
**Potential Success and Barrier Factors for
Implementation of the Transition to Independence
(TIP) Model**

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Abstract: In this qualitative study, 28 key stakeholders who work with transition-aged youth participated in focus group discussions addressing success and barrier factors regarding implementation of a transition to independence process (TIP) program for youth, ages 14–29, in three Midwestern cities. All participants had prior knowledge of TIP. The paradigm shift to client-oriented goals and services was acknowledged by respondents as the prime benefit of TIP; youth are more motivated to follow through on self-determined goals. Barrier factors for providers involved collaboration with agencies adhering to provider-oriented interventions, provision of TIP methods training, and reallocation of time and money. Barrier factors for youth involved mistrust of service providers, overcoming maturational deficits, and acquiring and maintaining relationships, reputations, and social supports.

Introduction

About That Magical Age of Readiness for Transition to Adulthood

At one time it was believed that the first manifestations of serious psychiatric disturbance did not occur until adulthood. Improved diagnostic techniques have revealed that the majority of psychiatric disorders trace their beginnings to the transition years (ages 14–29) and earlier (Murphey et al., 2014), with potentially devastating effects on an individual's ability to develop a healthy sense of identity and purpose, which could jeopardize the ability to cultivate and utilize the natural supports necessary for successful adulthood. The specter of mental disturbance can overshadow attempts at completing education and career preparations, and impede the formation of meaningful relationships. The consequences of these missed opportunities may encumber an individual throughout the entire course of their life, hampering efforts toward the assumption of adult responsibilities, such as finding and keeping housing and employment.

The disturbing reality that one-in-five youth shoulder the burden of serious mental illness in addition to the myriad challenges of growing up makes the provision of services and supports that smooth the transition to adulthood a matter of utmost importance (Chapman, Laird, Ifill, & Kewalramani, 2011). The magnitude of this situation is more readily realized when one considers that, by 2015 in the United States, there will be a projected 47.9 million transition-aged youth between the ages of 14 and 24, one-fifth of whom will be struggling with significant obstacles to vital mental health care services (ICF Macro, 2010).

Unfortunately, for this transition-aged group there exists in the United States a disconnect between child and adult mental health services. Currently, support systems in health care and social services are geared toward serving children separately from adults—and appropriately so—as the needs of each group are vastly different. The problem here is that the specific cultural and developmental needs of the young adult are not fully addressed by either child or adult services. Consequently, among transition-aged young adults we see unacceptably large rates of failure to adhere to treatment or program objectives, inability to pay for services, and high dropout rates (Clark & Unruh, 2010). There is the mistaken assumption in the world of policy administration that there exists a magical age when a client's needs transform from those of a child to those of an adult. This is based upon the supposition that an individual, at the age of 18 or even 21, suddenly possesses the skills and savvy to navigate the adult world.

Transition to Independence (TIP) Model

The transition to independence process (TIP) model offers an innovative solution to the dilemma of how to best serve the needs of transition-aged youth. Developed to facilitate provision of services and support for youth and young adults with emotional and/or behavioral difficulties, the TIP model focuses on “servicing and supporting the youth through strengthening age-appropriate, non-stigmatizing, and appealing transition-aged programs” (Clark, Deschênes, & Jones, 2000). It emphasizes the involvement of family and key community members who can provide natural supports to encourage the setting and achievement of goals that foster success in all facets of adult life, including mental and physical wellbeing, personal development, education, employment, housing, and community life. Above all, the hopes, dreams, and aspirations of the young person are nurtured with the ultimate outcome being self-realization and self-sufficiency (2000).

Methods

The middle-range theory applicable to this qualitative study is Resnick's self-efficacy model (Peterson & Bredow, 2009). Based on a multitude of internal and external interacting factors, the theory posits that change is influenced by an individual's level of motivation, understanding, beliefs, and capabilities that interact in appraising and deciding the best outcome (2009). The application of the self-efficacy model to this qualitative study provided the core foundation that was used to guide the exploration of the research question; specifically, during the planning stage for the implementation of the TIP model, what are the perceived success and barrier factors that could be used as favorable or unfavorable indicators for the TIP model within three cities in the Midwestern United States? The knowledge developed from the ensuing discussion was intended to influence the assumptions of formal key players regarding how best to overcome the barriers and how to leverage and nurture the successes (2009).

