

The Child-to-Adult Transition for Albertan Youth with Disabilities



PolicyWise
for Children & Families

EXECUTIVE SUMMARY

Fifteen percent of the children and youth in the Alberta school system in 2017 had a disability (e.g., physical, cognitive, or social impairments)¹. Children and youth with disabilities experience a higher frequency of adverse outcomes, including lower rates of educational achievement, less employment, more corrections involvement, and increased mental health issues compared to those without disabilities²⁻⁸. Due to their increased needs, youth with disabilities often require multi-system services and supports to facilitate their participation in society. Many children and youth with disabilities experience challenges accessing these services and programs⁹⁻¹⁰. In particular, youth with disabilities and their families report challenges in the child-to-adult transition due to service and program changes⁹⁻¹⁰. In Alberta, at the age of 18, youth with disabilities often experience changes in income supports, disability supports, educational services, health care services, and justice system services.

To inform decisions on how to better support youth with disabilities, the aim of this study was to identify challenges youth with disabilities face during the child-to-adult transition in Alberta. We looked at four challenges faced by youth with disabilities in the transition, as identified by stakeholders: 1) educational outcomes and support use, 2) health care use, 3) corrections involvement, and 4) homelessness. To identify situations that may be strategically targeted to reduce challenges faced in the transition, we investigated the association between social (e.g., city size, income), individual (e.g., high school diploma status, sex), and service/program use (e.g., health care use, income support use) factors, and challenges youth with disabilities faced. We further differentiated by type of disability.

Summary of Findings

The findings in this report suggest that many social, individual, and service/program factors during the transition from child-to-adult services are associated with common challenges youth with disabilities face (educational outcomes and support use, health care use, corrections involvement, and homelessness). This report provides evidence that mental health needs are an important issue to address in the transition, with connections to health care use, corrections involvement, and homelessness.

- 1. Educational outcome and support use:** Youth with disabilities were found to have poorer educational achievement and more dependence on supports after the child-to-adult transition than youth without disabilities. We also identified social, individual, and service/program factors that played a role in youth with disability's educational achievement. Decision makers may influence these factors to improve transition outcomes. For example, promoting funding and supports for education for youth with disabilities to increase postsecondary use may decrease dependence on supports, as higher educational achievement has been associated with greater employment¹¹. In addition, targeted employment programs may benefit the youth (pages 4-6).
- 2. Health care use:** Disability severity is an important consideration for understanding health care use for youth with disabilities. Youth with severe disabilities had fewer health care visits after transitioning from child-to-adult services, including disability and mental health related visits. While it is possible that this reduction in health care visits may be due to less health care need after the transition, some youth may be falling off the "support cliff" and unable to access services needed to fully participate in society. For example, a loss of mental health support is concerning as poor mental health is associated with work loss and relationship issues¹²⁻¹³ (pages 7-9).
- 3. Corrections involvement:** Youth with disabilities had higher corrections involvement than youth without disabilities. While we identified risks for future corrections involvement (e.g., behavioural mental health issues, being male, etc.), we also found that some trajectories were associated with more resilience to corrections (e.g., having disability supports or graduating from high school). This suggests that support can be protective for youth with disabilities over the transition. One group identified for potential support is youth with Fetal Alcohol Spectrum Disorder (FASD), due to a sharp increase in corrections involvement after the transition (pages 10-11).
- 4. Homelessness:** Youth with disabilities were six times more likely to be identified as homeless after transitioning than youth without disabilities. Mental health service use and income support use were associated with homelessness, therefore, transition navigation services might help reduce these risks. For example, services to navigate mental health services across the transition may benefit youth with severe disabilities as the youth also showed a drop in mental health visits over the transition (pages 12-13).

The findings from this report can be used by policymakers and support providers to inform strategies on how to support youth in the child-to-adult transition period. Future research and discussion should expand on these findings through engagement with youth with disabilities, family members, and support workers. To facilitate transition support and planning, we included transition considerations on page 14.

Note: This report is part of the Longitudinal Project by the Child and Youth Data Laboratory (CYDL) in collaboration with partnering Alberta government ministries. Please see the last page for a brief description of the project and go to <https://policywise.com/data/p2/> to access other deliverables.

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ANALYSIS NOTES (variables are described in depth on pages 15 to 17)

This analysis is based on six years of reported service use in Alberta (2005/6 to 2010/11), using data from the PolicyWise for Children & Families: Child and Youth Data Laboratory (CYDL; see page 24 for details on the CYDL).

Target comparison groups

Students were included in the analysis if they were registered with Alberta Education for at least one year from 2005/6 to 2010/11 and had full-time health care registration from 2005/6 to 2010/11. For the educational outcome and support use, health care use, and corrections analyses, students were 16 years old in 2005/2006. For the homelessness analysis, students were 14, 15, or 16 years old in 2005/06. Students were defined by special education code severity as: no code (not coded as requiring support), mild code (coded for low or moderate levels of educational support; codes 30, 51, 52, 53, 54, 55, 56, 57, 58), or severe code (coded for high levels of educational support; codes 41, 42, 43, 44, 45, 46, 47). Category of code analyses targeted codes that had at least 10 individuals per code category, as per CYDL reporting agreements (see page 15 for category of code descriptions).

Outcomes

1 - Educational outcome and support use: This analysis targeted three outcomes, youths' 1) educational achievement, as receiving a credentialed high school diploma or postsecondary education over the six year period, 2) adult support use (at all) over the six years (Assured Income for the Severely Handicapped [AISH], Persons with Developmental Disabilities [PDD], Income Supports, and/or Income Support Learners), and 3) use of postsecondary education in the last two years (20 to 21 years old). Postsecondary use (3) was used for predictive modelling.

2 - Health care use: This analysis targeted four health care visit outcomes, youths' 1) yearly overall health care visits (the sum of physician, emergency department, inpatient, and outpatient visits), 2) yearly physician, emergency department, inpatient, and outpatient visits, 3) yearly neurodevelopmental disabilities (NDD; e.g., Autism, Fetal Alcohol Spectrum Disorder [FASD], etc.) visits, as a majority of disabilities are categorized as NDDs, and 4) yearly internalizing or externalizing mental health visits (e.g., depression or conduct disorder). The first two health care outcomes were segmented into two year periods, pre-transition, post-transition, and two years post-transition, and the NDD and mental health outcomes compared the first year (16 years old) to the last two years (20 to 21 years old), as disability services require diagnoses made around the transition (around the age of 18).

3 - Corrections involvement: This analysis targeted youths' Albertan provincial corrections involvement (youth sentenced for crimes). Corrections involvement percentages were calculated by any occurrence in two year segments: pre-transition, post-transition, and two years post-transition. The last two years of corrections involvement were used for predictive modeling.

<i>Year</i>	<i>2005/2006</i>	<i>2006/2007</i>	<i>2007/2008</i>	<i>2008/2009</i>	<i>2009/2010</i>	<i>2010/2011</i>
Age (years)	<i>16</i>	<i>17</i>	<i>18</i>	<i>19</i>	<i>20</i>	<i>21</i>
Time window labels	<i>Pre-Transition</i>		<i>Post-Transition</i>		<i>Two years post</i>	
1 - Educational outcome and support use	Diploma or postsecondary education use, and support use					
1 - Postsecondary education					Postsecondary education use	
2 - Health care use	Yearly visits		Yearly visits		Yearly visits	
2 - NDD and MH visits	Yearly visits				Yearly visits	
3 - Corrections involvement	Any involvement		Any involvement		Any involvement	

Outcomes and their time ranges for analyses 1, 2, and 3



ANALYSIS NOTES continued (variables are described in depth on pages 15 to 17)

Outcomes (continued)

4 - Homelessness: This analysis targeted youth identified as homeless, by the presence of any health care visit homeless International Classification of Diseases (ICD) code. The analysis focused on youth identified as homeless before and after the transition (based on the age of 18), and used modeling to predict which youth were identified post-transition.

Year	2005/2006	2006/2007	2007/2008	2008/2009	2009/2010	2010/2011
Age 14 cohort	14	15	16	17	18	19
Age 15 cohort	15	16	17	18	19	20
Age 16 cohort	16	17	18	19	20	21
4 - Homelessness	Pre-Transition Homelessness (light grey)			Post-Transition Homelessness (dark grey)		

Ages of pre-transition and post-transition outcomes for Analysis 4.

Analyses

1 - Educational outcome and support use: This analysis presents percentages of youth with high school diplomas or postsecondary education use (educational achievement), support use (AISH, PDD, Income Support, or Income Support Learners), and support use with and without the presence of a diploma or postsecondary education. Outcomes are reported by special education code severity and category of code, and are presented with 95% confidence intervals (Figures 1 to 6). In addition, regression modelling was performed to estimate the relative risk (using a log-Poisson method) of youth with any special education code to receive postsecondary education in 2009/10 or 2010/11 (Figure 7). Factors in the model are based on the first 4 years and are social (e.g., rural vs. urban, neighborhood income), individual (e.g., received a high school diploma, sex), and service/program use (e.g., health care use, income support use) factors (e.g., income support use, AISH use, etc.). These factors were chosen due to their relevance to the transition time period and were selected using a backwards selection process that retained factors that significantly explained more of the variance associated with postsecondary education use.

