1. A transfer from a pediatrician to an adult health care provider, if pertinent.
2. Medical coverage including how to select a health plan and a physician; as well as
3. preparing an AHCCCS application ready for submission on 18<sup>th</sup> birthday;
4. Provide information on Advanced Directives, as indicated in [ADHS/DBHS Provider Manual Section 3.12.](#)

### **Safety/Crisis Plans**

The team is responsible for ensuring that Safety and Crisis plans are in place, as described in the Child and Family Team Practice Protocol. Coordination with the adult case manager and/or adult clinical team to ensure the transitioning young adult is aware of the crisis services available in the adult system is also necessary.

### **Financial**

Young adults need to be taught about financial matters such as budgeting and setting up a checkbook, using credit cards and saving money starting as early as possible. It is important that the team have discussions with the young adult and family/caregiver about any needs for assistance with financial matters such as a payee service. Together, the team should review and

update any federal and/or state financial forms to reflect the change in status of the young adult to ensure there will be no disruption in the receiving of financial assistance. It is especially important to ensure the young adult and family/caregiver are informed on changes related to Social Security benefits and the programs especially designed for young adults and their families, including Social Security Work Incentives planning.

### **Vocational/Employment/Education**

It is important for the Child and Family Team to identify vocational and educational needs as early as possible in the transition process. A representative from the adult system needs to be involved in these meetings to ensure both areas are addressed before, during and after the transition to adulthood. Collaboration between the Child and Family Team and the educational system is important in helping the young adult and their family/caregivers understand the “Transfer of Rights at the Age of Majority.”

Under Arizona State Law, the age of majority is 18. When a child reaches the age of majority, the right to make informed educational decisions transfers to that child. A student with a disability, between the ages of 18 and 22 (who has not been declared legally incompetent) can choose to execute a “Delegation of Right to Make Educational Decisions”. This means that the student can appoint a parent or professional to make educational decisions on his/her behalf. The student can choose to terminate this agreement at any time and assume his/her educational rights. According to the Individuals with Disabilities Education Act (IDEA), “beginning not less than one year before the child reaches the age of majority under State law, the Individualized Education Plan (IEP) must include a statement that the child has been informed of their rights under Part B of the Act, if any, that will transfer to them on reaching the age of majority.” This means that schools must inform all youth with disabilities on or before their 17<sup>th</sup> birthday that certain rights will automatically transfer to them upon turning age 18.

As the Child and Family Team collaborates with the young adult and their family/caregivers on the continuation and or the opportunities for post secondary education, it is important to ensure that they are familiar with and made aware of the accommodations available to them under the Rehabilitation Act of 1973 and the Americans with Disabilities Act. Both of these Acts apply while they attend any university or college that receives federal funds. In addition, young adults with disabilities may request accommodations in testing formats. A reader, extended time, or audio, are a few examples.

It is necessary that the Child and Family Team along with involved system partners discuss and prepare the young adult for employment opportunities. Discussions regarding job readiness skills, work related habits and attitudes as well as vocational skills are essential areas that need to be addressed by the Child and Family Team early in the transition process, with specific goals related to these areas being included in the youths Individual Service Plan (ISP) where appropriate. Involvement with the Department of Education and Rehabilitation Services Administration can help facilitate this process and include such areas as goals in the young adult’s IEP as well as their Individualized Plan for Employment (IPE), thereby coordinating these plans with the ISP.

In order to effectively prepare young adults for employment, vocationally related services should begin during middle school and no later than freshman year in high school. It is important for employment goals and services to be incorporated into the IEP, as opposed to waiting until the young adult has an IPE in place. Services related to these goals can be implemented through the curriculum and by linking the student to community entities/resources. IEP and IPE services can be focused on both school completion and post-school preparation concurrently. If the young adult is involved with Rehabilitation Services Administration, it is helpful to have the Vocational Rehabilitation Counselor involved in IEP planning. There must be an emphasis on social skills development in both the IEP and IPE. The Vocational Rehabilitation Counselor should spend time with the client outside of the school environment to better understand strengths, weaknesses, interests, and necessary supports.

Members of the Child and Family Team can initiate self exploration with the young adult to identify strengths, challenges, and areas of interest. They must provide the young adult with opportunities to learn about, acknowledge, and accept his/her disability. It is important that the young adult's support system is educated about his/her disability as well, in order to provide the proper supports and assist the young adult in identifying supports that may be needed in the workplace or in the classroom.