For the purpose of this endeavor, a meeting was convened in each of three cities in the Midwestern United States at which key informants/stakeholders were asked to participate in a focus group discussion that explored the feasibility of implementing the TIP model program in their respective communities. Recruitment of focus group participants was accomplished through contacts with program managers who provided assistance in making arrangements for the meetings. Non-randomized purposive sampling was used to assure that individuals with expertise and experience were involved in this process (Patton, 2002). Particular care was taken to include a cadre of individuals who, in addition to having experience working with transition-aged youth, had prior knowledge of the TIP model, and were knowledgeable about the community and its mental disorders and substance abuse prevention needs and opportunities.

At each focus group meeting, following collection of informed consent documents and demographic information, handouts were distributed describing the TIP model and questions about the model were fielded. The discussions were guided by questions designed to assist focus group members to describe what aspects of working with the TIP model were most challenging and what aspects were most rewarding, discuss the barriers and successes they have experienced in the development of collaborative relationships with other agencies (i.e., school officials, employment specialists, housing coordinators, and mental health clinic providers), and share feedback from transition-aged youth on successes and barriers encountered during the provision of services. Data reduction and analysis involved the following: demographic data were tabulated, tape-recorded discussions were transcribed with notations added to preserve contextual auditory cues, and responses were clustered into topics according to the insight they provided into the discussion questions. All quantitative data was coded to mask participant identity and to insure anonymity and confidentiality.

Results

Twenty-eight key stakeholders in three Midwestern cities participated in focus group discussions consisting of 14, 10, and 4 members. Twenty-two females and six males were included, all of whom had prior exposure to the TIP model. They had acquired information about TIP through a variety of sources, including mentors, workshops, reading, visiting the TIP website, training, and putting the methods into practice with clients, with one individual having certification as a TIP method trainer. Post-secondary education of focus group members ranged from two years

to nine years, with a group mean of 5.2 years. Their years of experience with transition-aged youth ranged from a few months to 18 years, with a group mean of 6.3 years. Included were business persons, educators, employment specialists, a mental health board member, mental health care providers, mentors, parents or family members, case managers, therapists, nurses, and group home coordinators.

Participants responded freely to the questions regarding perceived success and barrier factors in the implementation of a TIP program in their cities. Whereas not all participants had extensive clinical experience with the TIP model, there was overwhelming consensus among participants that they had a keen interest in the program.

Rewarding Aspects of TIP

The focus group participants were very vocal about the most rewarding aspects of the TIP model. Most notable is the frequency of remarks extolling the merits of client-driven programming for transition-aged youth. Indicative of the conviction that the program more directly addresses the needs of the client is this response:

Whereas at one point I was saying [to the adolescent], "This is what *you* need to work on," [TIP] allows the adolescent to tell me, "This is what *I* need to work on." And if *they* tell *me* what they are willing to work on...they are more apt to follow through, because they have *enough* people telling them what they need to do, how to do it: "Go to school. Do this. Do that." No one has taken the time out to say, "Well, what is going on with you? What do you need to work on? What do you see as your problem?"

This sort of feedback has been replicated across all three focus groups. Using TIP promotes increased engagement of youth, allowing service providers to "see the level of motivation increase in young people." The TIP model makes it easier for youth to comprehend what was expected of them because, sometimes for the first time, the youth perceive that "the goals are actually meaningful." This case manager astutely explained the youths' perspective: "Many of them have been therapied [*sic*] for years and years and years, and using this model...they feel as if they are in more of a partnership with me." Ownership of goals ultimately motivates youth to make "a commitment to themselves and to our community."

A youth employment specialist confessed that she adopted the TIP model out of fear she might "fall into the generational gap mentality." Renewed mindfulness of her mentoring style allows her to become more effective, although she notes that she still has a tendency to "fall back into lecture mode from the past experiences, and found that I was losing a lot of my interaction with youth." The overarching implications are that, by empowering youth to contribute ideas to their own treatment plan, TIP enables the facilitation of programs that truly reflect the dreams and goals of the client.