2 - Health care use: This analysis presents medians and inter-quartile ranges for each outcome time period based on special education code severity. This analysis tested for differences in median changes between each time period. Inter-quartile ranges (25% to 75%) are shown vertically on figures and significant differences between time periods are presented horizontally with arrows and mention of direction (loss=an increase in visits from the earlier time period; gain=a decrease in visits; Figures 8-13, 15). In addition, the percentage of each category of special education code that had a NDD or mental health medical visit are presented on Figures 14 and 16 with 95% confidence intervals.

3 - Corrections involvement: This analysis presents the percentage of youth that had corrections involvement in each time period by special education code severity, category of code, and FASD diagnosis. Ninety-five percent confidence intervals are presented on Figures 17 and 19 and a significance test is presented for the FASD figure, with horizontal arrows for significant differences (Figure 18). In addition, regression modelling was performed to estimate the relative risk (using a log-Poisson method) of youth with any special education code to be involved in corrections in 2009/10 or 2010/11 (Figure 20). The same factors and selection process described in Analysis 1 was used.

4 - Homelessness: This analysis presents the frequencies and percentages of youth to have a homeless code by time period, presence of a special education code (severity is combined due to a low outcome count), and category of special education code. Ninety-five percent confidence intervals are presented on Figures 21 to 23. Regression modelling was performed to estimate the relative risk (using a log-Poisson method) of youth to be homeless in the post-transition period (Figure 24). The factors and selection process described in Analysis 1 were used, with factors based on any of the six years. In addition, a model focusing on special education youth was performed, and is commented on as a note due to reporting restrictions (i.e., many outcome frequencies were below 10).

Note: For all regression models parallel logistic regression models were performed to maximize the amount of variance explained. Fit statistics for these models are provided as a note below the log-Poisson model results.

FINDINGS

Analyses 1, 2, & 3: Target comparison groups

- These analyses identified 34,389 students that were 16 years old in 2005/06 and enrolled with Alberta Education for at least one year from 2005/06 to 2010/2011.
- 29,694 (86.3%) had no special education code, 3,395 (9.9%) had a mild or moderate code, and 1,300 (3.8%) had a severe code. Further details on this cohort are reported in Table 1; page 18.

1. Educational outcomes and support use

1-1a. Educational outcomes and support use. Youth with no special education code had a high percentage of receiving a high school diploma or postsecondary education (Figure 1). Educational achievement decreased as special education code severity increased. In contrast, youth that had a special education code were more likely to use disability or income supports (AISH, PDD, Income Support and/or Income Support Learners) than youth with no code (Figure 2). Support use increased as code severity increased.

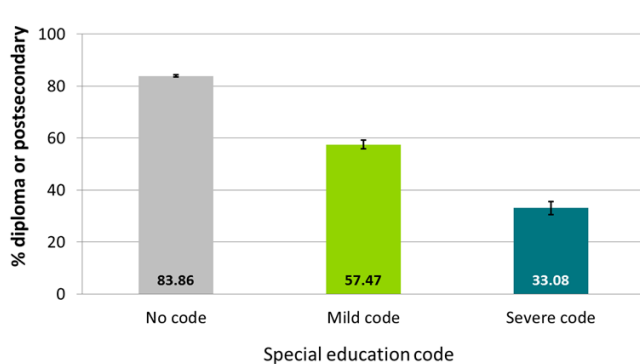


Figure 1. Special education code severity and educational achievement

Figure 2. Special education code severity and support use

1-1b. Youth that had better educational outcomes, were less likely to use supports, and overall support use depended on special education code severity (Figure 3).

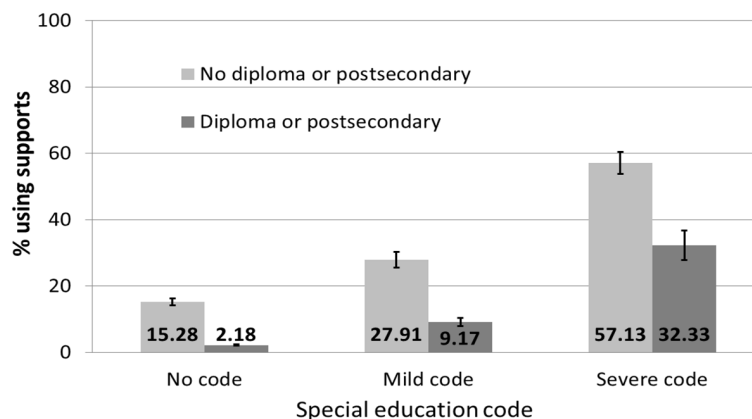


Figure 3. Support use and educational achievement

Implications: These results provide evidence that youth with disabilities often have poor educational achievement and continued support dependence after the transition. Furthermore, youth were less likely to use supports when they had better educational outcomes. This provides evidence of the connection between education and support use. Improving educational achievement or providing employment training to youth with disabilities might decrease support dependence post-transition. While education is supported post-transition through current programs, addressing issues early (i.e., in the years leading up to the transition or in the early childhood years) is thought to improve transitions¹⁴⁻¹⁵. See the Early Childhood services report for information on potential early areas of support¹⁶. As a limitation of this analysis, we note that the connection between support use and achievement is likely related to both decreased need and eligibility for support when youth have better educational achievement.



FINDINGS (continued)

1-2. Category of code, and educational and support outcomes

This analysis reports outcome percentages for different categories of special education codes that were represented by at least 10 youth per outcome type. Descriptions of code categories are on page 15.

- 1-2a. Educational outcomes and category of special education code.** Youth assigned severe cognitive disability codes had the lowest percentages of receiving a diploma or postsecondary education, followed by severe multiple disability, severe emotional and behavioural disability, and severe physical and medical disability (Figure 4).

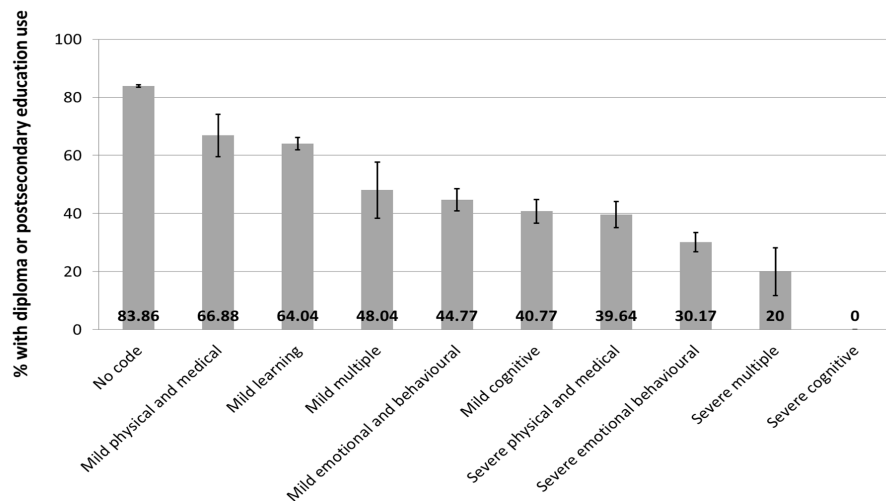


Figure 4. Special education category of code and educational achievement

- 1-2b. Support use and category of special education code.** Youth assigned moderate or severe cognitive disability had the highest percentages of support use, followed by severe multiple disability, severe physical and medical disability, and severe emotional and behavioural disability (Figure 5).

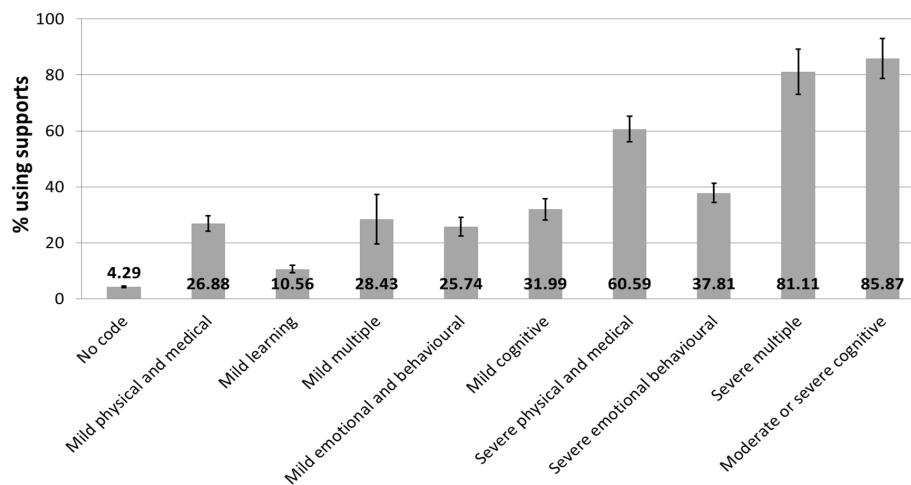


Figure 5. Special education category of code and support use

Implications: These results provide evidence of which youth with disabilities had lower educational achievement and which received supports after the transition. Overall, youth with poorer educational achievement had higher support use. These findings may be taken into account as support providers consider where additional transition support may be beneficial to youth. For example, youth with emotional and behavioural disability had poor educational achievement and relatively less support use than other code categories. While this may be due to less support need, it might also put these youth at risk for negative outcomes, which we will address in the following sections on health care use, corrections, and homelessness.

