

## ***Student Transition Readiness Tool***

### **What is the goal of the tool/resource?**

To assess youths' readiness skills to transition to adult behavioral health care by engaging youth to set behavioral health priorities, address self-care skill needs to prepare them for adult behavioral health care after high school and prepare them to independently access behavioral health and wellness services.

### **Who is the audience?**

The tool can be used with any student beginning at age 14-16 and can continue to be used through high school. This is especially useful for juniors and seniors as they plan their transition from high school.

### **Who should facilitate this tool/resource?**

Someone who has an ongoing, trusted relationship with a student and has behavioral health knowledge and the ability to refer to behavioral health services, if needed. This can include school mental health providers, school-based health center staff, school psychologists, professional school counselors, and school social workers.

### **How should the staff team member facilitate this tool/resource?**

This tool can be offered annually to identify and discuss with students their behavioral health needs and knowledge of health and wellness services. This can be conducted via virtual or in-person meetings. Students can complete the tool independently or together with the facilitator. The facilitator can offer education and resources on needed skills identified through the tool. This tool can be used along with the "Post-Graduation Wellness Plan" and the "Resource to Find Medical or Mental Health Services" tool.

If the student reports being a danger to themselves or others, or reports a history of neglect/abuse, or expresses emotional/behavioral distress, appropriate reports and referrals should be made according to school and professional guidelines.

# Student Transition Readiness Tool

Directions: Please fill out this form to help us see what you already know about your mental health and how to continue caring for your mental health after high school.

Preferred Name: \_\_\_\_\_

Pronouns: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date Completed: \_\_\_\_\_

**On a scale of 0 to 10, please check the number that best describes how you feel now.**

How likely are you to want to continue therapy or counseling after high school?

0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10  
not \_\_\_\_\_ very

How confident are you in your ability to find therapy or counseling after high school?

0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10  
not \_\_\_\_\_ very

**MY MENTAL HEALTH** *Please check the box that applies to you now.*

	NO	I WANT TO LEARN	YES
I have concerns about my mental health.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I can name my learning differences, disability, medical, or mental health diagnosis (examples: asthma, diabetes, ADHD, anxiety, depression).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I can explain my learning differences, disability, medical, or mental health needs and symptoms to others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have someone I can talk to if I have a problem.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know what helps my mental health needs and symptoms.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know what stresses me out and how to avoid or cope with it.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know signs of when I am going into crisis.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know what to do in case I am in crisis.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**ACCESSING MENTAL HEALTH SERVICES** *Please check the box that applies to you now.*

	NO	I WANT TO LEARN	YES
I know how to connect with mental health services at school if needed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know how to connect with mental health services in the community if needed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know how to make my own therapy or counseling appointments.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have a way to get myself to my therapy or counseling appointments.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know who to call for help if my therapist's or counselor's office is closed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know that when I turn 18, my parent/caregiver will not have access to my health records, unless I allow it.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know when I need to get my own health insurance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know how to find information to sign up for health insurance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I carry or have a photo of important health information with me every day (insurance card, emergency contact information, medication(s) list).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have a pediatrician or other primary care provider.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know or can find the number of my pediatrician or other primary care provider.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**If you take psychiatric medication, please continue.**

**PSYCHIATRIC MEDICATION** *Please check the box that applies to you now.*

	NO	I WANT TO LEARN	YES
I know the name(s) of my medication(s).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know why I take medication.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know when to take my medication each day.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know how to refill my medication.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know the possible side effects of my medication.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>