Provider Successes

The truth is, transition-aged youth have more problems than any single agency can possibly address. In deference to this reality that "there is so much these young people need, and none of us can do it all," a mental health board member emphatically underscored the importance of service providers being willing to "learn together and share resources together." The same individual pointed out "in communities there tend to be turf battles. But I think now we are faced with financial stresses more than we have ever faced before, so I think people are coming

together out of need to figure things out." So, in the view of this respondent, tightening economic times may actually play a positive role in the adoption of a collaborative approach.

The TIP model promotes the utilization of financial resources in a responsible and meaningful way, and that can result in savings, as with this program manager's example, "In the shelter program...when they wrote the grant, they thought the transitional age youth would need \$5,000 to \$6,000 a month worth of services. And right now we are tracking about \$3,000 to \$3,200." A different program manager expressed skepticism of such financial benefits, yet lauded the way TIP enhances the effectiveness of the counselor:

The counselor that we have is able to go out into the community to see the young adults where they are, and you get so much more information. A counselor actually seeing [the client's] environment and seeing how they interact in it, you see more than you ever could in an office setting. But of course, that is a cost, because of travel time. Because travel time is not productivity. We will see. ...Will [the county] be able to fund things differently?

A housing support specialist appreciated that with TIP "goals are not so big that they are not achievable, and being that it is client-driven most of the time, our people will stay engaged." She affirms that offering support is easier and more effective when even "baby steps" are being acknowledged:

We are able to celebrate those [small] successes with them, because it gets away from the traditional [approach used with transition-aged youth]. There is some room there for us, as the housing support specialist in the shelter program, to share that moment with the client. And that starts to build that support and allows them to get motivated to continue moving forward with the direction that they want to go.

This comment prompted a housing support specialist to explain how gratifying it is when a provider "can see the hope in someone's eyes come to life," as illustrated by this example of how the TIP model had made it possible for a particularly hopeless client to transform his life:

We had a young man who was homeless, not too many supports. ...He had kind-of given up on himself. ...Some of the strengths he had...he really did not consider to be strengths. ...And so, I really worked diligently at focusing in on those characteristics. ...[This young man] has now found hope, and started to identify goals driven by himself, and is really making a lot of progress and accomplishments. I got to watch this young person come to life in a very short window of time just using this specific model [TIP].

This individual went on to describe how the young man had gone into a tailspin with his progress when his service provider was switched to an agency that did not utilize TIP. Fortunately, he was able to get his services restored to a TIP-guided provider, and his trajectory of progress resumed a positive course. This provides an excellent example of how collaboration enables service providers to address needs as they arise and to maintain a client-centered focus, thus ensuring continued engagement and success for all those involved.

By placing youth at the center of the paradigm, the TIP model becomes a mechanism through which communication and collaboration can occur among agencies. For success to occur,

system issues will have to be addressed, including allocation of resources, such as funding, time constraints, and utilization of qualified service providers.

Successes of Youth

One of the major hurdles confronting service providers and youth is the maturational dilemma; youth who are in their late teens or even in their 20s in terms of chronological age are often comparable to youth who are in their early teens or even preteens in terms of intellectual and emotional maturity. This counselor insightfully explained that a service provider's ability to be accepting of a youth's bumbling expressions of identity can encourage the eventual emergence of a self-assured adult:

So [when using TIP I can provide] that empowerment piece, personal empowerment, is like they get that power and they are so excited, and they use it so oddly...The challenge is getting the family...or the support units to give that particular youth that time to awkwardly make mistakes, and over-exaggerate as they are feeling out that personal power. Because that is what it is going to take to allow them to find their self-esteem.

Focus group participants affirmed "once they start to have some success, typically, that is enough fuel to get them maybe another one, and another one." That insight provided the prelude for a housing support specialist to have this revelation:

We are helping them...to realize that they are a person of value, and that they have a lot to offer....The TIP model is great because it allows so much freedom...to engage [and] go outside the box of what is the norm of...traditional care.

