# An Overview of Quality Programs that Support Transition-Aged Youth

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**Abstract:** This article provides a concise overview of several programs that deliver services to transition-aged youth, ages 14–29. Included are family support, the Assisting Unaccompanied Children and Youth program, the Substance Abuse and Mental Health Services Administration services, the wraparound approach, intensive home-based treatment, multisystemic therapy, foster care, independent living, mentoring, the Steps to Success program, the Jump on Board for Success program, the Options program, the Positive Action program, the Transition to Success model, and the Transition to Independence Program. Primary focus is placed upon the usefulness of each of the programs in facilitating successful outcomes for transition-aged youth.

# Introduction

Provision of services to transition-aged youth can be a daunting task. Research indicates that sixty percent of this vulnerable population is currently unable to work, live independently, and enjoy a reasonable quality of life (Hagner, Cheney, & Malloy, 1999). Much has been written about various supports that address the needs of transition-aged youth, ages 14–29 (Bruns & Osher, 2004; Clark, Pschorr, Wells, Curtis, & Tighe, 2004; Coatsworth, Santisteban, McBride, & Szapocznik, 2001; Collins, 2001; Davis, 2004; Fetzer, Garner, Shepler, Thom, & Firesheets 2008; Henggeler, 1999; Huey et al., 2004; Helsen, Vollebergh, & Meeus, 2000; Julianelle, 2007; Karpur, Clark, Caproni, & Sterner, 2005; Keller, 2005; Koroloff, Pullmann, & Gordon, 2007). Different programs emphasize distinct dimensions of the lives of youths. Several of these programs will be briefly discussed in this article. The importance of these supports, including family support, Assisting Unaccompanied Children and Youth programs, and Substance Abuse and Mental Health Services Administration (SAMHSA) programs, will be described for their significant contributions to transition-aged youth. Other notable programs that focus on helping youths include high fidelity wraparound, intensive home-based treatment (IHBT), multisystemic therapy (MST), the Foster Care program, Independent Living, and mentoring. The next four programs will be described because of their similarities to the Transition to Independence (TIP) model: the Steps to Success program, Jump on Board for Success (JOBS), the Options program, and the Positive Action program. Last, will be a description of the TIP model, an innovative program that emphasizes inter-agency collaboration to maximize resources and client-directed goals, thus enhancing outcomes due to ownership. These programs were selected for this review based on their potential for evidence-based data and positive outcomes for youths as referenced by Clark and Unruh (2009).

## Family Support

Family support is extremely crucial to young people. The strength and depth of family support and the amount of time spent with family helps design the guiding blueprint for interpersonal relationship patterns beginning at infancy and continuing throughout life. Even when relationships with family members are not positive, and even when those relationships are detrimental to the youths' development, family presence has a lasting influence upon the self-esteem of the youths. Adolescents who received adequate parental support tend to develop meaningful and supportive peer groups that facilitate navigation through the transitional years (Dekovic & Meeus, 1997; Helsen et al., 2000; Laible, Carlo, & Raffaelli, 2000). According to Lipschitz-Elhawi and Itzhaky (2005), whereas peer support did not significantly influence youths' adjustment processes, family support had positive correlations with personal and academic success. Family support helped to ease personal stressors and adjustments, and bolster academic performance (Noack & Puschner, 1999; Sandler, Miller, Short, & Wolchik, 1989).

Multiple studies have shown that there is a significant relationship between family support and a young person's capacity to adjust to the demands of life (Barrera & Li, 1996; Colarossi & Eccles, 2003; Sartor & Youniss, 2002). McCarty, Vander Stoep, Kuo, and McCauley (2006) indicated that youths who lacked parental support were susceptible to clinical depression, especially during stressful events. On the other hand, youths who had positive interactions and support from their family members were less susceptible to clinical depression over time (Reinherz et al., 1993; Stice, Ragan, & Randall, 2004). Relative to gender, girls who lacked strong family

connections appeared more likely to become depressed during stressful events when compared to boys (Eccles, Early, Fraser, Belansky, & McCarthy, 1997).

## Assisting Unaccompanied Children and Youth

Many programs have been developed to assist transitional-aged youths who have mental illnesses and substance abuse disorders as they cope with the demands of young adulthood; among these is the Assisting Unaccompanied Children and Youth program. As described by Julianelle (2007), this program emphasizes youth-friendly approaches through listening and building trust, talking about goals and interests, and engaging young people in school-based activities. The program consists of an interagency task force with representatives from the school district, social services, youth shelters, and other key community-based leaders who are responsible for reviewing and revising service delivery models and policies in their communities. One of the primary purposes of the Assisting Unaccompanied Children and Youth program is to establish a centralized approach to assist youth through the implementation of common procedures, clear articulation of purpose, and interconnectedness among the agencies and institutions that serve them (Julianelle, 2007).

