



## Transition-Age Youth and Families Initiative – Literature Review Series

### How Teens Become Engaged in Youth Development Programs: The Process of Motivational Change in a Civic Activism Organization

Pearce & Larson

*Applied Developmental Science* (2006)

This article is specific to youth engagement in programming from a service organization called Youth Action in Chicago. All youth participated in programming in order to earn service-learning credit hours and/or because they were paid. The authors interviewed 10 youth over 4 months in order to gain insights into the change process that occurs, which took these youth from being unmotivated and bored to becoming psychologically engaged with program activities. Three stages were identified in the change process:

1. Entry phase: Because all youth joined for extrinsic reasons, they reported low motivation during this initial stage. They reported that they came to meetings but were bored.
2. Personal connection: A transformation in their motivation occurred when they made a personal connection to Youth Action's mission of fighting injustice in schools. As they attended meetings, they saw similarities between their personal experiences in school and those of other youth. They began to identify with the issues and problems that Youth Action was addressing. The key was the realization that their experiences were not unique to themselves and that there was a collective cause.
3. Intrinsic motivation: Youth shifted from passive attendance to active participation in this stage. They began to voluntarily take on tasks and responsibilities. Youth reported that the work they were doing was energizing and rewarding. Many stayed with Youth Action after they had fulfilled their 40-hour requirement to gain credit.

The authors also found that two environmental factors are important in engaging youth: peer support and leader support. Peers were important because they provided a welcoming and friendly atmosphere and camaraderie made the work more enjoyable. Talking with peers and sharing experiences also increased youth's commitment to the program's mission. The leader was important because he fostered the welcoming atmosphere and kept the youth focused on issues on injustice. He also challenged youth participants and provided non-directive assistance in completing tasks.

Another article published by these authors in *Developmental Psychology* in 2011 looked more deeply into how youth formed a personal connection. Youth in this study attributed their increased engagement to experiencing a change in the personal relevance or meaning of the program activities. The activities had acquired greater significance related their personal values, ambitions, or identity, something the authors referred to as increased convergence between self and the activity. They also identified three types of personal connections:



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1. Learning for the future: Youth formed a personal connection when they discovered that there was a connection between the skills they were learning from participating in program activities and their educational or vocational goals for the future.
2. Developing a sense of competence: Youth reported a greater sense of competence that came from doing well in program activities and having that effort acknowledged by others. Their personal connection was attributed to the meaningful affirmation they received.
3. Pursuing purpose: Youth formed personal connections with the organization's goals, which transcended their self-interest. This gave youth the opportunity to accomplish something that is both meaningful to them and is consequential to others.



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### Defining Engagement in Adolescent Substance Abuse Treatment

Pullmann, Ague, Johnson, Lane, Beaver, Jetton & Rund

*American Journal of Community Psychology* (2013)

This article is specific to adolescent engagement in substance abuse treatment. It provides a discussion of the definition of “engagement” and concludes with a new definition that was developed through focus groups of youth in treatment. Pullmann begins by discussing the way engagement has been previously defined and measured as *initiation, attendance, and/or retention*. This definition evolved to include behavioral and altitudinal components, which added the requirement that a youth actively participates in a way that reflects commitment to his or her care.

Engagement has also been defined as being similar to the therapeutic alliance between a therapist and a client because it entails a positive working relationship and focuses on interactions between the youth and others rather than solely on the behavior of the youth. The result of the focus groups (which were collaboratively designed and conducted by researchers and a youth-led advocacy organization) is a definition of engagement called CARES: Conduct, Attitudes, Relationships, Empowerment, and Social Context. It is summarized in the attached PDF entitled Pullmann table.