Note: Moderate and severe cognitive disabilities were combined in the support use results due to a low sample size.

FINDINGS (continued)

1-3. Postsecondary education model

1-3a. Postsecondary education use. Youth with no special education code had a higher percentage of receiving postsecondary education in 2009/10 or 2010/11 than youth with special education codes (Figure 6). Postsecondary education use decreased as code severity increased.

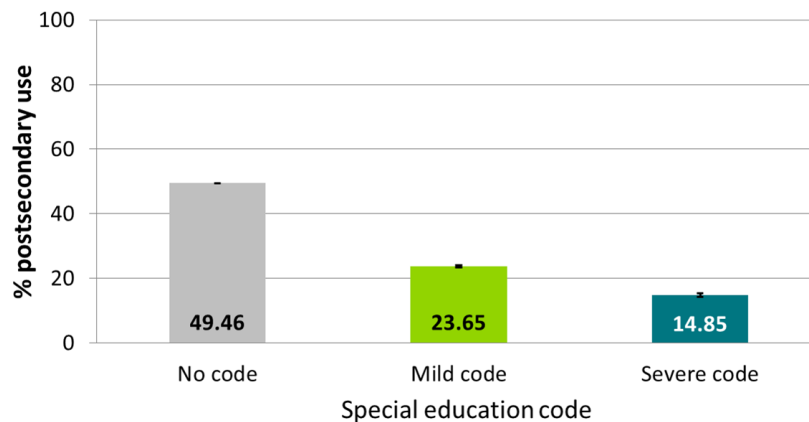


Figure 6. Special education code severity and postsecondary education use

1-3b. Model for postsecondary education. This model provides a relative risk for each factor—how much having a factor related to the chance for youth with a special education code of being in postsecondary education (Figure 7). For example, a '2' means that the factor has approximately twice the chance compared to not having this factor, '0.5' means half the chance, and '1' means the same chance. **Note that this model is not causal.** Details of the analysis are discussed on pages 2-3 and numbers of youth experiencing each factor are in Table 2; page 19.

Results: Youth with disabilities that received non-postsecondary income supports (AISH or Income Support), were male, and were from rural settings were less likely to receive postsecondary education. On the other hand, youth that received a diploma, were in English as a second language, had education income support, or had high health care support were more likely to receive postsecondary education.

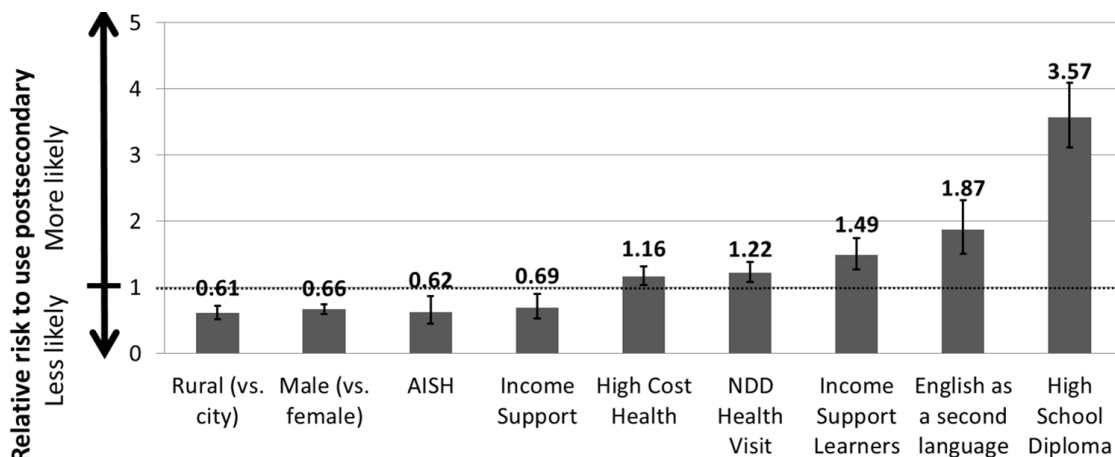


Figure 7. Relative risk, predicting postsecondary use

Implications: This analysis provides evidence that social, individual, and service/program factors are associated with the postsecondary use of youth with disabilities. The factors in this model may be used to coordinate support service delivery to improve the postsecondary trajectories of youth with disability. For example, promoting income support learner programs for youth on income supports may improve their employment outlook and decrease their need to receive income supports, as better educational achievement has been linked to better employment outcomes¹¹.

Note: A parallel logistic regression model was performed and showed a likelihood ratio of $\chi^2(9, 4493) = 638.61, p < .0001$, and a $c = .754$, with overall evidence of fair model fit.



FINDINGS (continued)

2. Health care use

2-1. Overall visits. Youth with a severe special education code tended to experience an overall drop in health care visits over the transition. A slight increase in visits was seen for not coded youth (Figure 8).

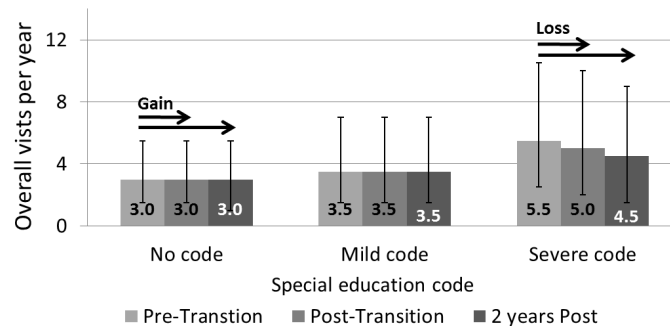


Figure 8. Special education code severity and overall health care visits (median with inter-quartile range)

2-2. Type of health care visits (physician, outpatient, emergency department (ED), and hospitalization). The drop in visits for youth assigned severe special education codes was primarily seen in physician visits and outpatient visits, with increases seen in not coded youth in physician, ED, and hospitalization visits (Figures 9-12).

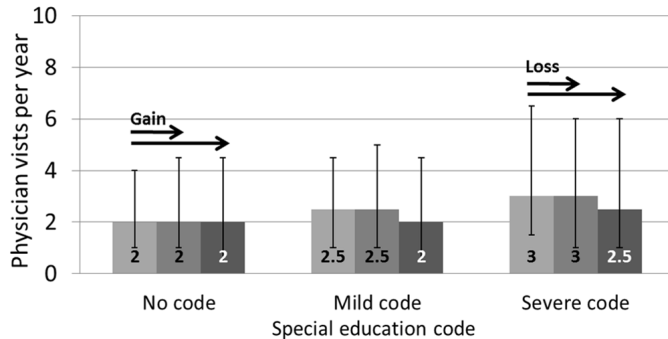


Figure 9. Special education code severity and physician visits (median with inter-quartile range)

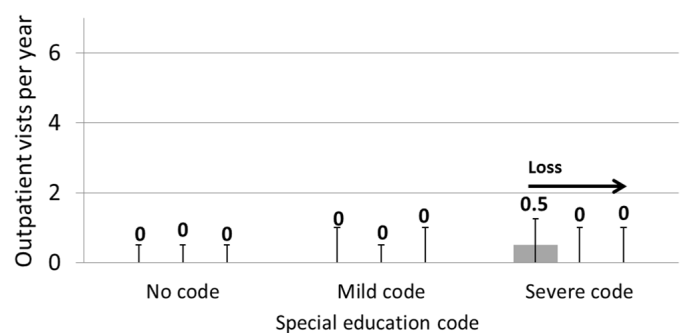


Figure 10. Special education code severity and outpatient visits (median with inter-quartile range)

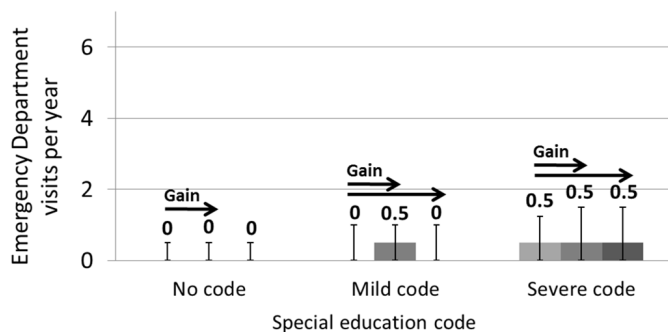


Figure 11. Special education code severity and ED visits (median with inter-quartile range)

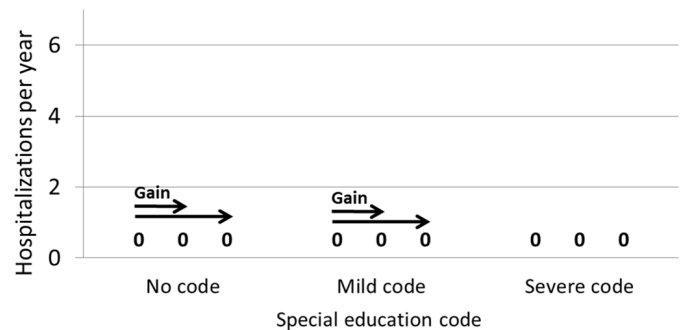


Figure 12. Special education code severity and hospitalization (median with inter-quartile range)

Implications: These results provide evidence that youth with severe disabilities show decreases in physician and outpatient health care visits after the transition. This change likely relates to the transition from pediatric to adult health care at the age of 18. However, these findings alone are hard to interpret as less use could be both positive (e.g., better health) or negative (less supported youth). As such, the next two analyses investigated visits related to specific disability needs.