## Substance Abuse and Mental Health Services Administration (SAMHSA)

The Substance Abuse and Mental Health Services Administration (SAMHSA; 2008) utilizes a care model that builds partnerships with schools and other child-service agencies; collectively, this system of care is centered on identifying and servicing the mental health and substance abuse prevention and treatment service needs of youths. The most common origins of referrals for youth who need more extensive and intensive community-based services are schools (25 percent) and mental health agencies in communities (21 percent). The program recognizes the importance of family, schools, and community in promoting the potential of all children and youths, regardless of the severity or the depth of their social needs (SAMHSA; 2008).

## High Fidelity Wraparound

The theoretical underpinnings of the wraparound approach is based on the premise that individualized services that utilize family-centered, youth-focused interventions, and professional involvement reflect the best option for addressing the specific and complex needs of children and youths. A shift toward community-based interventions for youths is the result of observations that children and youths removed from their home environments and placed in institutions for treatment eventually returned to their homes and communities. In their natural environments, young people struggled to adapt the new thinking and behaviors to family and community demands, and, as a rule, the gains that occurred in the controlled institutionalized settings could not be maintained (Bruns & Osher, 2004).

A basic assumption of the high fidelity wraparound model is that home-based interventions are cost-effective and less disruptive for youth and family members. Treatment plans that are implemented within the youths' home environments and communities have a better likelihood of being maintained by all of the key players, including the parents and other family members (Bruns, Suter, Force, & Burchard, 2005). At the same time, the youth's quality of life, and learning objectives that are associated with independent living can be addressed realistically. Tenure in the family and the community are more likely to become a reality as others in the environment learn how to assist the youths during the important transitional years (Burns, Schoenwald, Burchard, Faw, & Santos, 2000; Stroul & Friedman, 1994).

In a study conducted by Ogles et al. (2006), youths (n=72) were placed in wraparound services at the initial phase of their treatment. Over a nine-month period, data revealed positive changes as measured by shifts toward health in relation to the previous degrees of severity of their problems. Significant improvement was observed in overall daily functioning, the frequency of targeted complaints, and an increased number of self-reports about individual goal attainment.

Toffalo (2000) found that youths who participated in a wraparound treatment program showed improvement in targeted behaviors such as aggression, bullying, activities of daily living, financial management, and job attainment and maintenance. Similarly, Bickman, Smith, Lambert, and Andrade (2003) found that both wraparound services and intensive treatment produced improved functioning and decreased problems among youths in community-based treatment programs. Carney and Buttell (2003) analyzed data from the Juvenile Delinquency Task Force Implementation Committee, a group that was created to address the programmatic needs of 370 delinquent youths in Columbus, Ohio. Importantly, when compared to youths (n=68) who received conventional services that were offered by the juvenile court system in the county, a significantly greater number of youths who received wraparound services did not miss school, were not expelled or suspended from school, did not run away from home, and were not involved with law enforcement for conduct-related behaviors (2003). The findings empirically supported the hypothesis that youths who received wraparound services were less likely to engage in at-risk and delinquent behaviors.

### Intensive Home-Based Treatment (IHBT)
Intensive Home-Based Treatment requires a family therapeutic approach that builds an alliance with each family member with the ultimate goal of providing an environment that fosters mental health for families of transition aged youth. Based upon family system theories, IHBT emphasizes the interaction patterns among family members who, along with the youths, are expected to participate in therapy, which can occur in the home, an office, or some other setting (Coatsworth et al., 2001).

Several randomized controlled trials of family therapy have shown the effectiveness of the IHBT approach for engaging and retaining youths and families in treatment, as well as achieving improved outcomes for the youths and their families (Cunningham & Henggeler, 1999; Liddle et al., 2001; Waldron, 1997). Thompson, Bender, Lantry, and Flynn (2007) studied nineteen families involved in twelve sessions of strength-based family therapy delivered in their individual homes. Their findings supported previous research, which suggested a strong therapeutic alliance between the therapist and family members significantly predicts positive outcomes for all of the members (Shelef, Diamond, Diamond, & Liddle, 2005).