Students involved in school based work activities (paid or non-paid) are able to "test the waters" of the work world, develop a work history, better understand their strengths and weaknesses, explore likes and dislikes, and begin to develop necessary soft skills of the work world. School based work should start during middle school and no later than freshman year in high school. After the student reaches the age of 17, he/she can be given work experience in the community, whether it is a volunteer job or internship. It is best for school-based and community-based work experience to be short term, so that the student has the opportunity to work in several different fields, or perform several different job duties. Regardless of whether the student excels or struggles at the job, the experience is highly valuable in both developing skills and in developing an appropriate long term vocational plan.

Benefits counseling and Work Incentives planning should begin no later than the age of 17. As students are narrowing their career focus, it is useful to tour employment sites, job shadow, and interview employers and employees in their top fields of choice. After obtaining employment, the Vocational Rehabilitation Counselor assists the student in evaluating his/her workplace to identify any necessary accommodations. Providing on-going support after employment has been obtained is imperative to assisting the young adult to maintain successful employment while identifying natural supports amongst employers/supervisors and co-workers.

### **Guardianship**

Discuss guardianship prior to turning 18, if applicable. The Child and Family Team can be an invaluable mechanism of support for the family and ensure that the appropriate participants are available in the discussion of the need to apply for guardianship. If the team decides a guardian is needed, arrange for filing of paperwork prior to the 18<sup>th</sup> birthday.

### **Housing**

It is important that the team address housing needs and options as part of the planning process. Safety should be one of the key considerations when reviewing needs in this area. If necessary, the team can assist the youth with paperwork for public housing. Further information in the area of housing is included in *Attachment B*

### **Family Involvement/Natural Supports/Cultural Considerations**

Family involvement and culture must be considered at all times. Although this period in a young person's life is considered a time for independence, many families and cultures are interdependent and it is important to prepare the families for the transition, as well as the young adult. With the assistance of the Child and Family Team, families can be provided a support framework for the transition. This may help them understand the increasing responsibilities facing a young adult and remind the team that the family remains an integral part of the young adult's life. The Child and Family Team, through understanding the family culture, can help promote successful transition in a number of other ways, including;

- Informing families of appropriate family support programs available in the adult behavioral health system;
- Providing a Family Mentor to act as a "Liaison", introducing the youth and family to the adult behavioral health system;
- Helping to recognize, and working together to understand and acknowledge, each family's culture and their roles and patterns related to 'independence';
- Working within complex family dynamics and with families that may be involved with one or more state agencies.

It is important for the Child and Family team to recognize these potential situations and provide the involved family/caregivers, as well as the young adult, with options and resources. The youth's home and living environment may not change when they turn 18 and legally become an adult.

### **Transportation**

When transitioning to the adult behavioral health system, it is important that the family and young adult are aware of the transportation options available through the adult system to help ensure continued attendance at service locations and medical and counseling appointments; as well as ensuring transportation options are safe. The team can also take this opportunity to explore and plan for other transportation needs not necessarily associated with medical or behavioral health.

### **System Partners**

Coordination needs to occur among all system partners, including; Child Protective Services, Division of Developmental Disabilities, Department of Juvenile Corrections, Office of the Courts, Rehabilitation Services Administration and the Department of Education to ensure that the young adult has access to all available resources. Close collaboration among system partners is especially important during this time. Our system partners can help young adults and their families/caregivers ensure that they have all needed documentation, such as: copies of birth certificates; social security cards; medical records; any determinations; assessments; IEPs; certificates of achievements; diplomas; GED transcripts; application forms for college; case

plans for youth continuing in the foster care system; treatment plans; documentation of completion of probation or parole; guardianship applications and social security applications for benefits.

### **Choice & Options**

In keeping with the Arizona Vision in the children's system and the five principles of Person Centered Planning in the adult system, those involved in the transition process will ensure that young adults and their caregivers/family are provided with choices and options as it pertains to services available in the adult system of care.

### **Procedures**

**ADHS/DBHS Provider Manual Section 3.17.7-A**, requires that transition planning begin at **age 16**. It is important members of the Child and Family Team look at the transition planning as not just a transition into the adult system, but as a transition to adulthood.