**Table 1** CARES definition and indicators of engagement from focus groups and existing literature

Dimension	Definition	Examples of dimension emerging during focus groups	Examples of dimension from existing literature
Conduct	Observable client behaviors related to recovery and positive youth development	Attendance at treatment sessions Treatment compliance Active and unprompted participation in treatment Progress towards goals Disclosure Notifying provider if arriving late or missing a session	Attendance at treatment sessions Treatment compliance Initiation of treatment Completion of treatment Progress towards goals Completing homework and other displays of effort outside of sessions
Attitudes	“The emotional investment in and commitment to treatment that follows from believing that it is worthwhile and beneficial.” (Staudt 2007, p. 185)	“Buy-in” or commitment to treatment/motivation to change Accepting responsibility for behaviors Emotional involvement in sessions “Authentic” participation Body language: smiling, eye contact, open body posture	“Buy-in” or commitment to treatment/motivation to change Emotional involvement in sessions
Relationships	Shared understanding between clients and therapists, including bond (a sense of liking and trust), agreement on goals and tasks, collective action on tasks, and a sense that treatment is a collaboration	Rapport Therapeutic Alliance/Working Alliance Asking for help Agreeing on goals and tasks Sense that clinicians that are open and welcoming Sense that clinicians respond to youth’s goals and needs	Rapport Therapeutic Alliance/Working Alliance Therapeutic Involvement Agreeing on goals and tasks Collective action on task achievement Sense that treatment is a collaboration Sense of a cultural match between clinician, client, agency
Empowerment	Youth power in the treatment process, reflected by youth roles that transcend the traditional client role	Youth on clinic advisory boards or board of directors Youth-driven participatory action research	Youth peer support specialists Youth engagement liaisons Youth-driven community engagement efforts Youth-run media
Social context	Family-, social network-, and community-level capacity, willingness, and involvement in youth recovery and positive youth development efforts	Parent and family support of and/or participation in treatment Mobilized families and social networks Youth participation in positive activities outside of treatment Community stigma/support of treatment	Parent and family support of and/or participation in treatment Mobilized families and social networks Youth participation in positive activities outside of treatment Positive community connections and recovery networks Community stigma/support of treatment Cultural relevance of treatment to socio-cultural youth context Agency presence in the community—booths at community fairs, networking with community natural supports

Participants could identify engagement when youth and clinicians came to agreement about shared goals and tasks, when youth asked for help to accomplish their goals, and when youth and clinicians seemed to have a bond. Participants felt that a major part of engagement was clinicians engaging in activities to build this relationship. They did this by providing an open and welcoming environment, identifying the youth’s goals and helping structure activities to meet those goals, encouraging fun and rewarding activities

for youth, and reaching out to connect with youth who were not attending treatment. Finally, a few participants felt that relationships were easiest to build when there was a cultural match between clinician, client, and agency. They emphasized what they felt as the importance of clinicians and agencies who understood and could appropriately respond to multi-cultural needs, including youth culture.

There were two other dimensions of engagement that do not typically appear in the research literature on this topic,



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### Consumer Participation in a Youth Mental Health Service

Monson and Thurley

*Early Intervention in Psychiatry* (2011)

This article is the only one found so far that describes the elements of a program that includes significant engagement of youth who are mental health consumers. It details a program called Orygen Youth Health for inpatient mental health consumers in Melbourne, Australia. While it describes a youth mental health service, it does not specify an age range that was served. Nonetheless, it specifies elements that may prove helpful and may provide validation for approaches such as incorporating peer support.

The program includes the following elements:

- Youth participation coordinator: A paid employee who is responsible for coordinating various activities and who supervises two consumer employees.
- Platform team: Members are made up of past and current consumers. They meet every 2 weeks to provide consultation with service providers to help them engage in more youth-friendly practices and to discuss ideas about service improvement.
- Peer support: Peer support workers are former consumers who receive comprehensive training. They work with hospitalized consumers and use “planned self-disclosure regarding their own illness and recovery” to build rapport and to support these consumers. They also advocate for consumers and help them understand how they can participate and provide feedback.
- Youth steering committee: Committee members include representatives from programs, the youth participation coordinator, and young people. Rather than creating rigid policies that direct youth participation, which may lead to tokenism, the steering committee instead looks for ways to support adoption of different ways to participate based on the interests and capabilities of the young people.