Lietz (2009) showed that intensive in-home services played an important role in child welfare programs. His research assessed the effectiveness of IHBT and examined whether families perceived that they were stronger and more self-sufficient after their involvement with the intervention. The study results revealed that the majority of the families (75 percent) felt stronger and more self-sufficient after participating in the IHBT.

### Multisystemic Therapy (MST)
The broad theoretical basis for multisystemic therapy (MST; Henggeler, 1999) is grounded in the premise of social ecology and family therapy. Bronfenbrenner's (1979) social ecology concept helps to define individual behaviors by internal factors (biological and psychological), as

well as by interactions with environmental factors (including family, peers, school, community, and cultural ethnic and racial forces). Certain parenting factors, such as harsh and inconsistent limit setting, can put youths at risk for developing behavioral problems. In such instances, the approach to parenting is addressed in an intensive, short-term home-based intervention that is led by a skillful therapist. Other needed mental health services are provided to youths and family members within the home or in the community. Referrals, as needed, for the family are orchestrated by the therapist with assistance from family members (Henggeler, Schoenwald, Pickrel, Rowland, & Santos, 1994).

Multisystemic therapy has produced favorable outcomes with adolescents who are violent and substance-abusing or drug-dependent (Henggeler & Borduin, 1990; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998). Therapists involved in MST should have low caseloads in order that they may remain available to clients twenty-four hours a day, seven days a week. They use an approach that combines problem-solving and strength-building treatment strategies that are family focused. Some of the therapeutic interventions that are frequently used in MST include traditional family therapy, behavioral parent training, and cognitive-behavioral therapy (Henggeler, 1999; Huey et al., 2004).

Following multiple study reviews, Randall and Cunningham (2003) concluded that MST was an effective form of treatment. In a study by Henggeler, Melton, and Smith (1992) with chronic juvenile offenders (n=84), MST decreased the incarceration rate by 46 percent. Schoenwald, Ward, Henggeler, Pickrel, and Patel (1996), in their study of MST with juvenile offenders (n=118) reported a decrease in the total days of out-of-home placement by 50 percent at six months post-treatment. Additionally, Brown, Henggeler, Schoenwald, Brondino, and Pickrel (1999) observed that MST increased attendance in regular school settings.

## Foster Care

Some youths are placed in foster care because they experience physical, emotional, and/or sexual abuse. Foster homes have been established as a refuge for youths who need protection until more permanent housing placement becomes available. Despite its stated mission to protect children and youths from maltreatment and neglect, and despite all positive efforts and intentions, abusive or other traumatic events sometimes occur in the foster system (Collins, 2001; Courtney & Heuring, 2005; Courtney, Piliavin, Grogan-Kaylor, & Nesmith, 2001).

According to the Adoption and Foster Care Analysis and Reporting System in 2013 (US Department of Health and Human Services, 2014), across the nation, approximately 238,000 youths exited the foster care system; nineteen percent were between 16 and 20 years of age. Emancipation, for better or for worse, was the outcome for 19,499, or five percent of youths (2014). It has been hypothesized that some of these youths may have become homeless. Homeless young adults with a history of foster care services during their formative years are at greater risk for mental health and addiction problems than homeless young adults with no experience with foster care (Lenz-Rashid, 2006). Similarly, Unrau and Grinnell (2005) reported that at-risk youths with a history of out-of-home care experiences were more likely to manifest physical and mental health problems when compared to youths with no history of out-of-home care. To add to the complexities, young adults transitioning from foster care are less likely to graduate from high school, which could comprise their opportunities for further education and skills acquisition (Courtney & Dworsky, 2006). Given the realities, it is not surprising that young

adults with a history of foster care placement are less apt to earn a four-year college degree (Pecora, Kessler et al., 2006; Pecora, Williams et al., 2006).

Maladaptive behavior problems have been consistently linked to an increased probability of out-of-home placement, which involves the possibility of more restrictiveness placement, and involves the likelihood of institutional placement (Barth et al., 2007; James, Landsverk, & Slyman, 2004; James et al., 2006; Reid et al., 2000). A study by Farmer, Mustillo, Burns, and Holden (2008) of youths (n=3,066) with mental health disorders who were initially involved in family-centered and individualized treatment showed that those whose behavior problems eventually led to placement out of their homes fared poorly in comparison to those who were able to continue with less restrictive family- and individual-based treatment. The results reported by Farmer et al. (2008) supported previous studies that posited that older youth; boys, in particular, experienced increased numbers of institutional placements (James et al., 2004; Walrath & Liao, 2005). Youths who have experienced more frequent out-of-home placements tended to be at greater risk for incarceration (Jonson-Reid & Barth, 2000).