Note: An analysis was also done on physician visits split by general physician (GP) and specialist physicians (SP). Gains in visits were primarily seen for GPs and losses for SPs, with the largest GP increases for youth with no code and the largest SP decreases for youth assigned severe codes.

FINDINGS (continued)

2-3a. Neurodevelopmental disorder (NDD) visits. As many youth with disabilities have neurodevelopmental disorders (NDDs; e.g., Autism, etc.), NDD visits were investigated. Among youth seen for any NDD visit in 2005/06, 2009/10 or 2010/11, a drop was seen in NDD visits from 2005/06 to 2009/10 & 2010/11 for all youth. This drop was larger for youth with special education codes (Figure 13).

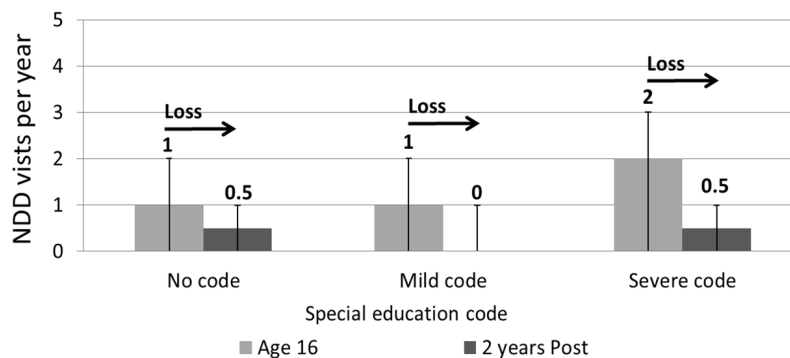


Figure 13. Special education code severity and neurodevelopmental disorder (NDD) visits (median with inter-quartile range)

2-4a. Category of special education code and NDD health care service use. Youth with severe cognitive disabilities were most likely to see a doctor about a NDD condition, followed by severe multiple disability, severe physical and medical disability, mild multiple disability, and moderate cognitive disability (Figure 14).

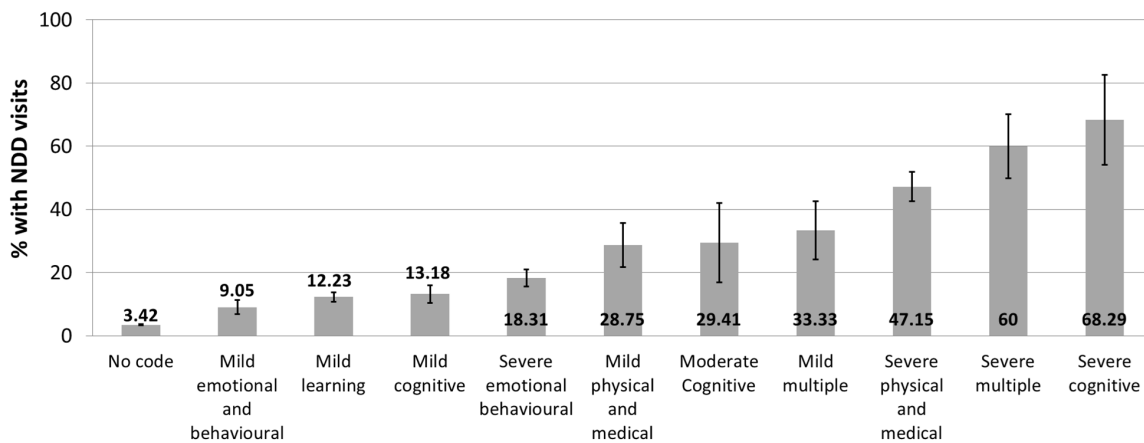


Figure 14. Special education category of code and any NDD visit in 2005/06, 2009/10, or 2010/11

Note: This analysis focuses on years that don't involve diagnosis for the early reception of disability related supports. Disability supports may require a diagnosis for a severe neurodevelopmental disorder or mental health-related condition.



FINDINGS (continued)

2-3b. Internalizing and externalizing mental health visits. As many youth with disabilities have mental health issues with internalizing (e.g., anxiety, depression) or externalizing (e.g., conduct disorder, substance use) behaviours, visits related to these mental health issues were investigated. Among youth seen for internalizing or externalizing mental health issues in 2005/06, 2009/10 or 2010/11, a drop was seen in visits from 2005/06 to 2009/10 & 2010/11 for youth assigned severe special education codes, compared to an increase for youth with no code (Figure 15).

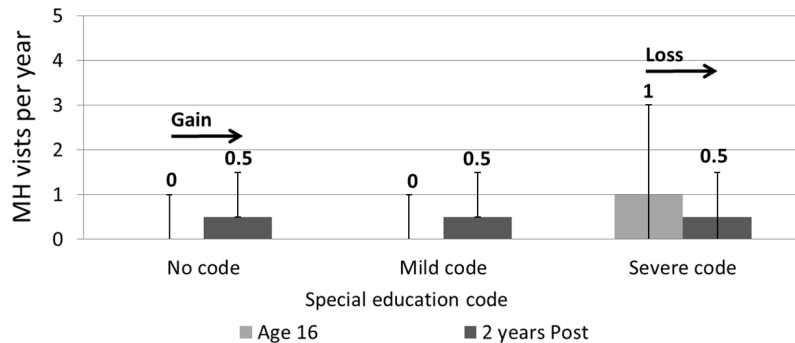


Figure 15. Special education code severity and mental health (MH) visits (median with inter-quartile range)

2-4b. Category of special education code and mental health service use. Overall, youth with a special education were more likely to use mental health services than youth with no codes. Youth with severe emotional and behavioural disability were mostly likely to see a doctor about an internalizing or externalizing mental health condition, followed by mild multiple disability and severe physical and medical disability (Figure 16).

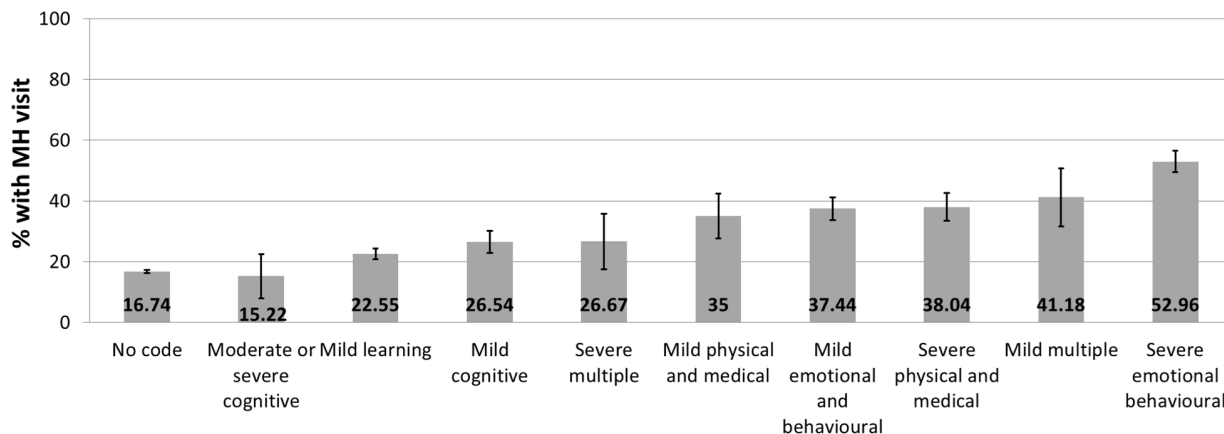


Figure 16. Special education category of code and Mental Health (MH) visit presence in 2005/06, 2009/10

Implications: These results provide evidence that youth with disabilities are seen less for neurodevelopmental disorders and mental health conditions post-transition. While this may be related to less need, this result may also be concerning for individuals that require this medical support to participate in society. For example, youth with cerebral palsy may need continued visits to address mobility support needs if they seek to move from home to the community. Similarly, a loss of mental health support is concerning as poor mental health is related to less ability to work and have healthy relationships¹²⁻¹³. Additional research is required to better understand how these changes impact youth with disabilities.