The authors state that many organizations have not been successful in engaging consumers because they attempt to fit consumer participation into existing structures such as inviting them to participate on existing committees. Consumers may also become frustrated if processes move too quickly, and therefore, they do not have enough time to share their ideas and opinions. Staff commitment is critical to success as is providing support to consumers who are participating.

The program has not been evaluated so there is no data on change that occurred with the consumers or the organization.



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### What a Difference Family-Driven Makes: Stories of Success and Lessons Learned

Slaton, Cecil, Lambert, King & Pearson

*American Journal of Community Psychology* (2012)

This article offers four first-person accounts of family leaders and their impact on governance, evaluation, legislative advocacy, and workforce development. It is not an academic article, which makes it accessible and easy to read. The article is specific to family-run organizations that employ family members within a system of care for children and youth with mental health conditions. Each family member gives recommendations based on their experiences. Recommendations include the following:

- Fill family leadership positions with people who have the “lived experience” and ensure that they have access to training to build the knowledge, skills, and abilities they need to be successful
- A family-driven system requires strategic placement of family leaders into all decision-making bodies of the system of care
- It is imperative to keep hope alive and to help families and others see the long-term picture and understand that change takes time
- Provide joint training early in an evaluation process for families and evaluators so that families and evaluators can work together to identify the information that stakeholders need to support both funding goals and mission
- Relationships must be based on mutual respect, understanding, and accountability

The article concludes with recommendations regarding the characteristics of the family members who were successful in their roles:

1. Successful family leaders began their journey with the experience of stigma, blame, judgment, shame and hopelessness in the face of raising their child with significant mental health needs in their community. This factor alone helped give them credibility with other family members as well as with policy decision makers.
2. They had at least some prior work and/or study experience that gave them knowledge, skills, and competencies useful to their advocacy work.
3. They were lifelong learners, especially about intangibles such as power, strategy, political will and discretion.
4. They understood that trust, credibility, and informal authority are earned characteristics.
5. Their personal characteristics included tolerance for delayed gratification and risk-taking. They understood that the changes they were effecting may take a full generation to impact the children in their community, eliminating the possibility that their own children would benefit. And they were willing to risk failure. They did not limit their efforts to obvious wins.
6. They displayed empathy for all stakeholders, including legislators, providers, and evaluators. They were able to develop and nurture relationships and change minds.



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7. They had a strong desire to improve the lives of children, youth, and families in society as demonstrated by their skilled mentoring of other family members, which led to an increased sense of empowerment and, for some, assignment to leadership positions.



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Assessments of Programs based on Transition to Independence (TIP) Model for Transition Age Youth

Transition to Adult Roles for Students with Emotional/Behavioral Disturbances: A Follow-Up Study of Student Exiters from Steps-to-Success

Karpur, Clark, Caproni & Sterner

*Career Development for Exceptional Individuals* (2005)

Predicting Improvement of Transitioning Young People in the Partnerships for Youth Transition Initiative: Findings from a Multisite Demonstration

Haber, Karpur, Deschenes & Clark

*The Journal of Behavioral Health Services & Research* (2008)

Karpur begins with an overview of challenges faced by transition age youth (TAY) and young adults with emotional/behavioral disturbance (EBD) in the domains of employment; post-secondary education; living situation; personal effectiveness and quality of life; and community life functioning. Karpur also provides the seven guidelines of the TIP model:

1. Engage young people through relationship development, person-centered planning, and a focus on their future
2. Tailor services and supports to be accessible, coordinated, developmentally appropriate, and built on strengths that enable the young people to pursue their goals across transition domains
3. Acknowledge and develop personal choice and social responsibility with young people
4. Ensure a safety net of support by involving a young person's parents, family members, and other informal and formal key players
5. Enhance a young person's competencies to assist him or her in achieving greater self-sufficiency and confidence
6. Maintain an outcome focus at the young person, program, and community levels
7. Involve young people, parents, and other community partners in the TIP system at the practice, program, and community levels

The program evaluated by Karpur, called Steps-to-Success, was based on the TIP model. It was implemented at a vocational high school in Florida and provided educational, psychosocial, and vocational training as well as follow-up services for youth in grades 9-12. Participating youth with EBD were classified by the school as receiving special education services for a disability. Two comparison groups were used: a comparable group of youth with EBD who did not participate in the program and youth who were not classified as having a disability. Forty-three TAY were followed for one year after they exited the program. Of the four outcome indicators, two showed differences with a medium effect size when compared with the control group of youth with EBD (see table below). Researchers concluded





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that overall, TAY who participated in Steps-to-Success for at least one year fared better on average than the TAY with EBD who did not.