Sheppard and Benjamin-Coleman (2001), in their review of placements for 2,803 Black and White youths who had been receiving services from a community mental health system, found that Black youths were more likely to be placed in correctional facilities and foster care, while White youths were more likely to be hospitalized. Consequently, White youths were anticipated to have increased opportunity to receive mental health treatment. The authors did note that one limitation of the study was the inability to assess and evaluate the severity of the presenting problems that might have been a factor in decision-making. Schneider et al. (2009) reported on a group of 368 California women, 18 years of age and older, with a history of out-of-home placement; a large proportion experienced mental health problems, reported poor health, smoked, was obese, had low educational attainment, was living in poverty, and had an increased use of public assistance during their adult years.

### Independent Living
In order for transitional-aged youths to develop meaningful roles in the community, Davis (2004) reported the importance of independent living along with other supports. In 1999, the U.S. Government Accountability Office (2008) surveyed independent living placement coordinators in all fifty states and the District of Columbia. The findings suggested that most services that were offered consisted of teaching older adolescent foster youths' basic skills that were associated with self-sufficiency and money management, job readiness and retention, housekeeping, and nutrition. Such content was essential, but not sufficient.

Transitional-aged youths, whether in or out of the foster care system, tend to face a 'transitional cliff' when they outgrow the system and are confronted with the challenges of learning how to survive and cope in a mental health system that has been designed to serve adults (National Collaborative, 2009). Transition can occur for youths at any time between 14 and 29 years of age (Clark, Deschênes, & Jones, 2000), a period in their lives that already places intense demands upon time, thinking, and energy. Young adults who remain unmarried and do not live with their parents are more prone to substance use than those who are married or who live with their parents (Bachman, O'Malley, & Johnston, 1984; Schulenberg, O'Malley, Bachman, & Johnston, 2000). According to Munson and McMillen (2006), transitional-aged youths who are maturing out of the foster care system often experience strong feelings of grief and loss when faced with the abrupt cessation of services and the termination of bonds with

familiar service personnel. Freundlich and Avery (2006) interviewed two groups; individuals 18 to 25 years of age (n=21) who had been transitioned out of the foster care system for up to five years and professional stakeholders (n=5) who were involved in serving the needs of youth. The young adults and the professionals concurred that the youths had experienced very poor preparation for life after foster care had ended. However, some of the young adults who had received educational and job training while in foster care expressed satisfaction with their preparation (2006).

Fetzer, Garner, Shepler, Thom, and Firesheets (2008) observed that the Ohio Independent Living Association expressed concern over the lack of supportive housing options for this population, as housing was a significant barrier to transitional-aged youths, especially if they were moving from foster care, residential treatment, or a family home. White, Havlicek, O'Brien, and Pecora (2005) reiterated the importance of providing affordable housing to transitional-aged youths upon departure from the juvenile justice system or the foster care system. Woolsey and Katz-Leavy (2008) assessed several transitional-aged programs, including the Village Integrated Service Agency's Transitional Age Youth program in Long Beach, CA; Options in Vancouver, WA; Our Town Integrated Service Agency in Indianapolis, IN; the Transitional Community Treatment Team in Columbus, OH; and Youth Source in Renton, WA. Their investigations revealed that most of the transitional-aged youths were in a state of near-homelessness at each of the five sites examined (2008). Consistent with Fetzer et al. (2008) and White, Hanlicek, O'Brien, and Pecora (2005), Woolsey and Katz-Leavy (2008) showed similar findings, which cut across all of their studied programs, demonstrating that none of the programs provided suitable, safe, and affordable transitional housing. Each of these research studies raised major concerns over the lack of appropriate supportive housing for transition-aged youth.

## Mentoring

Hair, Jager, and Garrett (2002) posited that adolescence is an important period of self-determination during which healthy development can be fostered by the establishment and the maintenance of quality relationships with healthy adults who are able to mentor the youths during the transition into adulthood. Successful mentoring influences the development of youths by enhancing social skills and emotional well-being, improving cognitive abilities, and advocating positive identity development. The primary method of mentoring programs incorporates pairing a caring, non-parental adult with an underprivileged or needy young person (Keller, 2005; Rhodes, 2002). Mutual trust, understanding, respect, and amiable rapport are essential features in a successful mentor-youth relationship (Rhodes, 2002; 2005).