Note: This analysis focuses on years that don't involve diagnosis for the early reception of disability related supports. Disability supports may require a diagnosis for a severe neurodevelopmental disorder or mental health-related condition.

FINDINGS (continued)

3. Corrections involvement

3-1. Corrections involvement and category of special education code. Youth with special education codes were more likely to be involved in corrections than youth without codes, and corrections involvement increased as code severity increased. However, no large change in corrections involvement was seen for youth across the transition time periods (Figure 17).

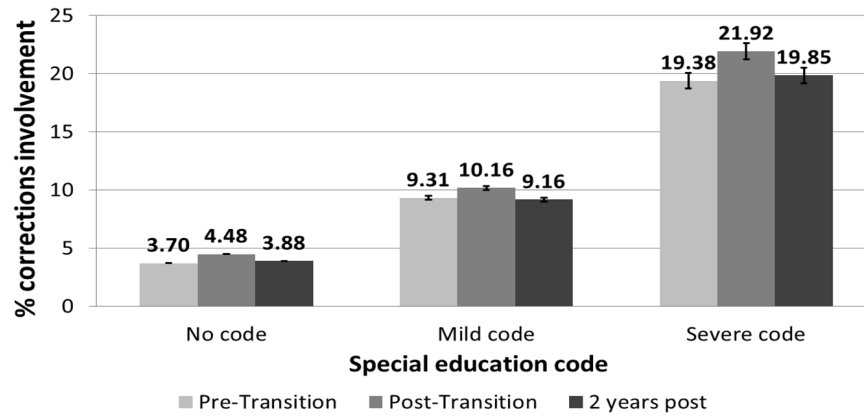


Figure 17. Special education code severity and corrections involvement

3-2. Fetal Alcohol Spectrum Disorder and category of special education code. Youth with Fetal Alcohol Spectrum Disorder (FASD) showed a large increase in corrections involvement over the transition (Figure 18).

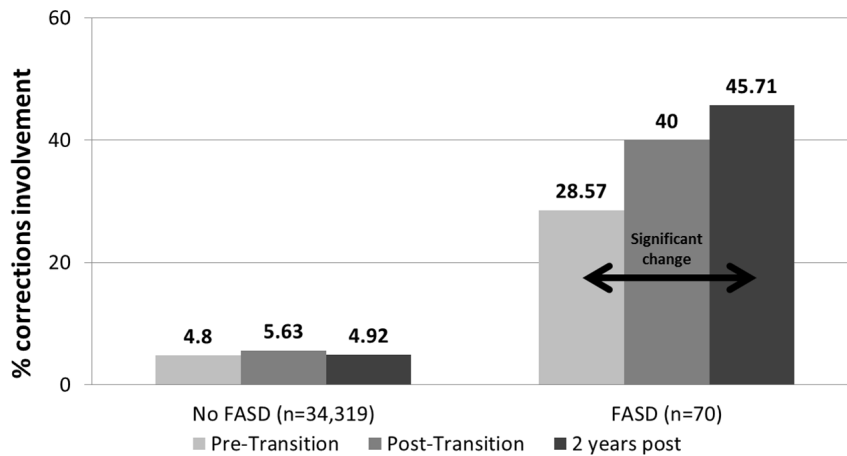


Figure 18. Special education code severity and Fetal Alcohol Syndrome Disorder diagnosis



FINDINGS (continued)

3-3. Category of code and corrections involvement in the 2 years post-transition period. This analysis excluded youth with FASD. Youth with mild and severe emotional behavioural codes were more likely to be involved in corrections in the two years post-transition time period, followed by youth with mild multiple disability, mild cognitive disability, and severe physical and medical disability (Figure 19).

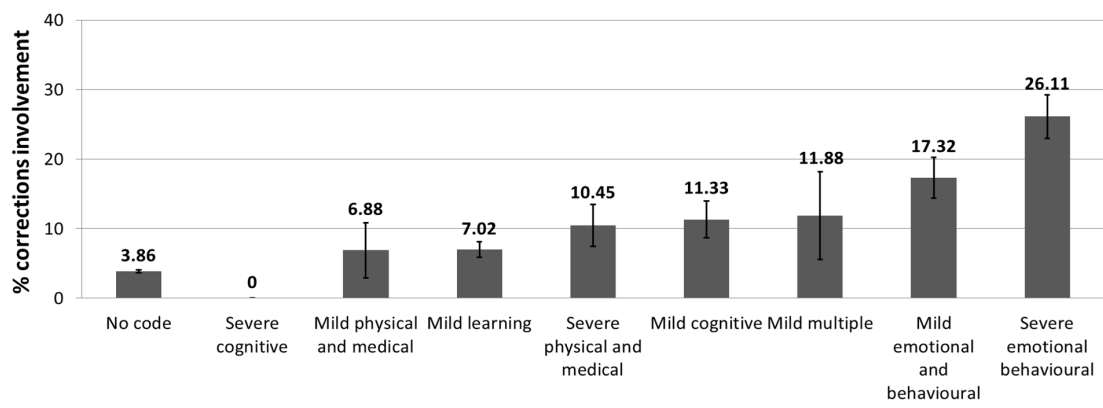


Figure 19. Special education category of code and corrections involvement 2 years post-transition

3-4. Model for corrections involvement. This model provides a relative risk for each factor—how much having this factor relates to the risk for youth in special education of being involved in corrections in 2009/10 or 2010/11 (Figure 20). A ‘2’ means that this factor has approximately twice the risk for corrections involvement compared to not having the factor, a ‘0.5’ means half the risk, and a ‘1’ means the same risk. **Note that this model is not causal.** Details of the analysis are discussed on pages 2-3 and numbers of youth experiencing factors are reported in Table 3; page 20.

Results: Youth with disabilities that had severe disability, were male, had previous corrections, had behavioural (externalizing) mental health issues, or used income supports were more likely to have corrections involvement after the transition. On the other hand, youth that were supported by disability supports or received a high school diploma were less likely to have corrections involvement.

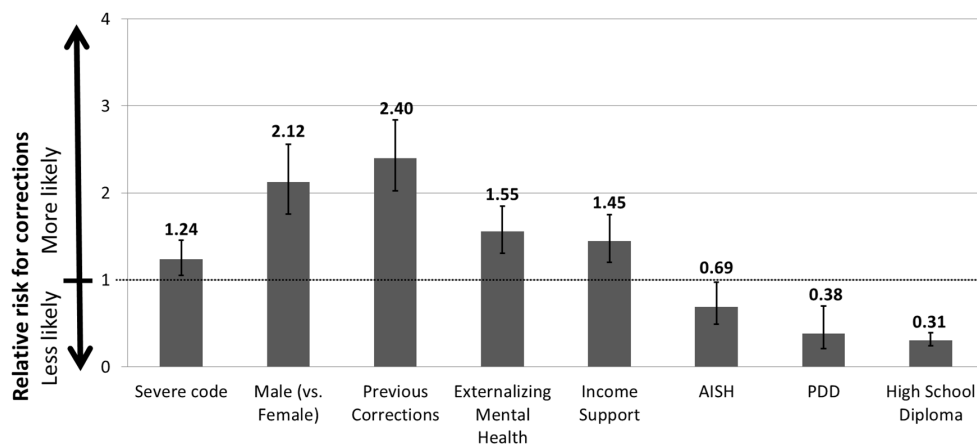


Figure 20. Relative risk, predicting corrections involvement

Implications: This analysis provides evidence of what factors play a role in the post-transition corrections involvement of youth with disabilities. While the analysis provides evidence of risks for future corrections (e.g., behavioural mental health issues, male, or previous corrections), it also suggests that some youth that are supported (i.e., by disability supports or do well in school) are more resilient. This suggests a benefit of providing support to youth with disability over the transition. We should also note that some youth with more disability support use may be less able to commit crimes due to their disability, but that support service use is also thought to serve a protective role in preventing corrections involvement¹⁷.

Note: A parallel logistic regression model showed a likelihood ratio of $\chi^2 = 715.78$, $p < .0001$, $a c = .824$, and overall evidence of good model fit.

FINDINGS (continued)

Analysis 4 (Homelessness): Target comparison groups

- This analysis identified 101,361 students that were 14, 15, or 16 years old in 2005/06 and enrolled with Alberta Education for at least one year from 2005/06 to 2010/2011.
- 85,638 (84.5%) had no special education code, 11,080 (10.9%) had a mild or moderate code, and 4,643 (4.6%) had a severe code. Further details on this cohort are reported in Table 4; page 21.

4. Homelessness

4-1. Pre- and post-transition homelessness. Youth were 3.2 times as likely to be identified as homeless in the health care system after the transition, compared to before the transition (Figure 21).