This important distinction of service providers facilitating youths' self-perception actualizes the difference that the TIP approach makes:

They begin to see themselves not as a diagnosis, or a court problem, or behavior problem. Because your conversations with them are around their goals...they start to see themselves as college students, as employees, as people living in a community-not living in a group home-living in an actual apartment.

It is obvious, from the focus group responses, that the participants were well aware of the challenges and the life circumstances which confront youth: limited educational attainment, inadequate job skills, and a dubious sense of confidence in their own capacities to make good decisions-all of which are frequently complications of maturational discontinuity. Trust issues thread throughout the comments that were made. Yet it is crystal clear that the enhancement of fruitful engagement with transition-aged youth-though not an easy task-is a most rewarding one for service providers.

Successes Achieved by Youth

With the TIP model, success can be evidenced by the reduction of maladaptive coping strategies and the substitution of healthier choices. A counselor confirmed how determination to make substantial strides forward had been enhanced through the utilization of TIP strategies:

An interesting success that I am noticing is an increased motivation of the young people with whom I'm working to be able to explore other means with dealing with their

symptoms besides doing medications-exploring more positive coping skills other than using alcohol and substances to reduce their symptoms, especially when they have pretty significant mental health [disorders]. One young person, in particular, that I've been really impressed with, her drive to provide for herself and her child, she is pretty highly motivated to do school, and get housing, and confront some of the things she needs to confront.

One participant commented on the impact that the schools have on youth:

How good the youth feel when things seem to turn around at school, and the school actually begins to say positives about them. Because they have become so horrendously labeled as problem kids for so long, so when some of the schools see the change and acknowledge it...they love it. They really do! They feel good about it because they are being recognized for it. ...They want some recognition of the work they are doing-it is not easy to be good.

Success is embedded in the TIP model when it is properly applied, as this case manager witnessed:

There is a guy I am working with now-before, he could not get involved in any positive activities-now, this kid made the basketball team. So just being there for him and just supporting him, I think it influenced him to try out for the team and he started making smart decisions.

The overarching purpose of implementing any new program in the service of transition-aged youth is to provide supports that really work in the short term, when dealing with situations that confront youth in their daily lives, and in the long term, by ensuring they have the tools they will need for the pursuit of a fulfilling life. With the use of the TIP model, clients are given the strategies to achieve success, to find healthy support systems, make prudent decisions, and to move toward healthy lifestyles. A case manager summarized quite well how important the various and incremental successes are in generating self-perpetrating success:

We are teaching them how to access resources and advocate for themselves. And so our goal is not that we are trying to entrench them in the mental health system, or that they need services forever. So continuing to help them build their home positive natural support network...our young people now feel empowered that they can do x, y and z on their own.

Challenging Aspects of TIP

The numerous positive reviews were tempered by legitimate concerns about challenges that the participants thought were inherent in the TIP model as they understood it. These revolve around mitigating differences of opinion when dealing with service providers who are unfamiliar with the principles of the TIP model, particularly in regards to how transition-aged clients should be treated. Another major concern is the difficulty in forming alliances with other agency personnel who are not proponents of TIP. The complaint rose that "trying to mesh a couple different systems [for the provision of services to youth] is difficult." Such conflicting elements were precisely the dilemma troubling this director:

I am certainly fully behind the philosophy [of the TIP model] and I see how well it works. The concern here...is that currently there does not seem to be much structure around the implementation. I mean, we have one agency [that implements the TIP model]...but then, from my perception, there continues to be the "traditional approach" [provider dictating to client what they should do] in the majority of the other agencies.

One focus group member blames this difficulty on "the generation gap—the older generations are not conforming to the needs of the younger generation." A counselor provided validation for the concerns that were emerging by acknowledging that it is very difficult indeed to be "working with other entities in the community who serve the same population but seem to have not grasped" the unique challenges confronting contemporary youth. She concluded with an endorsement of TIP methods in deference to the inevitability that "as generations continue to evolve, we have to change our approach."