**Service Expectations: T/RBHAs and their subcontractors will follow the procedures outlined in ADHS/DBHS Provider Manual Section 3.17.7 Transitioning of Persons, specifically Section 3.17.7-A Transition from child to adult services.**

**At age 17**, for young adults receiving services, a request to determine whether the youth will meet the Seriously Mentally Ill (SMI) eligibility criteria must occur. Following the process outlined in the **Provider Manual Section 3.10, SMI Eligibility Determination**, "if a young adult is determined eligible, or likely to be eligible," for services as a person who has a serious mental illness (SMI diagnosis), the adult case manager will be contacted to join the Child and Family Team and participate in the transition planning. **After obtaining permission from the parent/guardian, it is the responsibility of the behavioral health representative on the Child and Family Team to contact and invite this individual to the meeting.** The importance of securing representation from the adult system in this process cannot be overstated and the representative from the children's system should be persistent in their efforts to make this occur.

**Service Expectations: The T/RBHA and their subcontracted providers must ensure all young adults at age 17, who are receiving behavioral health services and are potentially eligible for adult services, have received an SMI Eligibility Determination, as outlined in the ADHS/DBHS Provider Manual Section 3.10 SMI Eligibility Determination.**

If a young adult does not qualify for SMI status, it is the responsibility of the behavioral health representative to assist the Child and Family Team to coordinate with the adult general mental health provider, and where possible give the young adult and their family the choice of staying with the children's provider.

The Child and Family Team and adult team members will assist the young adult and/or family/caregivers with issues, such as obtaining:

1. *a State ID;*
2. *Supplemental Security Income;*
3. *Health Insurance/AHCCCS;*
4. *guardianship/payee;*
5. *Vocational Training/Rehabilitation; and*

## 6. *Housing.*

The Child and Family Team, through their behavioral health representative and along with the adult services case manager, will address issues related to information sharing as outlined in [\*ADHS/DBHS Provider Manual Section 4.1 Disclosure of Behavioral Health Information.\*](#) If the young adult is not eligible for Title XIX or Title XXI, services that can be provided under Non-Title XIX/XXI Funding will continue as outlined in the [\*ADHS/DBHS Provider Manual Section 3.21, Service Prioritization for Non-Title XIX/XXI\*](#) and [\*Section 3.4 Co-payments.\*](#) In addition, the behavioral health representative on the Child and Family Team will ensure the behavioral health category assignment is changed and consistent with [\*ADHS/DBHS Provider Manual Section 7.5 Enrollment, Disenrollment and other Data Submission.\*](#)

**Service Expectations: The T/RBHA and their subcontracted providers must ensure that when a young adult has been determined ineligible to receive Title XIX or XXI services, that services are continued as outlined [\*ADHS/DBHS Provider Manual Section 3.21, Service Prioritization for Non-Title XIX/XXI\*](#) and [\*Section 3.4 Co-payments\*](#)**

One of the greatest challenges surrounding the transition process involves the funding associated with the State funding streams as defined in ARS 36-3410 J. and K for the Children and Adult behavioral health systems. The funding for the children’s system is designated to provide behavioral health services to individual’s birth through 17 . When an individual turns 18, the funding for their behavioral health services comes from money designated for adults (18 and older). These separate funding “silos” have contributed to a lack of continuity in the transition process and negatively impacted a seamless transition for our youth.

In order to address this challenge, the RBHA’s must develop clear and explicit written administrative policies, processes and procedures (to be included in Section 10 of the RBHA provider manual) that are distributed to their Provider community. These policies must define how the RBHA will support:

- Adult system staff attending and being part of the Child and Family Team (during the four to six months prior to the Title XIX and XXI child turning 18) in order to provide information and be part of the service planning, development and coordination effort that needs to take place so the individualized needs of that child can be met on the day they turn 18 years of age including:
  - identification of staff that will coordinate services,
  - identification of the services that will be needed,
  - identification of service provider(s) to meet those needs,
  - methods for insuring the payment for those services,
  - following the full intent of the Practice Protocol on Transition to Adulthood, and
  - meeting the provisions of the JK Settlement Agreement<sup>2</sup> and the Arizona 12 Principles.

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<sup>2</sup> The JK Settlement Agreement defines it’s “Class Members” as: all persons, under the age of twenty-one, who are eligible for the Title XIX behavioral health services in the State of Arizona and have been identified as needing behavioral health services.