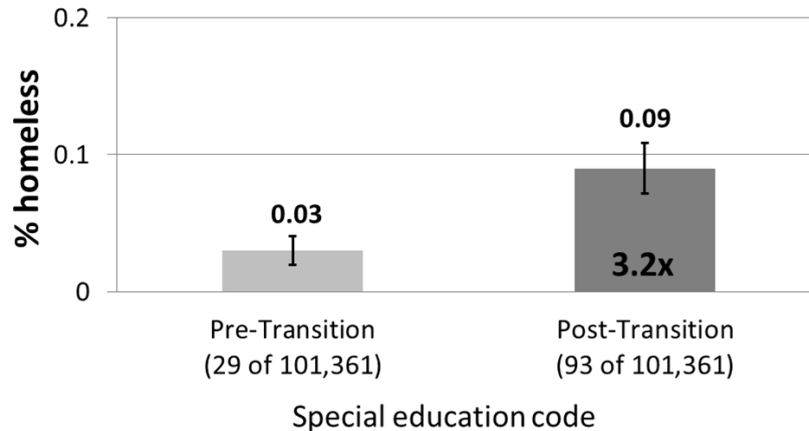


Figure 21. Homelessness pre- and post-transition

4-2. Special education code and homelessness. Youth with a special education code were 6 times as likely to be identified as homeless after the transition, than youth with no code (Figure 22).

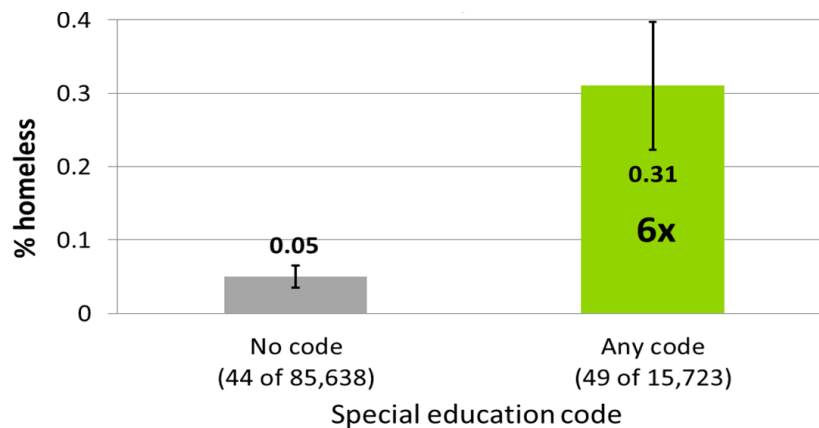


Figure 22. Special education code and homelessness post-transition



FINDINGS (continued)

4-3. Special education category of code and homelessness. Youth with emotional and behavioural disability (17.5 times that of not coded youth), and physical and medical disability (10.4 times that of not coded youth; Figure 23) were much more likely to be identified as homeless post-transition.

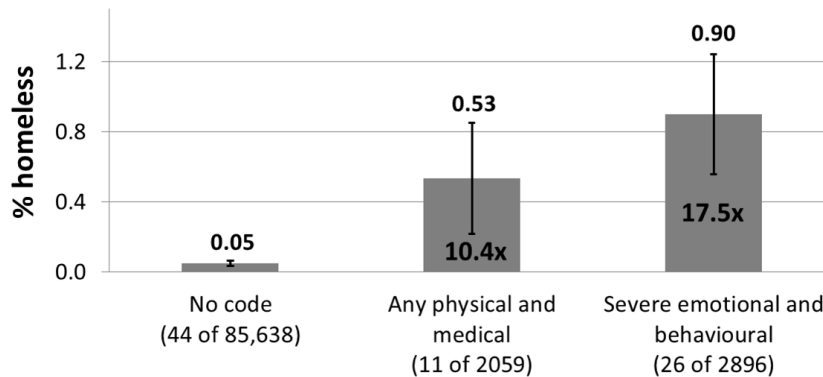


Figure 23. Category of special education code and homelessness post-transition

4-4. Model for homelessness. This model provides a relative risk number for each factor—how much having this factor relates to the risk for youth of being homeless post-transition (Figure 24). For example, a ‘2’ means that youth with this factor have approximately twice the risk for homelessness compared to not having this factor, a ‘0.5’ means half the risk, and a ‘1’ means the same risk. **Note that factors are non-causal.** Details of the analysis are discussed on pages 2-3 and numbers of youth experiencing each factor are in Table 5; page 22.

Results: Youth that had substance use issues, had internalizing behavioural issues (e.g., anxiety, depression), had corrections involvement, received income supports, were involved in child intervention, and were male were more likely to show up as homeless. On the other hand, youth from rural (vs. urban) settings and youth that graduated with a diploma were less likely to be homeless.

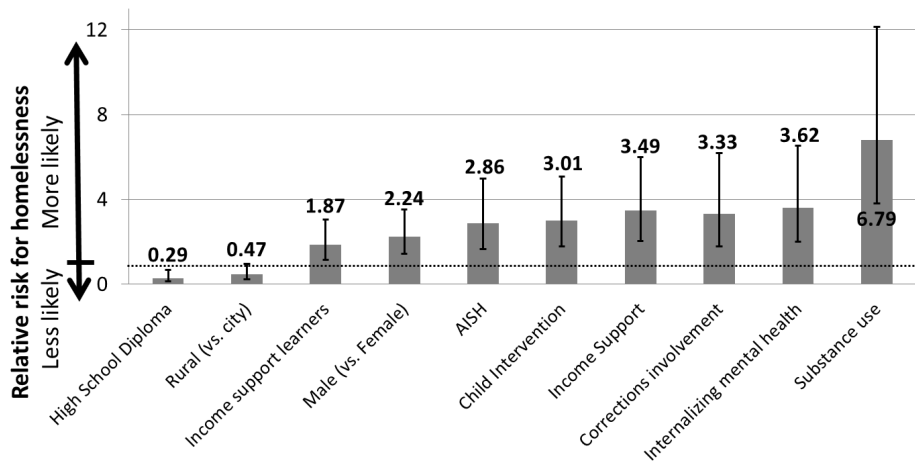


Figure 24. Relative risk, predicting homelessness

Implications: This analysis provides evidence that homelessness is an issue of concern for youth with disabilities. These data confirm that homelessness is associated with mental health and income levels. Transition navigation services might address both of these issues. For example, supporting mental health needs across the transition could reduce homelessness, as youth with severe disabilities also showed a decrease in mental health service use over the transition. A limitation of these data is that they only include youth that were identified in the health care system. Different patterns of homelessness may exist for other youth.

Note: A parallel logistic regression model showed a likelihood ratio of $\chi^2 = 516.96$, $p < .0001$, $a c = .923$, and overall evidence of good model fit. While the above model included all youth due to low homelessness outcome frequencies, a model directed at youth in special education found similar findings. As low outcome frequencies and many factors may lead to overfitting, we also provide outcome frequencies by each factor in Table 5; page 22.

CONCLUSION

These analyses provide evidence of the impact of the child-to-adult transition on youth with disabilities. The findings show a variety of challenges that youth faced in the transition, including: low educational achievement and high support use, a drop in health care visits, a risk for adult corrections involvement, and an increase in homelessness. The results also provide evidence of which youth are at risk for these trajectories based on special education codes, and social, individual and service/program factors. As a key finding, these analyses provide evidence of which supports provide resilience to negative transition outcomes, and which are associated with risks. This provides information on the nuances of how youth with disabilities experience the child-to-adult transition, based on their service and program use trajectories. As another key finding, this report shows that mental health needs are an important issue to address in the transition. Children with mental health needs are less likely to use support programs, are more likely to experience a drop in mental health-related health care services, are more likely to experience corrections involvement, and more likely to become homeless than other youth. We should note that this report does not include all information important to decisions related to the transition, and could benefit from future research to aid decisions, as well as input from stakeholders. Together the evidence provided by this report may be used by policymakers and support providers to inform strategies on transitional supports and planning for youth with disabilities in the transition period.

Transition Considerations

A list of considerations for how to implement support for youth with disabilities across the child-to-adult transition is provided. This list of considerations was created by other researchers through a literature review and focus groups with youth, parents, community members, service providers and policy makers in Ontario in 2009¹⁴. The list is meant to provide thoughts on how to support the transition, but would benefit from further discussion by service providers planning to implement change.