Another, a housing supervisor, worried that more time and money may be needed to make youth successful when using this model. A case manager chimed in on this theme, explaining how services provided may be "beneficial at the time, but, once we are out of the picture, it is back to the same things they are used to doing. So [a major concern is] just...giving them more time." These concerns are reflective of the existing practice of transition to adult services at ages 18 and 21, depending on the policies of various service providers. Utilization of TIP methods will allow for services to follow the client well into the transition period (up to age 29) until full-fledged confidence and competence have been attained.

Challenging aspects of TIP, then, are perceived to stem from the inevitable growing pains that arise from the adoption of any new approach and the resistance to change that is inherent in individuals as well as organizations. This brings with it the necessity for policy revisions and the re-allotment of time and money to enable the expansion of services spanning a more realistic transition period, which, it has been suggested, should encompass the ages of 14–29 (Clark & Unruh, 2010).

Provider Barriers

The TIP model provides opportunities for collaborative communication, as well as client-entered decision-making and program planning. The resultant mutual respect paves the way for skills acquisition and therapeutic interventions that are void of punitive and growth-restricting behaviors. One case manager cautioned that service providers themselves may present the main obstacle confronting the implementation of TIP programming, "We are going to have to retrain their [service providers] thinking, retrain their minds." A counselor also agreed that utilization of the TIP model will inevitably require a tremendous shift in emphasis, "We were going from the old fashioned perspective-you move the client to where you think he/she needs to be-as opposed to the client moving themselves with your guidance. I think that is the biggest key."

A program manager mentioned the need for "additional education opportunities for us to educate the other providers about what the TIP model is" after the observation that "not everybody that touches a young adult in this [community] has TIP model training, or are even aware of what that is." A case manager pointed out that some of that exposure occurs naturally in the course of interactions with colleagues:

In the TIP model, there is a need with each case for me to share the clinical direction and the clinical reasons for why I'm doing what I'm doing with [another service provider who is unfamiliar with TIP] so that they understand that this is where the client is coming from.

A program manager expressed the conviction that it is necessary, albeit time-consuming, to "make that effort for connection" among professionals and agencies, even when colleagues might be "taken aback" by the expectation of a team effort among different agencies. A counselor, coming from the side of the table of those who do not yet utilize TIP, expressed concern that "it takes a lot of time, especially up front, to work that relationship with that case manager that is trained in the TIP model." A housing support specialist concurred, expressing the need for "schedule flexibility," specifically, to enable providers to collaborate more efficiently, concluding with the observation that it all boils down to a need for changes in budgeting:

Hopefully, we [will be] able to have more of that time built in [for "spur-of-the-moment" consultation and immediate assistance regarding housing]. Because... if they [youth] have a provider at a different agency, being able to have that provider come into a meeting can be a huge barrier. It is very difficult to navigate...I think part of that is just related to funding.

Participants indicated that, not only are collaborative relationships across community agencies deterred by external barriers, but internal communication and collaboration are sometimes strained. The lack of knowledge pertaining to the TIP model among mental health professionals is a major obstacle. Additional disincentives include time limitations and financial constraints.

Barriers for Youth

Relationship development and maintenance is the cornerstone of therapeutic engagement. The basic act of making and maintaining contact, "tracking them down, and finding them, and teaching them how to identify why an appointment might be important, and how to get themselves to that appointment" were reported as very real and fundamental difficulties confronting mental health professionals attempting to serve with this very mobile population. Once a youth has been located, trust must be established, goals developed, and mentoring or monitoring should be fostered as natural components of the relationship. Difficulties with trust issues and "getting them to open up to you" were mentioned repeatedly; a service provider noted that youth are "wary of how to react to you."

One case manager attested to the devastating role that unsupportive or absent parents can play in undermining successful treatment for their transition-aged youth, describing the despair of young individuals whose lives are tortured by the belief that "if my mom doesn't want me, who else would want me?" Another case manager averred that the development of any sort of relationship can be particularly daunting among youth whose backgrounds include residential youth programs or foster care:

They don't have anyone that has cared about them before. So for us to try and say 'We care what you're doing and where you're going in your life,' they really don't want to believe us, because everybody else has let them down.