- The ability of a Provider Agency to properly encounter and receive payment for the involvement of Adult System staff in transition planning and service coordination activities as described above using children’s funding prior to the member turning 18 years of age.
- Methods for continuation of services that have been planned, developed and provided by Children’s System Provider Agencies, using adult funding, once the Member has turned 18 years of age (assuming that continuation of these services and providers is the choice of the Member who has reached the age of majority) and the ability of a Provider Agency to properly encounter and receive payment for the provision of services by Children’s Providers

In addition, it must be recognized that the RBHA is responsible for the provision of behavioral health services for Title XIX and XXI members 18 years of age through 20 years of age (who are still a part of the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program whether they qualify for SMI or GMH/SA services as adults, including:

- a. Case management services
- b. All covered services that their treatment team determines to be needed to meet their individualized needs.

**Service Expectations: The RBHA must establish policies, processes and procedures that allows funding allocated to children’s services be used to compensate adult provider participation in planning meetings prior to an individual turning 18 and allows funding allocated to adult services be used to compensate children’s provider participation in planning and service delivery after and individual turns 18 as detailed in this Transition Protocol.**

**Training and Supervision Expectations**

This clinical guidance document applies to T/RBHAs and their subcontracted providers who work with children and adults. It is the responsibility of T/RBHAs to ensure that all staff has received training in this clinical guidance document, and has set up a system to ensure that new staff receives the training. This is a document that should be included as part of on-going clinical supervision.

**Anticipated Outcomes and how they will be measured**

Anticipated outcomes include improved/stable/supported employment; avoidance of homelessness and increased abilities and available resources for independent living, increased and/or continued education and vocational involvement, increased skill development in all domains of the transitioning young adult’s life, and increased self-advocacy.

**How will Fidelity be monitored?**

Through chart audits, customer satisfaction surveys, functional outcome scores and review of System of Care Plans. Improved outcomes as measured by increases in the involvement in educational and vocational activities, improved availability and access to social activities and supports, and decreases in homelessness, hospitalizations, frequent crisis services, criminal justice involvement, and substance abuse.

## Transition and Services to the Young Adult Desktop Guide

### Service Expectations:

- Adhere to the [\*ADHS/DBHS Provider Manual Section 3.17.7-A\*](#).
- The Children's system behavioral health providers will coordinate with the Adult system providers, whether enrolled as General Mental Health/Substance Abuse or Serious Mental Illness
- Collaboration will occur with system partners: DDD, CPS, RSA, ADJC, and ADE
- Transition to adulthood discussions occur early (age 16) and are an ongoing topic as transition services are coordinated
- Inclusion of family members/caregivers and young adults are continued throughout the transition initiation and the duration of the transition
- Collaboration with system partners to begin early to ensure a smooth transition utilizing system partner Transition Policies to assist coordination
- Children's behavioral health providers are to follow ADHS/DBHS Provider Manual requirements
- Ensure every young adult receiving behavioral health services is informed and prepared for transition into the adult system with an internal and external guide for transition success
- Utilize **Attachment C: Resources** or develop/adopt similar ones for use within RBHA
- The RBHA must establish policies, processes and procedures that allows funding allocated to children's services be used to compensate adult provider participation in planning meetings prior to an individual turning 18 and allows funding allocated to adult services be used to compensate children's provider participation in planning and service delivery after and individual turns 18 as detailed in this transition protocol.

### Key elements to remember about this best practice:

- Transition planning should occur at least by age 16, and should include discussions and planning for transition to the adult behavioral health system, but should have a broader focus of transitioning to adulthood
- The behavioral health Representative from the Child and Family Team needs to coordinate with the Adult Service System and ensure services are in place prior to the young adult turning 18
- Transition needs to be an on-going supervision topic
- Explain and provide support to family and caregivers regarding how the adult system provides services
- Ensure that young adults and families understand legal ramifications of turning 18
- Ensure all paperwork has been submitted to the receiving adult provider
- Ensure the young adult has all the necessary paperwork and or copies that might be needed when applying for additional services, continued education, and or employment
- Ensure medical coverage and/or continuation of medical coverage is coordinated with all system partners

### Benefits of using this best practice:

- A smooth and successful transition for young adults moving into adulthood
- A smooth and successful transition from a children's system to an adult system

- A more informed behavioral health system and more coordinated and collaborative service delivery by all system partners (DDD, BHS, CPS, RSA, ADJC, ADE)
- Better outcomes for young adults