Spencer (2006) concurred that for a successful mentoring relationship to develop, grounding in authenticity, empathy, companionship, and collaboration were required. Grossman and Tierney (1998) found that the Big Brother/Big Sister program, which provides mentoring for children aged 6-18, resulted in 46 percent less illicit drug use, 27 percent less alcohol use, and 52 percent less school truancy. Multiple studies have verified that mentoring programs can positively affect a young person's competencies in the areas of school-based functioning (McPartland & Nettles, 1991; Slicker & Palmer, 1993; Zimmerman, Bingenheimer, & Notaro, 2002), extra-familial relationships, familial relationships (Grossman & Tierney, 1998), and life skills (Taylor, LoSiuto, Fox, Hilbert, & Sonkowsky, 1999). These outcomes, though impressive, serve to highlight the urgent need for developing similar mentoring programs for transition-aged youth. Freundlich and Avery (2006) recommended that state mental health authority

groups appoint a dedicated mentor to all youths who are transitioning out of foster care and into the adult system of care. Mentors could be family member, a friend, or a caring adult who would agree to make a long-term-commitment to the young person, and be available to assist him/her in daily decision-making. Mentoring activities should include preserving and strengthening the youth's psychological health, assisting with attaining successful academic performance at school, and helping them to understand the key elements that are associated with success in marriage, family, and community relationships.

## Steps to Success

Karpur, Clark, Caproni, and Sterner (2005) reviewed the Steps to Success (STS) program. This program was originally designed to serve youths K–3 who had been identified as at risk for the development of aggressive and antisocial mannerisms and in need behavior management. It utilized collaboration among student, teacher, classmates, and caregivers, and rewarded improvement in behavior. Once identified, a behavioral specialist worked with the identified child implementing classroom interventions, identifying inappropriate behaviors while encouraging appropriate behaviors which, in turn, were supported by peers and teachers. Parent/caregiver training was encouraged to support the child's communication, cooperation, limit setting, problem solving, friendship making, and confidence development. The three STS core concepts of screening, classroom intervention, and parent training are intertwined so as to feed off each success and failure, a feedback loop that continues until appropriate behaviors/mannerisms are maintained both at home and at school (US Department of Education, 2012).

Sixty-eight students participated in the program from 1997 to 2002 (Karpur, Clark, Caproni, & Sterner, 2005). Starting in 1997, using the emotional-behavioral disturbance (EBD) classification system, the effectiveness of the STS program was assessed by comparing outcomes for the group that had participated in STS in elementary school with the Miami-Dade program for youth. The post-secondary education involvement in the STS group was statistically significantly higher than that of the EBD-matched Miami-Dade comparison group. In addition, the STS participants had significantly fewer incarcerations than did the EBD-matched Miami-Dade comparison participants (2005). Based on these outcomes, the STS program became the inspiration and cornerstone for the TIP program, which involves communication among entities that work for the benefit of youths (Clark & Unruh, 2009).

## Jump on Board for Success (JOBS)

The Jump on Board for Success (JOBS) program is an interagency collaboration of education, corrections, vocational rehabilitation, and mental health agencies. Individuals with moderate to severe emotional disorders are eligible for admission to the JOBS program through age 20; services are offered up to age 22. Clark, Pschorr, Wells, Curtis, and Tighe (2004) reported that the JOBS program in Washington County, Vermont also pioneered some aspects of the TIP model. The effectiveness of the program was evaluated by first conducting a pre-post evaluation with 80 participants who graduated from the JOBS program between 1994 and 2001. The average age at entry was 18 and the subjects received approximately 7.6 hours of services per month. The participants showed positive increases in high school graduation rates or GED attainment. There was also an improvement in their work histories. In addition, there were significant decreases in the incidences of homelessness, residential treatments, intensive mental health treatments, welfare supports, and corrections involvements (2004).

### Options Program

Another program that offers comprehensive support and that has some elements that are embedded in the TIP model is the Options program, which was evaluated by Koroloff, Pullmann, and Gordon (2007). This program, located in Clark County, WA, had some interesting features in that the specific focus included individuals at risk for out-of-home placement who had a DSM- IV diagnosable mental health illness. At the time of intake, the subjects' ages ranged from 14 to 21. They could continue in the program until age 25, at which time they would be discharged from the services. During the initial nine months of treatment, the participants were able to utilize community-based services from within the four domains of housing, employment, education, and criminal justice prevention, if needed. Each participant received approximately 99 hours of service during the initial period. About half of the youths showed consistently positive outcomes in the four domains studied. Education attainment showed the most consistent gains; however, the largest improvement was reported as a decrease in the incidences of arrest and involvement with the criminal justice system. Koroloff et al. (2007) noted that the youths tended to have multiple and unique needs, and that their functioning and progress were not standardized. Instead, the individual and special needs of each of the youths were attended to in a systematic and careful manner.