Yet another case manager pointed to the havoc that can be wrought in the lives of youth when “there is always something pulling them back, whether it is they have a young child, or whether it is a parent that continues to be a negative influence in their life.” Along the same vein, another lamented about “attitudes and opinions that they formed from spending time with their peers and maybe some of their parents-they don’t think school is important.”

A discussion group member cautioned that many young clients have developed the cynical attitude that the service provider is just “another adult diagnosing, giving them more pills, and telling them how to live their lives.” This attitude is the by-product of years of being treated as children when they were chronologically teenagers. That is to say, transition-aged youth who have generally been ignored in the development of their own treatment plans have been taught by example to ignore or even disdain the advice of authority figures. The realization that clients harbor doubts about the competency of the service provider because “the majority of people [family and service providers] have never followed through” was the catalyst that convinced one case manager of the need to adopt TIP programming. This focus group member aptly described the tricky phase between childhood and adulthood:

These clients become lost as they transition from the child and adolescent system to an adult role, [from] a system that told them what and how they were supposed to respond. The youth want to be treated like adults, but finding themselves too dependent on the previous system makes the transition to adulthood more difficult.

A housing support specialist conceded that many young people, particularly those coming out of foster care or juvenile justice, “struggle with being able to identify what their goals are going to be, because they are used to somebody else already doing that.” Yet another case manager observed that young people who have been deprived of normal natural supports sometimes do not know the appropriate way to respond to genuine care:

[When they finally find themselves in a caring environment] where they are loved more than they were before, that [not knowing how to reciprocate] scares them enough that they want to run away, or they want to go out and do something [self-destructive behavior], because they have not experienced that kind of love or kind of caring before.

Another participant spoke of the necessity for teenagers to be permitted to make mistakes and to learn from those mistakes. Instead, opportunities for genuine maturation are lost, because the natural mistakes youth make are being labeled and diagnosed as aberrant, with pills being used to fix so-called problem behavior that is actually just an ordinary and essential part of trial-and-error maturation. The discussion group member elaborated:

When we are working with the youth who...have very appropriate goals that would match a 17- to 18-year-old...internally, they are operating much more at a 12- to 13-year-old maturity level, because they have not been able to be in an environment that allowed them to accomplish the typical stepping-stones that the average youth accomplishes as an adolescent. So as a 17- to 18-year-old, their goals should be “I would like to go to college,” and “I would like to get a job,” and “I would like to have my own apartment.” Now the reality is that, “I have a fifth-grade reading level, although I’m very bright.” And, “I have a high school education that spans eight or nine different schools, and yet still don’t have enough credits to graduate. And even though I would

like a job, to be honest, there is not a lot of responsibility that is developed yet that even allows me to be employable.”

Given these realities, troublesome obstacles confront youth even in the midst of their hopes and desires for a better life. While transition-aged youth might know intrinsically that they need help, they do not want to receive help from anyone who does not respect that “they are still their own person; they are adults.” As expressed by a clinical supervisor, when providers start to treat youth with a client-centered approach, interactions become more productive, and an honest relationship between youth and provider has the possibility of “helping them bridge that developmental ditch, so they don’t end up tripped up.”

Problems that transition-aged youth experience can stem from a multitude of issues, but one major barrier arises from having missed out on opportunities for the achievement of normal maturational milestones. Consequently, youth find themselves hurtling toward adulthood with developmental deficits that cover the gamut of human experience: building relationships, learning appropriate coping skills, acquiring and managing money, assuming responsibility for physical and mental health concerns, and developing into lifelong learners with the ability to self-advocate toward the achievement of long-term goals, to name just a few. One focus group member spoke of the troubling legacy of dysfunctional formative years for youth:

They are missing years of [learning] appropriate social skills and academics-just information, basic knowledge that we feel like we [any member of society] should have, and sometimes it is also because, maybe, they were overly medicated for a long time and they were not learning properly.