1. *Collaborative initiatives and policies for the transition to adulthood are important.*
 - a. Intersectoral (and interministerial) collaboration and communication is important due to the intersectoral needs of youth with disabilities.
 - b. Funding of services could benefit from collaborative efforts.
2. *Building the capacity of people and communities can enhance the transition process.*
3. *A 'navigator' within communities can facilitate the transition process.*
 - a. Navigators can facilitate the transition process in terms of planning and finding support. In addition, they may have more success by not being set in one ministry as this gives them more freedom to address their client's complex and varying needs.
4. *Information, resources, and services should be accessible to everyone involved.*
 - a. Focus groups envisioned a visible, regularly used, and accessible location for each disability community.
 - b. Information is more accessible if it is from a single point of access across the lifespan.
 - c. It is important that all services disclose information about transition services and their benefits.
 - d. Information can benefit more stakeholders if it is shared across service providers regularly.
 - e. Information should be presented in clear and understandable language to all parties.
5. *Education is an important component of any transition planning strategy.*
 - a. Education has benefits across different types of service providers (e.g., teachers, service providers, etc.)
 - b. Educational materials should be developed for different types of audiences (e.g., youth with disabilities, teachers, health care workers, etc.), as they have different needs and priorities.
6. *Ongoing research and evaluation is important as it provides evidence of what works best.*
 - a. Transition programs can benefit from evaluation to show effectiveness and what they can do to improve.
 - b. Larger, longer term studies can show the real impact of interventions.
 - c. Input from youth with disabilities, their families, and community members can benefit researchers as they know their situation best.
 - d. A variety of research methods should be used: administrative, quality of life, surveys, interviews, etc.



VARIABLE DEFINITIONS

Target comparison group notes

Special education code severity was determined by the presence (or absence) of a mild, moderate, or severe special education code. Category of code was determined by the most severe code for each special education code category (e.g., a code 41 [severe cognitive disability] took precedence over a code 52 [mild cognitive disability]).

Included categories of special education codes are¹⁸:

1. **Cognitive disability** (*mild*: code 51; *moderate*: code 52; *severe*: code 41): demonstrated delays and impairments in cognition that require higher levels of educational support.
2. **Emotional/Behavioural Disability** (*mild*: code 53; *severe*: code 42): displays chronic and pervasive behaviours that interfere with the learning and safety of the student, other students and/or staff.
3. **Learning disability** (*mild*: code 54): a number of disorders that affect the acquisition, organization, retention, understanding or use of verbal or nonverbal information.
4. **Communication disability** (*mild*: code 57): communicates ineffectively with peers and adults due to diagnosed mild to moderate disability in language or speech.
5. **Physical/Medical Disability** (*mild*: code 58; *severe*: code 44): has a diagnosis of a physical disability, specific neurological disorder or medical condition which creates an impact on their ability to function.
6. **Multiple Disability** (*mild*: code 59; *severe*: code 43): has two or more non-associated mild to severe disabilities that, in combination, impair student functioning.

Outcome notes

2 - Health care use: The health care use analysis calculated the sum of visits, divided by the number of years. Neurodevelopment disorder (NDD) visits and mental health (MH) visits were derived from the primary ICD code for visits using Alberta Health databases (Inpatient—Discharge Abstract Database, Ambulatory Care, and Practitioner Payments). NDD visit ICD codes were based on a previous ICD-9 definition¹⁹, with ICD-10 codes derived from this definition, Manitoba ICD code definitions and Canadian ICD code translation documents²⁰⁻²¹, with additional validation by a physician with experience with NDD support. The MH ICD codes included: depression, anxiety, adjustment disorder, conduct disorder, and substance use, and were based on previous Manitoba ICD code definitions²⁰. Mental health service use is a proxy for the presence of a mental health support need; some youth with mental health needs may not have accessed mental health services in Alberta during the year, and some mental health service use may have occurred for youth who did not have mental health needs.

4 - Homelessness: Homelessness was identified by the presence of the homeless ICD code under any diagnosis (ICD-9: V60.0; ICD-10: Z59.0) using the Alberta Health databases (Inpatient—Discharge Abstract Database, Ambulatory Care, and Practitioner Payments).

Variables

- Information on **sex** status was provided for each individual by participating programs. In the case of discrepancies between programs for sex, the most common value for an indicator was chosen. In the event of two or more most common values, the value for the indicator was chosen randomly from the most common values.
- **Socioeconomic Status (SES)** captures the social and material environments in which youth lived. A youth was assigned a socioeconomic status via an index based on the Statistics Canada dissemination area in which he or she resided²². Six indicators were included in the index: percent without a high school diploma, the employment rate, average income, percent of single families, percent of persons living alone, and percent of persons separated, divorced, or widowed. *SES was defined by the average SES, with the bottom 40% of neighborhoods being coded as low SES and the top 60% of neighborhoods being coded as high SES.*

VARIABLE DEFINITIONS (continued)

Variables (continued)

- Postal codes were used to derive **City size** for the youth, with a population of less than 10,000 being classified as rural and a population of 10,000 or more as a city. This definition is based on Statistics Canada definitions²³. *City size was defined as the average city type.*
- Alberta Education defines **English as a Second Language (ESL)** students as, “Children/students who require English as a Second Language program planning and instructional supports to achieve grade level learning expectations and reach their full potential²⁴. Students receiving ESL instruction must demonstrate challenges in English competencies, including reading, writing, speaking, and/or comprehension. In Alberta, ESL learners include students who have immigrated from countries outside of Canada. In addition, they include students who are Canadian-born, but whose first language is not English, such as students of Indigenous or Francophone descent²⁵. *ESL use was defined by at least one year of ESL designation.*
- **High cost health service use** was defined by cost estimates made based on the Canadian Institute for Health Information costs reported for physician visits (general practitioner or specialist), ambulatory care visits (emergency or other ambulatory care), and hospitalizations (by type of service). Estimated costs per visit were summed across all visits for each individual. *High cost health users were those in the top 5% of estimated costs for their age groups and genders for at least one of the years.*
- **Corrections involvement** was defined by the presence of at least one Albertan provincial non-custodial or custodial corrections involvement.
- **NDD health visit** use was defined by the presence of at least one neurodevelopmental disorder health care visit. NDD was defined using the definition described on page 15 under “*Outcome Notes: Analysis 2.*”
- **Internalizing mental health** was defined by the presence of at least one internalizing mental health visit (anxiety, depression, or adjustment disorder). Further details on the health care mental health visit derivations are described on page 15 under “*Outcome Notes: Analysis 2.*”
- **Externalizing mental health** was defined by the presence of at least one externalizing mental health visit (conduct disorder or substance use). Further details on the health care mental health visit derivations are described on page 15 under “*Outcome Notes: Analysis 2.*”
- **Substance use** was defined by the presence of at least one substance use health care visit. Further details on the health care mental health visit derivations are described on page 15 under “*Outcome Notes: Analysis 2.*”
- **High school diploma** was defined by the reception of a credentialed high school diploma in the target time period vs. other reported outcomes by Alberta Education.
- **Child Intervention (CI) services** are focused on meeting the safety and well-being of children, and helping families and communities to meet these needs. The Child Intervention program provides services to children and youth between the ages of 0 and 17 years who are or may be at risk of being abused, neglected or otherwise in need of intervention. Children and youth may be taken into care, or families may receive services while children remain in the home. Young adults (18 to 22 years of age) may also be eligible for post-intervention supports through the use of support and financial assistance agreements to help them transition to adulthood. *CI use was defined by at least one year of use.*
- The **Family Support for Children with Disabilities (FSCD)** program provides a range of supports and services to families of children with disabilities. FSCD works in partnership with eligible families to provide supports and services based on each child and family’s individual assessed needs. Services are meant to help strengthen families’ ability to promote their child’s healthy development and encourage their child’s participation in activities at home and in the community. Participation in the program is voluntary. *FSCD use was defined by at least one year of use.*



VARIABLE DEFINITIONS (continued)

Variables (continued)

- The **Assured Income for the Severely Handicapped (AISH)** program provides financial and health-related assistance to Albertan adults (18 years old or older) who have a severe handicap that is permanent and substantially limits their ability to earn a living. AISH requires that individuals have little income and few assets. In addition, it requires that individuals are pursuing medical treatment, rehabilitation and training to improve their ability to work.
- The **Persons with Developmental Disability (PDD)** program funds a range of programs and services to help adult Albertans (18 years old and older) with developmental disabilities to be part of their communities and live independently. PDD requires that individuals have a significant limitation in intellectual capacity and in adaptive skills.
- **Income Support (IS)** provides financial assistance to individuals (18 years old and older) who are unable to meet their basic needs. IS requires that individuals are unable to pay for their basic needs, have few assets, and less income than the benefit. In addition, individuals must be looking for work, working and not earning enough, or unable to work.
- **Income Support Learners** provides assistance to individuals who are in training (as foundational learning), including basic costs to maintain their household as well as supplemental, health, and training benefits.
- **Post-secondary education** students are individuals (17 years old or older) enrolled in publicly funded universities, public colleges, technical institutes, and non-profit private university colleges in Alberta.