Outcome indicator	Steps-to-Success (%)	EBD Control Group (%)	Effect Size
Employment	41.9	50.6	0.04 (low)
Post-secondary education	27.9	8.7	0.40 (medium)
Productivity index	55.8	50.6	0.10 (low)
Incarcerated or controlled release	2.8	11.6	0.40 (medium)

Haber also begins his article by reviewing the life challenges faced by transition-age youth with serious mental health conditions (SMC). In introducing the TIP model, he emphasizes the importance of coordinating services across community agencies and maximizing the input of youth and families on multiple levels. He states that in addition to the seven guidelines, an “essential ingredient” in TIP programs is the one-on-one relationship between the transition facilitator and the young person receiving support.

The programs Haber studied were part of the Partnerships for Youth Transition (PYT), which was funded by federal grants in 2002. Five community-based programs across the country provided support services for TAY with SMC. Four of the sites used the TIP model and one used the Assertive Community Team (ACT) model. Over the 3-year implementation phase, 562 TAY with SMC were enrolled in the five programs; however, one-year follow-up data was collected and analyzed for 193 participants. Outcome indicators included progress in education and employment, criminal justice involvement, and interference with daily activities because of mental health and substance abuse problems. No comparison group was used.

Researchers concluded that TAY with SMC showed transition progress on all or most the domains examined at all five sites with the most consistent improvement taking place in educational advancement and employment. The other indicators improved less or the improvement was not maintained. The discussion section of the article also details a number of findings from moderation analysis. For example, TAY up to age 19 did not show as much improvement as TAY who were 19 or older and females had better outcomes than males.



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### Investigating the Relationship Between Services and Outcomes in a Program for Transition-Age Youth

Koroloff, Pullmann & Gordon

*The 20<sup>th</sup> Annual Research Conference Proceedings: A System of Care for Children's Mental Health: Expanding the Research Base* (2008)

This article is the only one located so far that is an evaluation of a program based on the TIP model that was not conducted by the team that developed TIP. The Options program was based on four theoretical perspectives:

- Transition to Independence Process (TIP)
- Program for Assertive Community Treatment (PACT), which is a wraparound-type approach that focuses on building skills that promote independence and recovery with an emphasis on home visits and *in vivo* interventions
- Supported Employment, which provides continuous support both when seeking employment and while employed
- Core Gifts assessment (which has been replaced in TIP with a Strengths Discovery assessment)

The evaluation team focused on youths' progress in four domains: employment, education, housing, and criminal justice involvement. They created a "severity index" by combining psychiatric diagnosis, juvenile justice involvement, educational status, and the extent that mental health problems interfered with daily functioning. Participants were ages 14-19 years; 92% were Caucasian. Program participants were evaluated after nine months of program participation. The evaluation team found that 96% of participants experienced positive change in at least one domain and 68% experienced no negative change.

Staff time was primarily focused on activities related to community life adjustment and employment. Table 1 shows the distribution of service hours and the percentage of youth who received specific types of services.

Table 1  
Distribution of service hours and type by staff and youth

Service	% of total staff time spent on service	% of youth who received service
Community life adjustment	33.5%	90.0%
Employment services	27.5%	88.3%
Case management	9.8%	33.3%
Wraparound	7.1%	63.3%
Assessment/intake	5.8%	86.6%
Educational support services	5.7%	50.0%
Core gift statement	4.1%	41.6%
Housing support services	3.6%	46.6%
Team staffing	2.2%	55.0%
Crisis phone calls	0.02%	1.6%



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The authors found a statistically significant relationship between the number employment service hours and a positive change in employment; however, they did not find such relationships between service hours for other activities and positive change.