An insightful counselor, adding to the discussion of how difficult it must be for young persons to overcome a disadvantaged childhood, admonished colleagues to consider how difficult it must be for youth to be amenable to the changes service providers attempt to impose upon them due to their history of having been stripped of so many of the day-to-day experiences and privileges that are taken for granted as part of a normal childhood:

[It is vital that we, as service providers] allow them to have ownership to express the only thing they have for themselves, and have had for themselves, and that is their choice. They go from foster home to foster home, or system to system, and choices are taken away. So when you...start talking about their emotion, their [inappropriate] choices-that is the only thing they have to control. So when we, kind-of, come in there and want to start fixing, [as a service provider it may be more helpful to] maybe back away a little bit and realize that [our suggestions] could be [perceived as]...a threat to that individual because [personal choices, emotions, appearance, etc.] are the only thing they have had to control.

Oftentimes, young adults are held accountable for actions that were committed in the past, while still immature and incapable of being fully responsible. A focus group member expressed the emotional and situational dilemmas encountered by youth, and the seeming futility of attempting to change under the yoke of unremittent condemnation. The struggle to earn a new reputation can be complicated by the need to break away from one’s roots and reject the example of those who, under normal circumstances, should have been able to provide a foundation of personal identity and integrity. Family bonds run deep, despite what is often a

limited capacity on the part of family members to care for and nurture the youth, let alone provide appropriate role models, as was suggested by this respondent, a counselor:

They have difficulty separating who they are from who their families are, and what their families have done. And even if they can do that on an intellectual level, they still have that emotional tie that sometimes holds them back and keeps them from accomplishing what they need to accomplish.

Another focus group participant mourned the fact that youth “really do have difficulty overcoming the negative label they have received from peers and other community people.” Another participant added:

You get so many of them that have their identity stemming from their friends-and it is hard to get them to realize they are their own person...and [they] can step away from [their] friends-that it will be okay to go do this or that and not follow their [friend's] path.

That comment struck a chord with another focus group member, who recounted the words of a baffled young person whose attempts to embark afresh on the straight and narrow path were being thwarted by the inability to find a more supportive circle of friends:

Once I'm known as 'the bad kid', and then I want to turn myself around, well, guess what? [My new friend's] parents don't want [their child] hanging out with me because I've already got the reputation of being the bad kid. It is very difficult to actually change over to a more positive peer group, because I've already got a reputation.

Another respondent continued by explaining how youth who have spent time at the state juvenile corrections facility have been permanently branded with a record and frequently are automatically shuffled off into the alternative education program for behaviorally disruptive children. Seldom is consideration given that the young person might deserve the opportunity to resume a normal education among peers who might, incidentally, have a positive influence. This sort of handling of juveniles erects an enormous road block in the path of youth who have “done their time” and whose most sincere hope is to be allowed to pursue a brighter future.

Another member of the focus group explained what it means to be that young person whose future is being undermined by a troubled past, “They hear ‘I'm a bad person’...and they've heard that all their lives.” Yet another echoed the derisive taunt that haunts troubled youth, “You are not going to be nothing, your daddy wasn't nothing. Your momma wasn't nothing. You are just a chip off the old block.” A service provider shared her deep concerns about how such disparaging stereotyping condemns some youth to a fatalistic attitude toward the future, “Just to see that hurt and pain, when you have a client tell you, who is 17, ‘I don't expect to live to be 25 anyway.’ That is heart-breaking.”

A case manager elaborated on this unfortunate dilemma in which the aftermath of a disadvantaged upbringing radiates outward until it seems like, no matter how hard the young person may try to become a responsible member of society, “nobody wants to listen to them.” One focus group member outlined what a history of foster care, juvenile justice systems, limited

education, and even single parenthood can mean in a young person's endeavor to find housing. Another case manager concurred:

And then on top of that you [the transition-aged youth] have this bad reputation... so a lot of the people that could help you don't really want to because they don't trust you. They think you are going to go back to the same behavior. So it is really frustrating.

Embedded deeply into this observation is another related to concerns that employers might have about the youth:

One of the biggest barriers is getting businesses in the area to give employment, and open up their opportunities to the youth. Because many of the youth, according to the business partners that are out there, are not user-friendly. I think the youth are open and they are ready to try to work, but the businesses do not want to open their doors.