TABLES

Table 1: The demographics and service/program use of youth in the educational outcome and support use, health care use and corrections involvement analyses calculated over the first 4 years of the CYDL data (2005/06 to 2008/09)

	Sex	Number of youth	Percent of youth
	Female	17,267	50.21%
	Male	17,122	49.79
Socioeconomic status (SES)			
	Low SES	15,025	44.68%
	High SES	18,604	55.32%
City size			
	Rural (below 10,000)	8006	23.28%
	City (at least 10,000)	26,383	76.72%
Child Intervention			
	Used	1088	3.16%
	Not used	33,301	96.84%
Family Support for Children with Disabilities (FSCD)			
	Used	392	1.14%
	Not used	33,997	98.86%
Assured Income for the Severely Handicapped (AISH)			
	Used	398	1.16%
	Not used	33,991	98.84%
Persons with Developmental Disabilities (PDD)			
	Used	227	0.66%
	Not used	34,162	99.34%
Income Supports			
	Used	1101	3.20%
	Not used	33,288	96.80%
Income Support Learners			
	Used	1469	4.27%
	Not used	32,920	95.73%
High school diploma			
	Received credentialed diploma	25,613	76.15%
	Did not receive credentialed diploma	8021	23.85%
English as a Second Language (ESL)			
	Used	1043	3.03
	Not used	33,346	96.97
Total Population		34,389	100%

The percentage is the sum of all items in the factor, vertically summed (e.g., the sum of males and females for sex).



TABLES (continued)

Table 2: The number of youth with disabilities by postsecondary use status for factors in the regression model

	<i>Received Postsecondary education</i>	<i>Did not receive postsecondary education</i>
City size		
<i>Rural (below 10,000)</i>	137 (13.34%)	890 (86.66%)
<i>City (at least 10,000)</i>	859 (23.42%)	2809 (76.58%)
Sex		
<i>Female</i>	498 (26.80%)	1360 (73.20%)
<i>Male</i>	498 (17.55%)	2339 (82.45%)
Assured Income for the Severely Handicapped (AISH)		
<i>Used</i>	33 (8.80%)	342 (91.20%)
<i>Not used</i>	963 (22.29%)	3357 (77.71%)
Income Support		
<i>Used</i>	58 (12.89%)	392 (87.11%)
<i>Not used</i>	938 (22.10%)	3307 (77.90%)
High cost health care		
<i>Yes</i>	278 (21.16%)	1036 (78.84%)
<i>No</i>	718 (21.24%)	2663 (78.76%)
Neurodevelopmental disorder (NDD) visit		
<i>Yes</i>	217 (22.63%)	742 (77.37%)
<i>No</i>	779 (20.85%)	2957 (79.15%)
Income Support Learners		
<i>Used</i>	131 (25.00%)	393 (75.00%)
<i>Not used</i>	865 (20.74%)	3306 (79.26%)
Early English as a second language (ESL)		
<i>Yes</i>	48 (32.65%)	99 (67.35%)
<i>No</i>	948 (20.84%)	3600 (79.16%)
High school diploma		
<i>Received credentialed diploma</i>	728 (35.99%)	1295 (64.01%)
<i>Did not receive credentialed diploma</i>	241 (9.76%)	2229 (90.24%)

The percentage of each factor for each postsecondary use status is listed in parenthesis (%) and percentages are summed horizontally for group (e.g., female).

TABLES (continued)

Table 3: The number of youth with disabilities by corrections involvement status for factors in the regression model

Severe special education code	<i>Had corrections involvement</i>	<i>Did not have corrections involvement</i>
<i>Yes</i>	258 (19.85%)	1042 (80.15%)
<i>No</i>	311 (9.16%)	3084 (90.84%)
Sex		
<i>Female</i>	436 (15.37%)	2401 (84.63%)
<i>Male</i>	133 (7.16%)	1725 (92.84%)
Previous corrections involvement		
<i>Yes</i>	234 (41.20%)	334 (58.80%)
<i>No</i>	335 (8.12%)	3792 (91.88%)
Externalizing mental health issue		
<i>Yes</i>	189 (27.84%)	490 (72.16%)
<i>No</i>	380 (9.46%)	3636 (90.54%)
Income Support		
<i>Used</i>	121 (26.89%)	329 (73.11%)
<i>Not used</i>	448 (10.55%)	3797 (89.45%)
Assured Income for the Severely Handicapped (AISH)		
<i>Used</i>	31 (8.27%)	344 (91.73%)
<i>Not used</i>	538 (12.45%)	3782 (87.55%)
Persons with Developmental Disabilities (PDD)		
<i>Used</i>	11 (4.98%)	210 (95.02%)
<i>Not used</i>	558 (12.47%)	3916 (87.53%)
High school diploma		
<i>Received credentialed diploma</i>	75 (3.71%)	1948 (96.29%)
<i>Did not receive credentialed diploma</i>	455 (18.42%)	2015 (81.58%)

The percentage of each factor for each corrections involvement status is listed in parenthesis (%) and percentages are summed horizontally for group (e.g., female).



TABLES (continued)

Table 4: The demographics and service/program use of youth in the homelessness analysis calculated over all 6 years of the CYDL data (2005/06 to 2010/11)

	Sex	Number of youth	Percent of youth
	Female	50,557	49.88%
	Male	50,804	50.12%
Socioeconomic status (SES)			
	Low SES	43,862	44.15%
	High SES	55,491	55.85%
City size			
	Rural (below 10,000)	22,438	22.14%
	City (at least 10,000)	78,923	77.86%
Child Intervention			
	Used	4019	3.97%
	Not used	97,342	96.03%
Family Support for Children with Disabilities (FSCD)			
	Used	1372	1.35%
	Not used	99,989	98.65%
Assured Income for the Severely Handicapped (AISH)			
	Used	1671	1.65%
	Not used	99,690	98.35%
Persons with Developmental Disabilities (PDD)			
	Used	856	0.84%
	Not used	100,505	99.16%
Income Supports			
	Used	4782	4.72%
	Not used	96,579	95.28%
Income Support Learners			
	Used	6205	6.12%
	Not used	95,156	93.88%
High school diploma			
	Received credentialed diploma	75,186	76.21%
	Did not receive credentialed diploma	23,473	23.79%
English as a Second Language (ESL)			
	Used	3970	3.92%
	Not used	97,391	96.08%
Total Population		101,361	100%

The percentage is the sum of all items in the factor, vertically summed (e.g., the sum of males and females for sex).

TABLES (continued)

Table 5: The number of youth by homeless status for factors in the regression model

	<i>Homeless</i>	<i>Not homeless</i>
High school diploma		
<i>Received credentialed diploma</i>	<i>supressed</i>	<i>supressed</i>
<i>Did not receive credentialed diploma</i>	<i>supressed</i>	<i>supressed</i>
City size		
<i>Rural (below 10,000)</i>	12 (0.05%)	22,426 (99.95%)
<i>City (at least 10,000)</i>	81 (.10%)	78,842 (99.90%)
Income Support Learners		
<i>Used</i>	35 (.56%)	6170 (99.44%)
<i>Not used</i>	58 (.06%)	95,098 (99.94%)
Sex		
<i>Female</i>	34 (.07%)	50,523 (99.93%)
<i>Male</i>	59 (.12%)	50,745 (99.88%)
Assured Income for the Severely Handicapped (AISH)		
<i>Used</i>	19 (1.14%)	1652 (98.86%)
<i>Not used</i>	74 (.07%)	99,616 (99.93%)
Child Intervention		
<i>Used</i>	55 (1.37%)	3964 (98.63%)
<i>Not used</i>	38 (.04%)	97,304 (99.96%)
Income Support		
<i>Used</i>	56 (1.17%)	4726 (98.83%)
<i>Not used</i>	37 (0.04%)	96,542 (99.96%)
Corrections involvement		
<i>Yes</i>	73 (.69%)	10,534 (99.31%)
<i>No</i>	20 (.02%)	90,734 (99.98%)
Internalizing mental heal issue		
<i>Yes</i>	75 (.35%)	21,497 (99.65%)
<i>No</i>	18 (.02%)	79,771 (99.98%)
Substance use issue		
<i>Yes</i>	72 (.98%)	7304 (99.02%)
<i>No</i>	21 (.02%)	93,964 (99.98%)

The percentage of each factor for each homeless status is listed in parenthesis (%) and percentages are summed horizontally for group (e.g., female).



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THE CHILD AND YOUTH DATA LABORATORY

The **Child and Youth Data Laboratory's** (CYDL's) Longitudinal Project (Experiences of Albertan Children and Youth over Time, 2005/06 to 2009/10/11) is a joint initiative between PolicyWise for Children & Families and participating ministries in the Government of Alberta. The mandate of the CYDL is to link and analyze administrative data from Government ministries, to provide evidence for policy and program development.

The CYDL is managed by **PolicyWise for Children & Families**. PolicyWise is a not-for-profit organization whose mission is to develop and integrate evidence to inform, identify and promote effective public policy and service delivery to improve the well-being of children, families and communities in Alberta, Canada and internationally.

THIS PROJECT

The CYDL Longitudinal Project focuses on understanding the experiences of Albertan children and youth as they develop. The focus is service use within and across ministries, as it is related to key indicators and to the passage of time. Studying experiences over several years of development adds a valuable level of richness to an already ground-breaking initiative, providing detailed insight into the factors that help to shape our children and youth as they develop.

SUGGESTED CITATION

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Children's Services
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Community and Social Services
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