In their observations, Woolsey and Katz-Leavy (2008) noted that the Clark County Options program of Washington State encouraged a systems-approach that helped youths and their families to move from isolation to connection. They reported the program promoted positive youth development through the strengthening of the youth-adult relationships and the development of a seamless system of care supporting transitional-aged youths with serious emotional disturbances.

### Positive Action Program

According to Flay and Allred (2003), another system that teaches youths through motivation and skills mastery is the Positive Action program. The approach in the program is based around the philosophy of feeling good about oneself and learning to think and act in positive ways in all settings. A basic premise of the program was that positive thoughts lead to positive actions; consequently, positive actions lead to additional positive feelings, which create more positive thoughts and actions. Over time, the positive thoughts and feelings help transform the youth into manifesting more positive and useful behaviors and actions. The outcome is expected to help youths to live in communities as productive citizens.

### Transition to Independence (TIP) Model

Fetzer et al. (2008) observed that transitional-aged youths and their families should be considered equal partners in planning and implementing mental health treatment programs. As youths enter their transitional years, they need to be afforded greater control over their own individualized treatment plans and life goals. The Transition to Success (TIP) model emphasizes basic essentials, which may be defined as physical, environmental, social, economic, and clinical care dimensions. Included in the model are activities such as cooking, cleaning, balancing a checkbook, positive social support (Davis, 2004), employment, adequate housing, medication self-management, and other activities.

The TIP model is grounded in seven guidelines that drive the practice-level model program (Clark, Deschênes, & Jones, 2000):

1. Engaging young people through relationship development, person-centered planning, and a focus on their future;
2. Servicing and supporting youths through strengthening age-appropriate, non-stigmatizing, and appealing transitional-aged programs that are built on the youths' strengths and which foster goal achievements across all transition domains (employment/career, educational opportunities, and living situations);
3. Acknowledging and developing the concepts of personal choice and social responsibility;
4. Ensuring a safety net of support by involving the young person's parents, family members, and other informal and formal key players as supporters and advocates;
5. Enhancing the competencies of youths to assist them in achieving greater self-sufficiency and self-confidence;
6. Maintaining an outcome focus in the TIP system across the three domains of employment/career, educational opportunities, and living situation; and,
7. Involving the parents of youths, and other community partners in the TIP system at the practice, program, and community levels.

## Summary

Specifics about the programs that have been reviewed in this article provide insight into the universal and the particular therapeutic features each contributes to the success of transition-aged youth. The overlapping and linking themes that permeate these programs include emphasizing interagency collaboration, involving community-based agents and agencies, including families and youths in collaborative and respectful decision-making regarding their care, focusing on the strengths and potential of youths, and stressing culturally and developmentally appropriate services for the youth and family (Fetzer et al., 2008). Finally, healthcare providers are closely and intensely involved in these programs as a major component of the healthcare team. Collaboration and continuous communication are key elements necessary for the success of each of the program goals and objectives.

The over-riding common denominator among most youth-focused programs is social support. The defining attribute of social support develops from interpersonal relationships protecting individuals from the damaging results of stressful situations (Jackson, 1992; Seidman et al., 1999). Whether in the form of a biological parent, mentor, therapist, or foster parent, transitional-aged youths need proper guidance and appropriate models to mimic positive behaviors and help them navigate through the complexities of life.

## Implications

The existence of a variety of programs aimed at provided services to transition-aged youth belies the recognition by service providers of the value of tailoring services to the needs of individuals. Scanning through the services outlined in this article, which is by no means all-inclusive, provides insight into potential programs which target particular needs. Some programs are designed to fulfill specific purposes that are well-defined, while others have as their focus the provision of services that are specifically tailored to the individual needs of each client. Communities vary in the ability to access needed services. In the interests of sustainability and development of programs that influence the behavioral health of transition-aged youth, the following are some areas that deserve attention:

1. Advancement of studies that survey the existing need in communities nationwide for improved programs that serve transition-aged youth.
2. Refinement of tools to assess the specific strengths and deficits in existing programs.
3. Centralized and universal access to the results of such program assessments, thus facilitating decision-making for youths, their families, and their providers, as well as policymakers, stakeholders and the public.
4. Refinement of tools to assess the strengths and needs of clients for the purpose of matching youths to the most appropriate and beneficial service providers.

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