Many issues intersect to create barriers for youth as they try to negotiate the transitional years. The professionals expressed heartfelt empathy when discussing the challenges that are experienced by transitional aged youth. A counselor expressed concern about the multitude of vulnerabilities of transition-aged youth and "the number of risk factors that the [young] people are coming to us with-it is so overwhelming and there are so little protective factors in the environment." Despite these risks, focus group members overwhelmingly endorse the TIP model as a promising tool with great potential to encourage healthy growth and open the doors to a brighter future for their clients.

Discussion

In this study, the process of planning for the implementation of a TIP model program provides a preliminary roadmap for actually implementing TIP. The focus group meetings with key stakeholders in three cities in the Midwestern United States facilitates the reinforcement of advocacy group support for the implementation of the TIP program in those locales while providing evidence of an informed community of professionals, lay people, and consumers. This study serves to complement existing TIP sustainability strategies embedded across the area that promise to help assure its long-term survival and goal attainment. A major strength of this study is that it provides a forum for stakeholders to voice their concerns and experiences. Future TIP model programs in other areas could utilize the knowledge gained through this study as a guide to anticipate success factors and barrier factors that stakeholders may encounter during the process of planning for the implementation of the TIP model.

A limitation of the study is the wide spectrum of participant familiarity with TIP, ranging from direct experience in utilizing the program to knowledge that had been derived from literature only. Based on the responses from the focus group participants, it is evident that the TIP model is favored. Details provided by the focus group participants illustrate how the TIP model represents a shift in the treatment paradigm from a passive role of youth having their cases managed by a professional to an interaction model that would place the client at the center of the planning and management of decision-making processes, an approach that motivates the client and makes expectations clear and attainable. The result: empowerment and validation on both sides of the table, for youth and service providers alike.

Changing the way that services are provided is a concern that needs to be addressed. Major concerns for all parties who participated in the focus group discussions involve education of service providers in TIP methods, finding ways to ease resistance to change, reallocation and utilization of scarce resources (particularly time and money), and the establishment of collaborative avenues among service providers, including finding ways to mesh services with other agencies that may or may not use the TIP method. Other areas of concern: labels that follow the youth into perpetuity, their reputations, relationships between youth and family, service providers, peers, educators, employers, and landlords. Many of these concerns stem from maturational issues, which many focus group members felt could be best addressed through the application of TIP methods. The payoff for these efforts would be the provision of better mental health services for transition-aged youth to assist them in becoming productive citizens who enjoy a better quality of life.

Implications

As transition-aged youth stand at the crossroads of their lives, unsure of how which course to follow in the pursuit of personal success and fulfillment, it is essential for service providers to remove as many stumbling blocks as possible. A major hurdle youth face is trying to find the services and support they need when they have aged out of the supports they relied upon during their childhood years. It creates a situation that can be calamitous at its worst, and fraught with uncertainty even at its best. The TIP program offers a compassionate alternative. It promises to pave a smoother path for clients and providers alike by encouraging both parties to listen and respond to needs, to truly consider possibilities, and to continually refine goals. Providers and clients, alike, report increased satisfaction and success—at least the vast majority of them do. There are those who welcome change, and those who do not. Initially many providers express reluctance, anxiety, and annoyance with the process of mastering this method because it represents a complete reversal of nearly everything they have learned to rely upon, from counseling techniques, to batteries of screening and aptitude tests, to institutional expectations. With the incorporation of TIP methods, the provider is no longer encouraged to prescribe solutions according to the old time-proven techniques which did not always take into account the client's felt needs and desires. Nor can the client, under TIP methodology, passively wait for the provider to offer solutions. Under TIP, both parties would be required to communicate, to listen, to voice concerns, to explore options, and to work together. The provider would develop expanded networks of colleagues with mutual interest in helping transition-aged youth. Transition-aged youth would develop similar networks of natural supports that would go with them beyond the provider-client relationship and help them build a solid foundation for a fulfilling and successful future. The implementation of TIP methods promises a win/win outcome for providers and clients, with healthier environments, healthier behaviors, and healthier relationships for both.

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